



Stage 1 and Stage 2

version 1.2

CREDIBLE
Behavioral Health Software

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Introduction

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

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

This guide is for Credible Partners that have eligible professionals (EPs) pursuing meaningful use incentive payments through the Medicare or Medicaid EHR Incentive Programs. It provides the information necessary to use Credible in a meaningful way and capture the data needed for attestation. Credible Behavioral Health v.9.1 successfully passed the meaningful use certification criteria for ONC HIT 2014 Edition certification.¹



Notes:

- The Centers for Medicare & Medicaid Services (CMS) released a final rule that grants flexibility to providers who are unable to fully implement 2014 Edition Certified EHR Technology (CEHRT) for an EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability. For more information, go to http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html.
- For the Medicaid EHR Incentive Program, providers can receive an incentive payment for adopting, implementing, or upgrading EHR technology in the first year – they are not required to report on any of the meaningful use measures. In the remaining years, providers must demonstrate meaningful use to receive incentive payments.



¹ Certification Year: 2014 | Certifying Body: ICSA Labs | CHPL Product Number: 140216R00 | Product Classification: Complete EHR | Practice Type: Ambulatory
Additional Software Required: Direct Project, First DataBank, Greyware Domain Time II, MedlinePlus, Surescripts. ICSA Labs is an ONC-Authorized Certification Body that is accredited to both test and certify Electronic Health Record (EHR) technology for the Office of National Coordinator's Health IT Certification Program.

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. Go to the Certified Health IT Product List on the ONC website: <http://oncchpl.force.com/ehrcert?q=chpl>.
2. Click the appropriate Edition button.
3. Follow the instructions provided.

Resources

For introductory information on the Medicare and Medicaid EHR Incentive Programs, refer to Getting Started webpage on CMS.gov: http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Getting_Started.html.

The Stage 1 objectives, measures, exclusions, certification criteria, and attestation information in this guide are based on the Eligible Professional 2014 Definition specification (spec) sheets. Refer to the spec sheets for definition of terms and additional information; the [Eligible Professional Meaningful Use Table of Contents Core and Menu Set Objectives](#) document² has a link to each spec sheet.

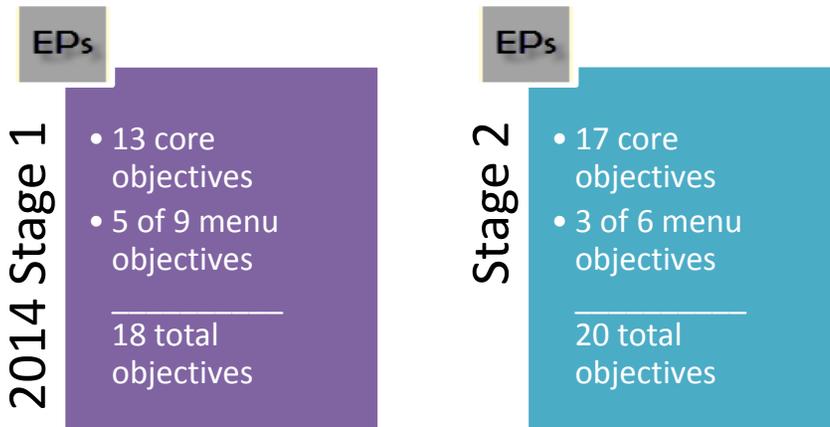
Likewise, the Stage 2 objectives, measures, exclusions, certification criteria, and attestation information in this guide are based on the Stage 2 Eligible Professional spec sheets. The [Stage 2 Eligible Professional Meaningful Use Core and Menu Measures Table of Contents](#) document³ has a link to each spec sheet.

² www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MU_TableOfContents.pdf

³ www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf

Stage 1 vs Stage 2

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



In the [EHR Incentive Programs Stage 2 Toolkit](#),⁴ CMS compares Stage 1 and Stage 2 as follows: “Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of these Stage 2 objectives, the threshold that EPs must meet for the objective has been raised.”

In addition to meeting the core and menu objectives, EPs have to report on 9 of the 64 approved clinical quality measures (CQMs). This requirement is the same for Stage 1 and Stage 2. When reporting CQMs, there is no minimum threshold that must be met; it is only necessary to report on the 9 CQMs. For more information, refer to the [2014 Clinical Quality Measures](#) webpage.⁵

⁴ http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Toolkit_EHR_0313.pdf

⁵ www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html

Stage 2 Navigation in this Guide

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

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

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

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

Note: 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.

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

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

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

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

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

The screenshot shows a form with the following fields and values:

- New Export** (button)
- Export Name:** MU Med Allergy Lis
- Form / Table Name:** Custom Query
- Custom Query:** spc_export_mu_allergy_list_detail

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.

Stage 1

Core 1: CPOE for Medication Orders

Objective

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

Certification criteria: §170.314(a)(1) CPOE

§170.314(a)(1) CPOE

Enable a user to electronically record, change, and access the following order types, at a minimum:

- (i) Medications;
- (ii) Laboratory; and
- (iii) Radiology/imaging.

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

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

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

Settings Security Matrix: PhysicianOrdersView, PhysicianOrdersAdd, and PhysicianOrderLineComplete or PhysicianOrdersSignAll

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

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

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

To edit a current order:

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

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

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

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

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

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

To discontinue an order:

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

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

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

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

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

Optional Alternate Measure

CMS

Optional
Alternate
Denominator

Number of medication orders created by the EP during the EHR reporting period

Optional
Alternate
Numerator

Number of medication orders in the denominator entered using CPOE

Credible



Number of physician orders of type 'Medications' OR medication where the provider is an employee (automatic for Credible eRx)

Number of orders in Credible denominator where the entering employee is a doctor, nurse, or licensed health professional

Stored procedure in Credible [spc_export_mu_cpoe_summary](#)

Core 2: Drug Interaction Checks

Objective	Implement drug-drug and drug-allergy interaction checks.
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Certification criteria: §170.314(a)(2) Drug-drug, drug-allergy interaction checks

§170.314(a)(2) Drug-drug, drug-allergy interaction checks	<p>(i) Interventions. Before a medication order is completed and acted upon during CPOE, interventions must automatically and electronically indicate to a user drug-drug and drug-allergy contraindications based on a patient's medication list and medication allergy list.</p> <p>(ii) Adjustments.</p> <p>(A) Enable the severity level of interventions provided for drug-drug interaction checks to be adjusted.</p> <p>(B) Limit the ability to adjust severity levels to an identified set of users or available as a system administrative function.</p>
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(1) Notifications. When you create a prescription in Credible, the system automatically checks for interactions with existing medications and allergies in the client's record. If the existing medication was added through the Add Medication function, it has to have been selected from the autopopulated dropdown to be included in the check. The same is true for existing allergies. The matching required for an interaction notification will not occur if the medication or allergy was entered via free text. All existing medications added through Create Prescription will be included in the drug-drug check (free text is not an option).

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

To create prescriptions, your agency needs the Credible eRx module and your IM/PSC needs to turn it on in your system.

Steps to Configure Refer to the *Credible eRx Setup* guide in the Credible Library (reference ID 32908).

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

Medication

- a. Click the **Add Medication** button.
- b. In the Medication field, enter the name of the medication or the first few letters in the name. *Select the appropriate medication from the dropdown that displays.*
- c. Enter the dosage, frequency, rationale, quantity, and number of refills.
- d. If applicable, select the provider from the dropdown.
- e. If the medication is a prescription, select Yes from the Is Prescription dropdown and enter the name of the pharmacy.
- f. Enter any instructions in the text box provided.
- g. Enter the start date for the medication and click **Add Medication**.

Prescription

- a. Click the **Create Prescription** button.
- b. Search for and select the medication you want to prescribe in the Medication Search screen.
- c. If you are not a prescriber, select the appropriate one from the Provider dropdown.
- d. Fill out the rest of the Sig Builder tab and print, e-send, or e-fax the prescription.

2. Add an allergy:

- a. Client tab > Client's name > **Allergy** on nav bar > **Add Allergy** button.
- b. In the Allergy field, start typing the name of the allergy. *Select the appropriate entry from the dropdown that displays.*
- c. If necessary, enter additional text in the field provided.
- d. Use the Severe dropdown to indicate the severity of the allergy.

- e. Enter a description of the reaction in the field provided (required).
 - f. If you want to flag the allergy is a medical allergy for reporting purposes, select the Med Allergy checkbox. This flag has no impact on the drug-allergy interaction check that happens when creating a prescription.
 - g. Click **Add Allergy**.
3. Create a prescription *for a medication that you know will interact with the medication and allergy added in steps 1 and 2*. The Create Prescription screen will have a warning message about the interactions and a tab for each interaction ([example⁶](#)).
 - a. Review the interactions information and if necessary, change the medication you are prescribing.
 - b. If you are not a prescriber, select the appropriate one from the Provider dropdown.
 - c. Fill out the rest of the Sig Builder tab and print, e-send, or e-fax the prescription.

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

Settings Security Matrix: SeverityLevelAdmin

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

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

⁶ http://help.crediblebh.com/crediblehelp/default.aspx?pageid=drug_drug_and_drug_allergy_interactions

Attestation: YES/NO

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

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

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

Core 3: Maintain Problem List

Objective

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

Certification criteria: §170.314(a)(5) Problem list

§170.314(a)(5) Problem list

Enable a user to electronically record, change, and access a patient's problem list:

- (i) Ambulatory setting. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in §170.207(a)(3); or
- (ii) Inpatient setting. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in §170.207(a)(3).

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

When adding an Axis I – III diagnosis, you specify the SNOMED CT description that corresponds to the ICD-9 description.⁷ If there is a one-to-one correspondence between the two codes, the SNOMED description dropdown will be preset with the appropriate SNOMED CT description. If the system cannot find any possible matches, you use the SNOMED Picker to search for the appropriate code. The mapping from ICD-9 to SNOMED CT is provided by data from the U.S. National Library of Medicine:

www.nlm.nih.gov/research/umls/mapping_projects/icd9cm_to_snomedct.html.

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

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

⁷ SNOMED CT stands for Systematized Nomenclature of Medicine – Clinical Terminology. “The Office of the National Coordinator for Health Information Technology (ONC) and CMS have adopted SNOMED CT as one of the key vocabularies for Meaningful Use Stage 2, EHR certification, and health information exchange” (for more information: http://ihtsdo.org/fileadmin/user_upload/Docs_01/Publications/SNOMED_CT/SnomedCt_MeaningfulUse_20130214.pdf).

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

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

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

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

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

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

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

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

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

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

[Back to Stage 2 Menu 4: Family Health History](#)

Attestation: §170.302(n)

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

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

Core 4: e-Prescribing (eRx)

Objective

Generate and transmit permissible prescriptions electronically (eRx).

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

§170.314(b)(3) Electronic prescribing

Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with:

- (i) The standard specified in § 170.205(b)(2); and
- (ii) At a minimum, the version of the standard specified in § 170.207(d)(2).

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

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

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

For non-prescribers: PrescriptionCreate or PrescriptionCreateNonSPI

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

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

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

Steps to Use To create a prescription:

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

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

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

Measure	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology (CEHRT).
Exclusion	<ol style="list-style-type: none"> 1. Any EP who writes fewer than 100 prescriptions during the EHR reporting period. 2. Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

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

	CMS	Credible
Denominator	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period	Count of Credible eRx prescriptions for non-Schedule 2 drugs where creation date is in EHR reporting period, signature exists, and status is one of the following: <ul style="list-style-type: none"> • (EC) ELECTRONIC - CURRENT • (PC) PAPER - CURRENT • (FC) FAX - CURRENT • (ECU) ELECTRONIC - CURRENT UNAPPROVED • (PCU) PAPER - CURRENT UNAPPROVED
Numerator	Number of prescriptions in the denominator generated and transmitted electronically	Count of prescriptions in Credible denominator where status is (EC) ELECTRONIC – CURRENT or (ECU) ELECTRONIC - CURRENT UNAPPROVED  Stored procedure in Credible spc_export_mu_erx_summary If your state regulations dictate that other Schedules should be excluded, the query behind the stored procedure will need to be modified.

Core 5: Active Medication List

Objective

Maintain active medication list.

Certification criteria: §170.314(a)(6) Medication list

§170.314(a)(6) Medication list

Enable a user to electronically record, change, and access a patient's active medication list as well as medication history:

- (i) Ambulatory setting. Over multiple encounters; or
- (ii) Inpatient setting. For the duration of an entire hospitalization.

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

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

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

Steps to Configure N/A

Steps to Use To add a concurrent medication:

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

To prescribe a medication:

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

To edit a current or concurrent medication:

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

To discontinue or reject a prescribed medication:

1. Click **discont** or **reject** and click **OK** when the confirmation popup displays.
2. If a Reason popup displays, enter the reason you are discontinuing or rejecting the prescription and click **Save**.⁸

⁸ Select *Use Med History Notes* in Partner Config to enable the Reason popup.

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

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

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

Attestation: §170.302(n)

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

	CMS	Credible
Denominator	Number of unique patients seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data	Count of clients in Credible denominator that have active medication (Credible eRx prescription or regular medication) OR have “Client has reported no current medications” checked. The following are considered active statuses: <ul style="list-style-type: none"> • (C) CURRENT • (CC) CONCURRENT • (EC) ELECTRONIC - CURRENT • (PC) PAPER - CURRENT • (FC) FAX - CURRENT • (ECU) ELECTRONIC - CURRENT UNAPPROVED • (PCU) PAPER - CURRENT UNAPPROVED • (A) APPROVED

 Stored procedure in Credible

[spc_export_mu_medication_list_summary](#)

Per the Federal Register: “As with the objective of maintaining a problem list, we clarify that the indication of “none” should distinguish between a blank list that is blank because a patient is not on any known medications and a blank list because no inquiry of the patient has been made.”⁹

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

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

Core 6: Medication Allergy List

Objective

Maintain active medication allergy list.

Certification criteria: §170.314(a)(7) Medication allergy list

§170.314(a)(7) Medication allergy list

Enable a user to electronically record, change, and access a patient's active medication allergy list as well as medication allergy history:

- (i) Ambulatory setting. Over multiple encounters; or
- (ii) Inpatient setting. For the duration of an entire hospitalization.

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

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

Settings Security Matrix: AllergyView, AllergyAdd, AllergyUpdate

Steps to Configure N/A

Steps to Use Add an allergy:

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

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

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

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

To discontinue an allergy:

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

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

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

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

Attestation: §170.302(n)

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

CMS

Credible

Denominator Number of unique patients seen by the EP during the EHR reporting period

Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked

Numerator Number of patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) in their medication allergy list

Count of clients in Credible denominator that have an active allergy OR have “Client has reported no allergies” checked.

 Stored procedure in Credible
[spc_export_mu_allergy_list_summary](#)

Per the Federal Register: “We agree that information on all allergies, including non medication allergies, provide relevant clinical quality data. However, while we agree that collecting all allergies would be an improvement, current medication allergy standards exists [sic] in a structured data format that may be implemented in Stage 1. We hope to expand this measurement to include all allergies as the standards evolve and expand to include non-medication allergies.”¹⁰

While you can flag an allergy as a medication allergy in Credible for reporting purposes, the presence of any allergy is evidence of having documented a client’s medication allergies for the purpose of this measure. Likewise, selecting the “Client has reported no allergies” checkbox is evidence that your staff has documented (affirmed) that the client has no medication allergies.

¹⁰ Vol. 75, No. 144 /Wednesday, July 28, 2010 /Rules and Regulations, page 44339

Core 7: Record Demographics

Objective

Record all of the following demographics:

- (A) Preferred language
- (B) Gender
- (C) Race
- (D) Ethnicity
- (E) Date of birth

Certification criteria: §170.314(a)(3) Demographics

§170.314(a)(3) Demographics

- (i) Enable a user to electronically record, change, and access patient demographic data including preferred language, sex, race, ethnicity, and date of birth.
 - (A) Enable race and ethnicity to be recorded in accordance with the standard specified in § 170.207(f) and whether a patient declines to specify race and/or ethnicity.
 - (B) Enable preferred language to be recorded in accordance with the standard specified in § 170.207(g) and whether a patient declines to specify a preferred language.
- (ii) Inpatient setting only. Enable a user to electronically record, change, and access preliminary cause of death in the event of a mortality.

In the client profile in Credible, you need to add dropdowns for Preferred Contact Method, Preferred Language, Ethnicity, and Race. You also need to have a date of birth field in the client profile. To add the dropdowns, you set up the fields as lookups using existing custom lookup categories. For the Preferred Language lookup items, the Stage 1 best practice is to update the prepopulated 50 most widely spoken languages with the ISO 639.2 Language Code List required for Stage 2. The Ethnicity and Race lookup items are prepopulated with values from the CDC website that are accordance with Federal standards.¹¹

¹¹ www.whitehouse.gov/omb/fedreg_1997standards (OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, October 30, 1997)

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

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

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

[Settings](#) DataDictionary, AdminLookupUpdate, ClientUpdate

- [Steps to Configure](#)
1. Admin tab > **Data Dictionary** > Table source = Clients | Type = View.
 2. Insert the preferred_contact, preferred_language, ethnicity_omb, and race_omb fields into the Clients table and set them as Lookup fields (lookup parameters: Lookup Table = LookupDict, Lookup Description = lookup_desc or lookup_code, Lookup Category = category that corresponds to the field).
 3. If your staff needs to be able to record more than one race for a client, insert race_omb2 and race_omb3 and set them as Lookup fields using the parameters above (lookup category will be race_omb).
 4. Insert the pd113_pi_effectivedate and immunization_protection_indicator fields.
 5. Set up immunization_protection_indicator as a lookup with the following parameters: Lookup Table: LookupDict, Lookup ID: lookup_code, External ID: hl7_code, Lookup Description: short_desc, Lookup SQL: lookup_code + ' ~ ' + short_desc, Lookup Category: immunization_protection.
 6. Insert the dob and date_of_death fields and select the Is Date checkbox for both. While date_of_death is not required for meaningful use, your staff can use it to record when a client dies. The Age field calculates a deceased client's age based on the dob and date_of_death fields.
 7. Make sure the User View checkbox is selected for first_name, last_name, sex, date_of_birth, preferred_language, ethnicity_omb, race_omb, race_omb2, and race_omb3.
 8. Click **Match Update to View** or add the field to the Update screen manually.
 9. Admin tab > **Custom Lookup Items**.

10. Configure the preferred_contact_method lookup:
 - a. Select preferred_contact_method from the Category dropdown and click **Display**.
 - b. Add different methods of contact to the category (for example, Email, Home Phone, Letter, or No Contact). For each entry except No Contact, enter the first letter of the description in the HL7 code field (for example, E for Email); this way you can link each one to a corresponding visit type for the Patient Reminders measure.
11. Add the languages in the ISO 639.2 Language Code List as preferred_language lookup items. For each preferred_language lookup item, enter the corresponding ISO 639-2/Alpha-3 code in the HL7 Code field. If a language has two codes, make sure to only use the "T" (terminology) code. For the code list, go to http://www.loc.gov/standards/iso639-2/php/English_list.php.
12. Add the HL7 codes below to the ethnicity_omb and race_omb lookup items (and race_omb2 and race_omb3 lookup items if applicable). If your Agency has multiples of the same ethnicity/race (for example, multiple American Indian lookup items), you can use the same HL7 code.

American Indian or Alaska Native	1002-5
Asian	2028-9
Black or African American	2054-5
Native Hawaiian or Other Pacific Islander	2076-8
White	2106-3
Other Race	2131-1
Hispanic or Latino	2135-2
Not Hispanic or Latino	2186-5

13. Add "Declined to Specify" as a lookup item to the preferred_language, ethnicity_omb, and race_omb categories (and race_omb2 and race_omb3 lookup items if applicable). Enter "Declined" in the Code field and "ASKU" in the HL7 Code field.

14. If you use different Client Profile fields for race and ethnicity, make sure the lookup items are coded in accordance with Federal standards.
15. Configure the immunization_protection lookup:
 - a. Add immunization_protection as a custom lookup category (Admin tab > Custom Lookup Categories > Add a New Lookup Categories Entry).
 - b. Add the lookup items in the table below to the immunization_protection lookup category (Admin tab > Custom Lookup Items > Select immunization protection > Display button > Add a New immunization_protection Entry). Note that N and Y must be used as the codes (there are no other valid values) and must be uppercase.

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

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

To record demographics for an existing client:

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

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

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

To view a client's demographics:

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

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

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

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

[Back to corresponding Stage 2 measure](#)

Core 8: Record Vital Signs

Objective

Record and chart changes in the following vital signs:

- (A) Height
- (B) Weight
- (C) Blood pressure
- (D) Calculate and display body mass index (BMI)
- (E) Plot and display growth charts for children 0-20 years, including BMI

Certification criteria: §170.314(a)(4) Vital signs, body mass index, and growth charts

§170.314(a)(4) Vital signs, body mass index, and growth charts

(i) Vital signs. Enable a user to electronically record, change, and access, at a minimum, a patient's height/length, weight, and blood pressure.

Height/length, weight, and blood pressure must be recorded in numerical values only.

(ii) Calculate body mass index. Automatically calculate and electronically display body mass index based on a patient's height and weight.

Optional – Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients.

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

Settings Security Matrix: MedicalProfileView, MedicalProfileUpdate

Steps to Configure N/A

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

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

To modify an existing medical profile:

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

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

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

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

Settings Security Matrix: MedicalProfileView

Steps to Configure N/A

Steps to Use Client tab > Client's name > **Medical Profile** on nav bar.

BMI is displayed in the upper right corner. Mouse over the info icon to see the corresponding weight status.

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

[Settings](#) Security Matrix: MedicalProfileView

[Steps to Configure](#) N/A

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

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

Measure	For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.
Exclusion	<p>Any EP who</p> <ol style="list-style-type: none"> 1. Sees no patients 3 years or older is excluded from recording blood pressure; 2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; 3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or 4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

CMS

Credible

New Denominator

Number of unique patients (age 3 or over for blood pressure) seen by the EP during the EHR reporting period

Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, visit type has Include Summary checked, and client is 3 or older at time of being seen for blood pressure

New Numerator

Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data

Count of clients in Credible denominator where across all medical profiles for a client: at least one medical profile has height in feet and inches, at least one medical profile has weight, AND at least one medical profile has blood pressure (top and bottom)

 Stored procedure in Credible
[spc_export_mu_vitalsigns_summary](#)

Core 9: Record Smoking Status

Objective

Record smoking status for patients 13 years old or older.

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

§170.314(a)(11) Smoking status

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

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

Settings Security Matrix: DataDictionary, ClientUpdate

Steps to Configure

1. Admin tab > **Data Dictionary** > Table source = Clients | Type = View.
2. Insert the smoking_status field and set it as a Lookup field (lookup parameters: Lookup Table = LookupDict, Lookup Description = lookup_desc, Lookup Category = smoking_status).
3. Select the User View checkbox.
4. Click **Match Update to View** or add the field to the Update screen manually.
5. **Admin** tab > **Custom Lookup Items**.
6. Select smoking status from the Category dropdown and click **Display**.
7. Add “Heavy tobacco smoker” and “Light tobacco smoker” as lookup items, entering 1 in the Code field and the SNOMED CT code shown below in the Ext Code field.

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

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

Steps to Use

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

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

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

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

 Stored procedure in Credible
[spc_export_mu_smoking_summary](#)

[Back to corresponding Stage 2 measure](#)

Core 10: Clinical Decision Support Rule

Objective

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

Certification criteria: §170.314(a)(8) Clinical decision support

§170.314(a)(8) Clinical decision support

(i) Evidence-based decision support interventions. Enable a limited set of identified users to select (i.e., activate) one or more electronic clinical decision support interventions (in addition to drug-drug and drug-allergy contraindication checking) based on each one and at least one combination of the following data:

- (A) Problem list;
- (B) Medication list;
- (C) Medication allergy list;
- (D) Demographics;
- (E) Laboratory tests and values/results; and
- (F) Vital signs.

(ii) Linked referential clinical decision support.

- (A) EHR technology must be able to:
 - (1) Electronically identify for a user diagnostic and therapeutic reference information; or
 - (2) Electronically identify for a user diagnostic and therapeutic reference information in accordance with the standard specified at §170.204(b) and the implementation specifications at §170.204(b)(1) or (2).
- (B) For paragraph (a)(8)(ii)(A) of this section, EHR technology must be able to electronically identify for a user diagnostic or therapeutic reference information based on each one and at least one combination of the data referenced in paragraphs (a)(8)(i)(A) through (F) of this section.

(iii) Clinical decision support configuration.

(A) Enable interventions and reference resources specified in paragraphs (a)(8)(i) and (ii) of this section to be configured by a limited set of identified users (e.g., system administrator) based on a user's role.

(B) EHR technology must enable interventions to be electronically triggered:

(1) Based on the data referenced in paragraphs (a)(8)(i)(A) through (F) of this section.

(2) When a patient's medications, medication allergies, and problems are incorporated from a transition of care/referral summary received pursuant to paragraph (b)(1)(iii) of this section.

(3) Ambulatory setting only. When a patient's laboratory tests and values/results are incorporated pursuant to paragraph (b)(5)(i)(A)(1) of this section.

(iv) Automatically and electronically interact. Interventions triggered in accordance with paragraphs (a)(8)(i)-(iii) of this section must automatically and electronically occur when a user is interacting with EHR technology.

(v) Source attributes. Enable a user to review the attributes as indicated for all clinical decision support resources:

(A) For evidence-based decision support interventions under paragraph (a)(8)(i) of this section:

(1) Bibliographic citation of the intervention (clinical research/guideline);

(2) Developer of the intervention (translation from clinical research/guideline);

(3) Funding source of the intervention development technical implementation; and

(4) Release and, if applicable, revision date(s) of the intervention or reference source.

(B) For linked referential clinical decision support in paragraph (a)(8)(ii) of this section and drug-drug, drug-allergy interaction checks in paragraph(a)(2) of this section, the developer of the intervention, and where clinically indicated, the bibliographic citation of the intervention (clinical research/guideline)

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). 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 you want to push the clinical support to the Client Portal. If necessary, you can deselect this checkbox later on to remove the clinical support from the Client Portal.
6. If you didn't push the support to the Client Portal, accept or reject it by selecting the corresponding option from the Accepted dropdown.

7. To keep the clinical support active, select the corresponding checkbox.
8. Click **Save Clinical Support**.

Steps for a client user to accept a clinical support:

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

[Back to corresponding Stage 2 measure](#)

Attestation: YES/NO

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

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

Core 11: Patient Electronic Access

Objective

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.

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

§170.314(e)(1) View, download, and transmit to third party

(i) EHR technology must provide patients (and their authorized representatives) with an online means to view, download, and transmit to a 3rd party the data specified below. Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f).

(A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data:

- (1) The Common MU Data Set** (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set).
- (2) Ambulatory setting only. Provider's name and office contact information.
- (3) Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization.

(B) Download.

(1) Electronically download an ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) in human readable format or formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set):

- (i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2) of this section.
- (ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(3) of this section.

(2) Inpatient setting only. Electronically download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion adopted at paragraph (b)(2) of this section).

(C) Transmit to third party.

- (1) Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) created in paragraph (e)(1)(i)(B)(1) of this section in accordance with the standard specified in § 170.202(a).
- (2) Inpatient setting only. Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in accordance with the standard specified in § 170.202(a).

(ii) Activity history log.

(A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section, the following information must be recorded and made accessible to the patient:

- (1) The action(s) (i.e., view, download, transmission) that occurred;
- (2) The date and time each action occurred in accordance with the standard specified at § 170.210(g); and
- (3) The user who took the action.

(B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient.

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 it 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](#) 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.

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

Measure	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, with the ability to view, download, and transmit to a third party.
Exclusion	Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information, may exclude the measure.

	CMS	Credible
Measure Denominator	Number of unique patients seen by the EP during the EHR reporting period.	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Measure Numerator	Number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information.	Count of clients in Credible denominator where number of business days from visit start date to the visit sign & submit date (transfer_date) is 4 or less and the client has at least one client user account created within four business days of the visit

 Stored procedure in Credible [spc_export_mu_vdt_summary](#)

If your organization is not using the Client Portal, you need to determine what you will provide electronically to clients and how this will be documented.

A business day is defined as a date that is both a weekday (Monday to Friday) and is not marked as a holiday. To enable the Company Holidays function, select *Use Company Holidays* in Partner Config. To designate a day as a company holiday: Admin tab > **Company Holidays** > click the appropriate date.

Core 12: Clinical Summaries

Objective

Provide clinical summaries for patients for each office visit.

Certification criteria: §170.314(e)(2) Clinical summary

§170.314(e)(2) Clinical summary

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

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

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

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

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

Client User Security Matrix: ClientUserSummaryView, ClientVisitListCU

Partner Config: Use Clinical Summary Features, CCD Author Address

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

- Steps to Configure**
1. Configure the visit type to include a clinical summary and support time-of-visit clinical summary generation (for more information, go to [Steps to Configure](#) for Attestation for Objectives with Automated Measure Calculation §170.302(n)/§170.314(g)(2)).
 2. Set up questions in the form so they will be included in the clinical summary. To meet this objective, you must include injected lab results, diagnoses, medications, and allergies.
 - a. Select the **Forms** tab and click the **new version** button for an existing form or add a new form.
 - b. For any question that you want to include in the summary, select the Include in Summary checkbox. Minimally, you need to include questions that inject a client's current lab results, diagnoses, medications, and allergies.
 - c. Make sure the category has one question that *doesn't inject data* that is *Category Required* to ensure the injected data is saved in the clinical summary.
 - d. Build and activate the form and then link it to the visit type you updated above.
 2. Give staff and client users the right to view clinical summaries.
 3. If you want staff to populate Reason for Visit and Chief Complaint fields via form mapping, add the fields to the appropriate forms and set them up for mapping (ClientVisit:reason for visit and ClientVisit:chief complaint).

Steps to Use To access a clinical summary:

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

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

To generate a time-of-visit CCD:

1. Complete a visit with the visit type you set up to include a summary.
2. Visit tab > **view** button for visit.
3. Click the **Create Clinical Summary** link in the Transfer XML CDA/CCR field.
4. If there are parts of the client's record you do not want to include in the CCD, uncheck the corresponding checkboxes.

If the client had multiple visits on the visit date indicated, they will be included in the time-of-visit CCD. If necessary, you can change the visit date.

5. Use the default output option Enclose CCD/CCR Summary in Zip File; it includes a style sheet for easier readability. (While the default option is recommended, you can also use Enclose Plain Text Summary in Zip File to generate a "human readable" version of the clinical summary. You should only use the Print Summary to Screen option for review purposes.)
6. Click Generate Summary.
7. Save the zip file locally. It contains an XSL style sheet, the CCD in an XML document, and the hash value in a text document. While a style sheet is provided in each CCD/CCR summary zip file, it is the same style sheet every time and will work with any CDA document.
8. Upload the zip file to the receiving agency – this process occurs outside of Credible. Provide the receiving agency with the following view instructions:
 - a. Extract the files from the zip file into a folder (the XSL style sheet and clinical summary have to be in the same folder).
 - b. Click the clinical_summary XML file to view it.

Important: the clinical summary contains protected health information – follow HIPAA guidelines to protect it.

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

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

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

Core 13: Protect Electronic Health Information

Objective

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

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

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

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

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

Settings N/A

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

Steps to Use To create a login for an employee:

1. Employee tab > Employee's name > **Login** on the nav bar.
2. If necessary, change the system-supplied username (the default is the first letter of the employee's first name and his/her last name). The system will let you know if the username is already taken when you try to add the user.

3. Enter a password and then reenter it in the Password Again field (password rules are available in Credible Help: http://help.crediblebh.com/CredibleHelp/default.aspx?pageid=updating_your_password).
4. Enter the employee's personal and office email.
5. Select the appropriate login profile from the dropdown and click **Add User**.

To remove a user:

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

For access control and authorization, Credible uses logins and assignments.

Logins

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

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

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

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

Assignments

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

Settings Security Matrix: SecurityUpdate, UserAdd, ClientUserView, UserUpdate, PasswordUpdate
Your IM/PSC needs to turn on the Client Portal for your system.

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

Steps to Use N/A

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

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

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

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

Settings Security Matrix: ClientFileView, ClientFileAdd, PatientSummaryGenerator

Partner Config: Show Hashing, Use Clinical Summary Features, CCD Author Address

Steps to Configure N/A

Steps to Use To view Credible's digital certificate:

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

To demonstrate the hash values match:

1. Generate a CCR from the client's profile and then import it into the client's record on your Test domain (refer to Steps to Use for [Stage 1 Menu 7: Transition of Care Summary](#)).
2. In the File Attachments screen, mouse over the Hash icon (a red circle icon next to Date Attached) and verify that the hash values match.

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

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

Settings N/A

Steps to Configure N/A

Steps to Use N/A

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

Settings N/A

Steps to Configure N/A

Steps to Use Generate an encrypted CCR from the client's profile (refer to Steps to Use for [Stage 1 Menu 7: Transition of Care Summary](#)). To encrypt the CCR, you select the corresponding checkbox and enter an encryption key in the field that displays. Always use a mix of lowercase/uppercase letters, digits, and special characters. Uploading the encrypted file and encryption key to the receiving agency occurs outside of Credible.

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

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

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

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

Settings Security Matrix: Report List
Report Security: ChangeLog Changes Report

Steps to Configure N/A

Steps to Use Reports tab > Admin button on nav bar > ChangeLog Changes Report > Run Report.

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

**§170.314(d)(3)
Audit report(s)**

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

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

Settings Security Matrix: ClientVisitViewLog, ClientViewLog

Report Security: Global HIPAA Log

Steps to Configure N/A

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

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

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

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

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

§170.314(d)(4) Amendments

Enable a user to electronically select the record affected by a patient's request for amendment and perform the capabilities specified in paragraphs (d)(4)(i) or (ii) of this section.

(i) Accepted amendment. For an accepted amendment, append the amendment to the affected record or include a link that indicates the amendment's location.

(ii) Denied amendment. For a denied amendment, at a minimum, append the request and denial of the request to the affected record or include a link that indicates this information's location.

With the Amendments function, you can record client requests to amend the information about a specific diagnosis, lab, medication, or completed visit. Once an amendment request is entered, the appropriate staff can review it and then accept or deny it. If a request is accepted, staff will have to manually update the corresponding diagnosis, lab, medication, or visit record. The actions of adding, updating, and deleting amendments are recorded in the HIPAA logs.

Settings Security Matrix: ClientAmendmentView, ClientAmendmentAdd, ClientAmendmentDelete

Steps to Configure N/A

Steps to Use To add an amendment request:

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

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

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

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

§170.314(d)(5) Automatic log-off

Prevent a user from gaining further access to an electronic session after a predetermined time of inactivity.

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

The idle logout functionality applies to the following screens:

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

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

Settings Partner Config: Idle Logout, Idle Logout Redirect

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

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

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

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

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

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

§170.314(d)(6) Emergency access

Permit an identified set of users to access electronic health information during an emergency.

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

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

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

Settings Security Matrix: ClientEmergencyAccess, ClientView, ClientViewLog, NotificationTriggers

Partner Config: Allow Emergency Access

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

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

- Steps to Use**
1. Employee tab > **My Record** > **Emergency** on Employee nav bar.
 2. Enter your password in the field provided and click **Continue**. The Emergency Client Assignment screen displays with filtering fields at the top. Searching for the client you need emergency access to minimizes inadvertent access to personal health information.
 3. Use the filtering fields to search for the client you need emergency access to. Only clients that you are not already assigned to will be included in the results.
 4. Find the client in the search results and click **assign**. The Client Overview screen for the client displays. (At this time, notification triggers will be sent and the emergency assignment will be logged.)
 5. Once the emergency access is no longer needed, use the Client function on the Employee nav bar to unassign the client from your record.

[Back to corresponding Stage 2 measure](#)

Attestation: YES/NO

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

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

Menu 1: Drug Formulary Checks

Objective

Implement drug formulary checks.

Certification criteria: §170.314(a)(10) Drug-formulary checks

§170.314(a)(10) Drug-formulary checks

EHR technology must automatically and electronically check whether a drug formulary (or preferred drug list) exists for a given patient and medication.

A formulary is a list of prescription drugs and non-drug items such as insulin test strips that are covered by a pharmacy benefit manager (PBM)/payer.¹² On a *weekly* basis, formulary data is automatically pulled from the PBMs and stored in your Credible system. When you create a prescription, Credible uses the medication code from the client's prescription (Rx) eligibility and the payer's formulary data to determine the formulary status. If a drug is on the list, it is considered "on-formulary." Each on-formulary drug is assigned a preferred level -- a PBM/payer rating of that drug's effectiveness and value compared to other drugs in the same therapeutic class. The higher the level, the greater the preference. Some on-formulary medications are designated as "non preferred."

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

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

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

¹² A PBM is a third-party administrator contracted by a payer to manage its prescription drug program. A PBM processes and pays prescription drug claims and creates and maintains the drug formulary for a health plan.

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

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

- Steps to Use**
1. Check the client's Rx eligibility:¹³
 - a. Make sure the client has a service to associate the Rx eligibility request with. It must be a completed or incomplete service that was started in the past 24 hours or a service that is scheduled for any time today or tomorrow.
 - b. Client tab > Client's name > **Medications** on nav bar > **Rx Eligibility** button.
 - c. If you are not a prescriber, select the appropriate one from the Provider dropdown.
 - d. Click **Run Rx Eligibility**.
 - e. After reviewing the Rx eligibility information, click **Done**.

You can click the Rx eligibility button at any time to review the information pulled during the last check.

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

¹³ You can only request Rx eligibility information for a client once every 72 hours (the information does not change that often) and there has to be a service to associate the request with. The following information is sent in the eligibility request: First Name, Last Name, Address, City, State, Zip DOB, and Gender.

Attestation: YES/NO

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

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

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

Menu 2: Clinical Lab Test Results

Objective

Incorporate clinical lab test results into EHR as structured data.

Certification criteria: §170.314(b)(5) Incorporate laboratory tests and values/results

§170.314(b)(5) Incorporate laboratory tests and values/results

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

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

- Method 1: use Credible eLabs to electronically import lab results into a client's record. When a lab sends results back, they are automatically imported into the client's record.
- Method 2: receive lab results in electronic or paper form (for example, in an email or document) and manually enter them into Credible.

Separate contracting is required to use the Credible eLabs module. If contracting for the eOrder/eReceive functions, the average lead time is 12 weeks. Please contact contracts@credibleinc.com if you would like to add this module to your Agency's domain. Once purchased, your IM/PSC needs to turn on the contracted eLabs functionality.

Method 2

Settings Security Matrix: eLabs

- 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**.

In Credible Help, refer to *Setting Up eLabs*.

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

To work with the Labs Picker popup: enter the first few numbers of the LOINC code or part of the lab test name, select the appropriate test from the list provided, and click **done**. The Test Code and Test Name fields are autopopulated based on your selection.
 - b. Use the Value, Abnormality, Units, and Range fields to record the details of the lab result.

- c. If the result is outside of the applicable range, select the Panic checkbox.
 - d. Select/enter the Result Date (required).
 - e. If you have supporting documentation for the lab result, click Choose File and find/select the file (see Credible Help for supported file types). Select the appropriate attachment type (Image, Narrative, Image & Narrative, or Other) and click Attach File. Note that there is no file type validation so you must select the appropriate type based on what is in the file.
 - f. Click **Save Lab Result**.
4. Repeat step 3 for each lab test associated with the order.
- To edit or remove test results from the client's record, use the corresponding button.
 - To add results for another order, click **Start New Result Header** and repeat steps 2 – 4.
 - To view the results entered, click **Return to Labs**. The Abnormal checkbox is automatically checked if the Abnormality is set to High or Low.

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

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

[Settings](#) Security Matrix: eLabs

[Steps to Configure](#) N/A

[Steps to Use](#) Client tab > Client's name > **eLabs** on nav bar.

While can edit and delete manually entered lab results, you can only delete lab results received electronically through Credible eLabs.

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

[Settings/Steps to Configure/Steps to Use](#) N/A

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

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

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

[Back to corresponding Stage 2 measure](#)

Menu 3: Patient Lists

Objective

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

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

170.314(a)(14) Patient list creation

Enable a user to electronically and dynamically select, sort, access, and create patient lists by: date and time; and based on each one and at least one combination of the following data:

- (i) Problems;
- (ii) Medications;
- (iii) Medication allergies;
- (iv) Demographics;
- (v) Laboratory tests and values/results; and
- (vi) Ambulatory setting only - Patient communication preferences.

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

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

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

[Settings](#) Security Matrix: AdvSearch, AdvSearchExport

[Steps to Configure](#) N/A

Steps to Use To generate a client list:

1. Client tab > **advanced search** button.
2. Enter and/or select the appropriate search criteria.
 - Problem list – select an Axis I and/or Axis II diagnosis from the dropdowns and/or enter the ICD-9-CM code or name of the Axis III condition in the corresponding field. If appropriate, select Primary Only to search only the primary diagnoses for the selected Axis filters.
 - Medication list – in the WEHRE statement, select the Medications or Med Class field from the Column dropdown. Select the appropriate operator and enter the name (full or partial) of the medication or med class in the Value field.

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

Use the COUNTS (Period Start/Period End) fields to find clients who were taking the medication during a specific date range.

- Demographics – in the WEHRE statement, select a demographic field and the appropriate operator and enter the desired value. Example: to find all clients under the age of 18, select Age and less than (<) and enter 18 in the Value field.
- Medical profile, allergies, and laboratory test results: click the **Medical** button and use the fields provided to enter search criteria.

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

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

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

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

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

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

To create a saved report:

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

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

2. If you want to let other employees run the report (it will appear in the Saved Reports dropdown for other users), do one of the following:
 - Select a specific team (you do not have to be assigned to the team) from the **Save Team** dropdown. When a team is selected, only the employee who created the report and the employees on the specified team can run it.
 - Select the **Global View** checkbox. When Global View is selected, all employees can view it even if a team is selected.

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

3. Click **Save Report**.

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

[Back to Stage 2 Core 11: Patient Lists measure](#)

[Back to Stage 2 Core 12: Preventative Care measure](#)

Attestation: YES/NO

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

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

Menu 4: Patient Reminders

Objective	Send reminders to patients per patient preference for preventive/follow-up care.
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Certification criteria: 170.314(a)(14) Patient list creation

170.314(a)(14) Patient list creation	Enable a user to electronically and dynamically select, sort, access, and create patient lists by: date and time; and based on each one and at least one combination of the following data: <ul style="list-style-type: none">(i) Problems;(ii) Medications;(iii) Medication allergies;(iv) Demographics;(v) Laboratory tests and values/results; and
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(vi) Ambulatory setting only - Patient communication preferences.

In Credible, you can use Advanced Client Search to generate a list of clients that need a reminder visit and then add the appropriate type of patient reminder visit for each client in the list via the Show Add Visit function. Note that appointment reminders are not considered preventive/follow-up care reminders. Client Advanced Search is used to help identify the clients needing preventive/follow-up care reminders; the 'Show Add Visit' checkbox allows for documenting the reminder. The actual emails, phone calls, letters, etc. would be sent outside of Credible.

Settings AdvSearch, VisitEntryMultiPerClient

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

- Steps to Use**
1. Client tab > **advanced search**.
 2. Enter the appropriate search criteria to find clients that need a reminder for preventive/follow-up care.
 3. In the WHERE column: Preferred Contact Method = <one of the contact methods>.
 4. Select the Show Add Visit checkbox and click **Filter**.
 5. Uncheck the Add Visit checkbox for any clients you don't want to add a patient reminder visit for and then click **Select Options to Add Visits**.
 6. In the Enter Visit screen, select the Patient Reminder visit type that corresponds to the contact method you entered in the WHERE clause.
 7. Fill out the other fields as appropriate and click **Add All Visits**.
 8. Repeat the process for the other contact methods.

[Back to Stage 2 Core 12: Preventative Care measure](#)

Attestation: §170.302(n)

Measure

More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.

Exclusion

An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

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

Menu 5: Patient-Specific Education Resources

Objective

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

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

§170.314(a)(15) Patient-specific education resources

EHR technology must be able to electronically identify for a user patient-specific education resources based on data included in the patient's problem list, medication list, and laboratory tests and values/results:

- (i) In accordance with the standard specified at §170.204(b) and the implementation specifications at §170.204(b)(1) or (2); and
- (ii) By any means other than the method specified in paragraph (a)(15)(i).

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

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

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

Notes:

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

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

Settings Security Matrix: ClinicalSupportAdmin, ClinicalSupportView, ClientUserView

Client User Security Matrix: ClinicalSupportCU

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

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

To add a clinical support file to the system:

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

To set up a clinical support:

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

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

Steps to Use

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

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

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

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

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

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

[Back to corresponding Stage 2 measure](#)

Menu 6: Medication Reconciliation

Objective

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

Certification criteria: §170.314(b)(4) Clinical information reconciliation

§170.314(b)(4) Clinical information reconciliation

Enable a user to electronically reconcile the data that represent a patient's active medication, problem, and medication allergy list as follows. For each list type:

- (i) Electronically and simultaneously display (i.e., in a single view) the data from at least two list sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date.
- (ii) Enable a user to create a single reconciled list of medications, medication allergies, or problems.
- (iii) Enable a user to review and validate the accuracy of a final set of data and, upon a user's confirmation, automatically update the list.

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 Security Matrix: DataDictionary, ClientUpdate, RxView, RxUpdate

Settings

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 Security Matrix: ClientFileAdd, ClientFileView, RxView, RxUpdate
Settings

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

Settings

Partner Config: Use Clinical Summary Features

Steps to Configure N/A

Steps to Use

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

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

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

	CMS	Credible
Denominator	Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition	Number of transitions into care; question has SNOMED CT code 1861000124105 for Transition of care (finding) and the question type is calendar control
Numerator	Number of transitions of care in the denominator where medication reconciliation was performed	<p>Number of transitions into care in Credible denominator with Performed (SNOMED CT code 398166005) as the answer to the "Documentation of current medications (procedure) performed" question (SNOMED CT code 428191000124101)</p> <p>Date of the medication reconciliation is documented with a separate calendar control question that has SNOMED CT code 428191000124101</p> <p> Stored procedure in Credible spc_export_mu_med_reconcile_summary</p> <p>You will need to edit an existing form or create a new one to capture the denominator (date of transition of care) and numerator (whether or not medication reconciliation was performed) information</p>

Menu 7: Transition of Care Summary

Objective

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

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

§170.314(b)(1) Transitions of care – receive, display, and incorporate transition of care/referral summaries

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

**§170.314(b)(2)
Transitions of
care – create and
transmit
transition of
care/referral
summaries**

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

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

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

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

Settings Security Matrix: ClientVisitSummaryView, ClientFileView, ClientFileAdd, PatientSummaryGenerator

Client User Security Matrix: ClientFileViewCU

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

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

Steps to Configure Refer to [Appendix A](#) for information on setting up the Client Portal.

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

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

If you uploaded a zip file, the system will automatically unzip it. You can access the file in the File Attachments screen. If the imported clinical summary is a CCD, it will have a "browser view" icon. When viewing the CCD in your browser, there is a hyperlinked table of contents below the demographic information that you can use to jump to the different sections in the document.

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

To generate a real-time CCD for a client:

9. Client tab > Client's name > **Profile** on Client nav bar > **Generate Clinical Summary.**
10. If there are parts of the client's record you do not want to include in the CCD, uncheck the corresponding checkboxes.
11. Make sure the Referral to other provider checkbox is selected.
12. From Provider dropdown, select External Care Provider that you are sending the clinical summary to.
13. Enter the reason for the referral in the corresponding field.
14. If necessary, use the dropdown provided to change the number of visits that will be included.
15. Select Encrypt Summary checkbox and enter an encryption key. Always use a mix of lowercase/uppercase letters, digits, and special characters. Jot down the key as you will need to send it to the receiving agency.

16. Use the default output option Enclose CCD/CCR Summary in Zip File; it includes a style sheet for easier readability. (While the default option is recommended, you can also use Enclose Plain Text Summary in Zip File to generate a “human readable” version of the clinical summary. You should only use the Print Summary to Screen option for review purposes.)
17. Click Generate Summary.
18. Save the file locally. The zip file contains the CCD in an XML document and the hash value in a text document.
19. Upload the zip file to the receiving agency – this process occurs outside of Credible.

To generate a real-time CCR for a client:

20. Client tab > Client’s name > **Profile** on Client nav bar > **Generate Clinical Summary**.
21. Select the CCR Summary checkbox.
22. Fill out the Summary detail section:
 - a. In the From field, enter your name or the name of your agency (required).
 - b. In the “from” Role field, enter your job title or information that further identifies your agency (required).
 - c. Optional: use the To field and “to” Role field to identify the person and/or agency receiving the client summary.
 - d. Optional: enter the reason the CCR is being sent.
23. Select Encrypt Summary checkbox and enter an encryption key. Always use a mix of lowercase/uppercase letters, digits, and special characters. Jot down the key as you will need to send it to the receiving agency.
24. Select the zip file output option and click **Generate Summary**. (You should only use the “Print summary to screen” option for review purposes.)
25. Save the file locally. The zip file contains the CCR in an XML document and the hash value in a text document.
26. Upload the zip file and encryption key to the receiving agency – this process occurs outside of Credible.

[Back to corresponding Stage 2 measure](#)

Attestation: §170.302(n)

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

	CMS	Credible
Denominator	Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider	Number of approved visits with an answer coded to an intervention from the CMS50v2 value set. There are approximately 180 intervention codes (qdm_category = Intervention); select the ones relevant to your Agency when setting up the possible answers to the question. For more information, refer to Viewing the Value Set for a CQM and CMS50v2 Closing the Referral Loop: Receipt of Specialist Report .
Numerator	Number of transitions of care and referrals in the denominator where a summary of care record was provided	<p>Number of visits in Credible denominator that have CLINICAL SUMMARY GENERATED in its log</p> <p> Stored procedure in Credible spc_export_mu_transition_care_summary</p> <p>You will need to edit an existing form or create a new one to capture the denominator (type of referral made) information. The clinical summary will need to be generated from the same visit used to document the referral.</p>

Menu 8: Immunization Registries Data Submission

Objective	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.
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Certification criteria: §170.314(f)(1) Immunization information & §170.314(f)(2) Transmission to immunization registries

§170.314(f)(1) Immunization information	Enable a user to electronically record, change, and access immunization information.
§170.314(f)(2) Transmission to immunization registries	EHR technology must be able to electronically create immunization information for electronic transmission in accordance with: <ul style="list-style-type: none"> (i) The standard and applicable implementation specifications specified in §170.205(e)(3); and (ii) At a minimum, the version of the standard specified in §170.207(e)(2).

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

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

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

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

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

Partner Config: Use Immunizations, Immunization HL7 Exports

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

1. Admin tab > **Data Dictionary** > Table source = Clients | Type = View.
2. Insert the race_omb field and set it as a Lookup field (Lookup Table = LookupDict, Lookup ID & External ID = lookup_id, Lookup Description = lookup_desc or lookup_code, Lookup Category = category that corresponds to field).
3. Select the User View checkbox.
4. Repeat steps 2 and 3 for ethnicity_omb.
5. Click **Match Update to View** or add the fields to the Update screen manually.

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

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

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

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

To record an immunization:

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

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

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

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

[Back to corresponding Stage 2 measure](#)

Attestation: YES/NO

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

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

Submission to Immunization Registries

Menu 9: Syndromic Surveillance Data Submission

Objective

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

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

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

EHR technology must be able to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with:

(i) Ambulatory setting only.

A. The standard specified in §170.205(d)(2).

B. Optional. The standard (and applicable implementation specifications) specified in §170.205(d)(3).

(ii) Inpatient setting only. The standard (and applicable implantation specifications) specified in §170.205(d)(3).

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.

[Back to corresponding Stage 2 measure](#)

Attestation: YES/NO

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

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

Stage 2

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

Objective	Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
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For certification criteria and Credible configuration and use information, refer to [Stage 1 Core 1: CPOE for Medication Orders](#).

Attestation: §170.302(n)

Measure	More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.
Exclusion	Any EP who writes fewer than 100 medication, radiology, or laboratory orders during the EHR reporting period.

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

	CMS	Credible
Measure 1 Denominator	Number of medication orders created by the EP during the EHR reporting period	<div style="background-color: #1a3d4d; color: white; padding: 2px; display: inline-block; margin-bottom: 5px;">Meds</div> Number of physician orders of type 'Medications' or OR medication where the provider is an employee (automatic for Credible eRx)
Measure 1 Numerator	Number of orders in the denominator recorded using CPOE	Number of med orders in Credible denominator where the entering employee is a doctor, nurse, or licensed health professional  Stored procedure in Credible spc_export_mu_cpoe_summary

CMS

Measure 2 Denominator Number of radiology orders created by the EP during the EHR reporting period

Measure 2 Numerator Number of orders in the denominator recorded using CPOE

Credible

Radiology Number of physician orders of type 'Radiology'

Number of radiology orders in Credible denominator where the entering employee is a doctor, nurse, or licensed health professional

Stored procedure in Credible [spc_export_mu_cpoe_summary](#)

CMS

Measure 3 Denominator Number of laboratory orders created by the EP during the EHR reporting period

Measure 3 Numerator Number of orders in the denominator recorded using CPOE

Credible

Labs Number of physician orders of type 'Labs'

Number of lab orders in Credible denominator where the entering employee is a doctor, nurse, or licensed health professional

Stored procedure in Credible [spc_export_mu_cpoe_summary](#)

Core 2: e-Prescribing (eRx)

For the objective, certification criteria, and Credible configuration and use information, refer to [Stage 1 Core 4: e-Prescribing \(eRx\)](#).

Attestation: §170.302(n)

Measure	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using certified EHR technology.
Exclusion	Same as Stage 1 Core 4: e-Prescribing (eRx)

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

	CMS	Credible
Denominator	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period	Count of Credible eRx prescriptions for non-Schedule 2 drugs where the creation date is in the EHR reporting period, a signature exists, and status is one of the following: <ul style="list-style-type: none"> • (EC) ELECTRONIC - CURRENT • (PC) PAPER - CURRENT • (FC) FAX - CURRENT • (ECU) ELECTRONIC - CURRENT UNAPPROVED • (PCU) PAPER - CURRENT UNAPPROVED
Numerator	Number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.	Count of prescriptions in Credible denominator where status is (EC) ELECTRONIC - CURRENT or (ECU) ELECTRONIC - CURRENT UNAPPROVED Formulary checking is automatic <i>provided</i> 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.

Core 3: Record Demographics

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

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

§170.314(a)(3) Record demographics	<p>Enable a user to electronically record, change, and access patient demographic data including preferred language, sex, race, ethnicity, and date of birth.</p> <ul style="list-style-type: none">• Enable race and ethnicity to be recorded in accordance with the standard specified in §170.207(f) and whether a patient declines to specify race and/or ethnicity.• Enable preferred language to be recorded in accordance with the standard specified in §170.207(g) and whether a patient declines to specify a preferred language.
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For Credible configuration and use information, refer to [Stage 1 Core 7: Record Demographics](#).

Attestation: §170.302(n)

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

For denominator/numerator information and the stored procedure name, refer to [Stage 1 Core 7: Record Demographics](#).

Core 4: Record Vital Signs

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

For certification criteria and Credible configuration and use information, refer to [Stage 1 Core 8: Record Vital Signs](#).

Attestation: §170.302(n)

Measure	More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.
Exclusion	Same as Stage 1 Core 8: Record Vital Signs

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

Core 5: Record Smoking Status

For the objective, certification criteria, and Credible configuration and use information, refer to [Stage 1 Core 9: Record Smoking Status](#).

Attestation: §170.302(n)

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

For denominator/numerator information and the stored procedure name, click [Stage 1 Core 9: Record Smoking Status](#).

Core 6: Clinical Decision Support Rule

Objective

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

For certification criteria and Credible configuration and use information, refer to [Stage 1 Core 10: Clinical Decision Support Rule](#).

Attestation: YES/NO

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

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

Core 7: Patient Electronic Access

For the objective, certification criteria, and Credible configuration and use information, refer to [Stage 1 Core 11: Patient Electronic Access](#).

Attestation: §170.302(n)

Measure	<p>Measure 1:</p> <p>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.</p> <p>Measure 2:</p> <p>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.</p>
Exclusion	<p>Any EP who:</p> <p>(1) Neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office contact information, may exclude both measures.</p> <p>(2) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude only the second measure.</p>

CMS

Credible

<p>Measure 1 Denominator</p>	<p>Number of unique patients seen by the EP during the EHR reporting period.</p>	<p>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</p>
<p>Measure 1 Numerator</p>	<p>Number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information.</p>	<p>Count of clients in Credible denominator where number of business days from visit start date to the visit sign & submit date (transfer_date) is 4 or less and the client has at least one client user account created within four business days of the visit</p>

Stored procedure in Credible [spc_export_mu_vdt_summary](#)

If your organization is not using the Client Portal, you need to determine what you will provide electronically to clients and how this will be documented.

A business day is defined as a date that is both a weekday (Monday to Friday) and is not marked as a holiday. To enable the Company Holidays function, select *Use Company Holidays* in Partner Config. To designate a day as a company holiday: Admin tab > **Company Holidays** > click the appropriate date.

CMS

Credible

Measure 2 Denominator Number of unique patients seen by the EP during the EHR reporting period.

Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked

Measure 2 Numerator The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information.

Count of clients in Credible denominator where there is at least one successful client user login into the Client Portal where the login date/time is in the reporting period

Stored procedure in Credible [spc_export_mu_vdt_summary](#)

Core 8: Clinical Summaries

For the objective, certification criteria, and Credible configuration and use information, refer to [Stage 1 Core 12: Clinical Summaries](#).

Attestation: §170.302(n)

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

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

Core 9: Protect Electronic Health Information

Objective

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

For the following certification criteria, refer to [Stage 1 Core 13: Protect Electronic Health Information](#):

- §170.314(d)(1) Authentication, access control, and authorization
- §170.314(d)(2) Auditable events and tamper-resistance
- §170.314(d)(3) Audit report(s)
- §170.314(d)(4) Amendments
- §170.314(d)(5) Automatic log-off
- §170.314(d)(6) Emergency access
- §170.314(d)(8) Integrity

Certification criteria: [§170.314\(d\)\(7\) End-user device encryption](#)

§170.314(d)(7) End-user device encryption

Paragraph (d)(7)(i) or (ii) of this section must be met to satisfy this certification criterion.

(i) EHR technology that is designed to locally store electronic health information on end-user devices must encrypt the electronic health information stored on such devices after use of EHR technology on those devices stops.

(A) Electronic health information that is stored must be encrypted in accordance with the standard specified in §170.210(a)(1).

(B) Default setting. EHR technology must be set by default to perform this capability and, unless this configuration cannot be disabled by any user, the ability to change the configuration must be restricted to a limited set of identified users.

(ii) EHR technology is designed to prevent electronic health information from being locally stored on end-user devices after use of EHR technology on those devices stops.

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

Attestation: YES/NO

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 its risk management process.
Exclusion	No exclusion.

EPs must attest YES to conducting or reviewing a security risk analysis and implementing security updates as necessary to meet this measure.

Core 10: Clinical Lab Test Results

Objective	Incorporate clinical lab-test results into certified EHR technology (CEHRT) as structured data
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Certification criteria: §170.314(b)(5) Incorporate laboratory tests and values/results

§170.314(b)(5) Incorporate laboratory tests and values/results	<ul style="list-style-type: none"> (i) Receive results – <ul style="list-style-type: none"> (A) Ambulatory setting only – <ul style="list-style-type: none"> a. Electronically receive and incorporate clinical laboratory tests and values/results in accordance with the standard specified in §170.205(j) and, at a minimum, the version of the standard specified in §170.207(c)(2). b. Electronically display the tests and values/results received in human readable format. (ii) Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (iii) Electronically attribute, associate, or link a laboratory test and value/result with a laboratory order or patient record.
---	---

For Credible configuration and use information, refer to [Stage 1 Menu 2: Clinical Lab Test Results](#).

Attestation: §170.302(n)

Measure	More than 55 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
Exclusion	Same as Stage 1 Menu 2: Clinical Lab Test Results

For denominator/numerator information and the stored procedure name, refer to [Stage 1 Menu 2: Clinical Lab Test Results](#).

Core 11: Patient Lists

For the objective, certification criteria, and Credible configuration and use information, refer to [Stage 1 Menu 3: Patient Lists](#).

Attestation: YES/NO

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

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

Core 12: Preventative Care

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

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

170.314(a)(14) Patient list creation	Enable a user to electronically and dynamically select, sort, access, and create patient lists by: date and time; and based on each one and at least one combination of the following data: <ul style="list-style-type: none">(i) Problems;(ii) Medications;(iii) Medication allergies;(iv) Demographics;(v) Laboratory tests and values/results; and(vi) Patient communication preferences.
---	--

For information on using Advanced Client Search to generate a list of clients that need a reminder visit and then add the appropriate type of patient reminder visit for each client in the list via the Show Add Visit function, refer to [Stage 1 Core 4: Patient Reminders](#).

For information on using Advanced Client Search to generate lists of clients that meet specific search criteria, refer to [Stage 1 Menu 3: Patient Lists](#).

Attestation: §170.302(n)

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

CMS

Denominator Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR reporting period

Numerator Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period

Credible

Unduplicated/distinct count of clients that have two approved visits in the 24 months prior to the reporting period start date where employee on visit is flagged as MU Provider and visit type has Include Summary checked

Count of clients in Credible denominator where reminder visit date is in the reporting period, reminder is identified via External ID on the visit type, and client has preferred contact method recorded in client profile

 Stored procedure in Credible
[spc_export_mu_patient_reminder_summary](#)

Core 13: Patient-Specific Education Resources

For the objective, certification criteria, and Credible configuration and use information, refer to [Stage 1 Menu 5: Patient-Specific Education Resources](#).

Attestation: §170.302(n)

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

For denominator/numerator information and the stored procedure name, refer to [Stage 1 Menu 5: Patient-Specific Education Resources](#).

Core 14: Medication Reconciliation

For the objective, certification criteria, and Credible configuration and use information, refer to [Stage 1 Menu 6: Medication Reconciliation](#).

Attestation: §170.302(n)

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

	CMS	Credible
Denominator	Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition	<p>Number of transitions into care; calendar control question has SNOMED CT code 1861000124105 for Transition of care (finding)</p> <p>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)</p> <p>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:</p> <ul style="list-style-type: none"> • 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	CMS	Credible
	Number of transitions of care in the denominator where medication reconciliation was performed	<p>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</p> <p> Stored procedure in Credible spc_export_mu_med_reconcile_summary</p>

Core 15: Summary of Care

For the objective and certification criteria, refer to [Stage 1 Menu 7: Transition of Care Summary](#).

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

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

If your system is not currently configured for Direct Project support, use the configuration and use steps for [Stage 1 Menu 7: Transition of Care Summary](#).

Settings Security Matrix: PatientSummaryGenerator, ClientFileAdd

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

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

6. Optional: add a file folder and name it Clinical Summaries (Admin tab > File Folders Admin > fill out Add Folder section).

Steps to Use To upload a clinical summary received via Direct Project:

1. Client tab > Attachments on Client nav bar > Import Clinical Summary button > Direct Summaries radio button.
2. Fill out the File Categorization section.
3. Select appropriate clinical summary from Received Clinical Summaries list and click Upload File.
4. Close the "Summary successfully uploaded" popup and click the Attachments button on Client nav bar to view uploaded clinical summary. If the imported clinical summary is a CCD, it will have a "browser view" icon. When viewing the CCD in your browser, there is a hyperlinked table of contents below the demographic information that you can use to jump to the different sections in the document.

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

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

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

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

Measure	<p>EPs must satisfy both of the following measures in order to meet the objective:</p> <p>Measure 1:</p> <p>The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.</p> <p>Measure 2:</p> <p>The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.</p> <p>Measure 3:</p> <p>An EP must satisfy one of the following criteria:</p> <ul style="list-style-type: none">• Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2).• Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
Exclusion	<p>Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.</p>

	CMS	Credible
Measure 1 Denominator	Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider	Number of approved visits with an answer coded to SNOMED CT for referral: <ul style="list-style-type: none"> Clinical consultation report (record artifact) (SNOMED CT code 371530004) Report of clinical encounter (record artifact) (SNOMED CT code 371531000) Confirmatory consultation report (record artifact) (SNOMED CT code 371545006)
Measure 1 Numerator	Number of transitions of care and referrals in the denominator where a summary of care record was provided	Number of visits in Credible denominator that have CLINICAL SUMMARY GENERATED in the visit log

 Stored procedure in Credible
[spc_export_mu_messaging_summary](#)

	CMS	Credible
Measure 2 Denominator	Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider	Same Credible denominator as Measure 1
Measure 2 Numerator	Number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization	Number of visits in Credible denominator that have CLINICAL SUMMARY GENERATED or SEND CLINICAL SUMMARY VIA DIRECT in the visit log; the latter counts toward summary of care record provided and electronically transmitted

 Stored procedure in Credible
[spc_export_mu_messaging_summary](#)

Measure 3: YES/NO

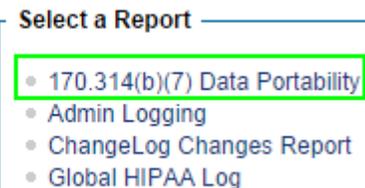
The EP attests YES to one of the two criteria:

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

§170.314(b)(7) Data portability

Certification criteria	<p>Enable a user to electronically create a set of export summaries for all patients in EHR technology formatted according to the standard adopted at §170.205(a)(3) that represents the most current clinical information about each patient and includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s):</p> <ul style="list-style-type: none">(A) Encounter diagnoses. The standard specified in §170.207(i) or, at a minimum, the version of the standard at §170.207(a)(3);(B) Immunizations. The standard specified in §170.207(e)(2);(C) Cognitive status;(D) Functional status; and(E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information.(F) Inpatient setting only. Discharge instructions.
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With an Admin report in Credible, you can create a batch of clinical summaries in CDA (CCD) format for all clients in your system.



Generating the Data Portability report results in a zip file that contains a clinical summary for *every client in your system* (for some Partners, this may mean 50,000 files) and an XSL style sheet for viewing purposes. The clinical summary file naming convention is `cda_client_id_datetimestamp_count`. For example, `cda_1009_2014300716301.xml` is for client 1009, was generated at 4:30pm on July 30, 2014, and was the first in that batch. The system will not generate clinical summaries for purged or deleted clients or clients with a DUPLICATE status (the result of merging two clients together).

To avoid system performance degradation, the report is queued up after you request it and is generated during non-peak hours. Note that Data Portability report is only available for download for 30 days. To keep the report, you need to download and save it before the 30-day time frame is up.

Generating the clinical summary for clients via the Data Portability report is logged for each client as CLINICAL SUMMARY GENERATED.

Settings Security Matrix: ReportList

Report Security Matrix: 170.314(b)(7) Data Portability

Important: access to the Data Portability report can give employees access to client data they may not usually have access to. For this reason, you should only give the 170.314(b)(7) Data Portability right to Admin-level staff.

Clinical summaries contain protected health information (PHI) – follow HIPAA guidelines to protect it.

Steps to Configure N/A

- Steps to Use**
1. Reports tab > Admin button on nav bar > 170.314(b)(7) Data Portability >  >  .
 2. Click OK to close the “successfully submitted” popup. The Report Inbox screen displays.

Report Inbox						
	Deliverable Name	Parameters	Date Requested	Status	Date Completed	
	CDA	Report ID: 1602 Requested By: Jane Smith	10/7/2014 8:51:18 PM	Pending		<i>Report is not ready for viewing</i>

3. Use the corresponding button on the Reports nav bar at a later time to see if the Data Portability report is available.



4. When the report is available, the red circle changes to green, the status changes to Completed, and the date/time the report was completed is indicated.

Report Inbox						
	Deliverable Name	Parameters	Date Requested	Status	Date Completed	
	 CDA	Report ID: 1602 Requested By Jane Smith	10/7/2014 8:51:18 PM	Completed	10/9/2014 5:22:42 PM	Download

5. Click the Download link to download the Data Portability zip file.
6. For attestation purposes, upload the Data Portability zip file to the appropriate third party – this process occurs outside of Credible. Provide the third party with the following view instructions:
 - a. Extract the files from the zip file into a folder (the XSL style sheet and clinical summary files have to be in the same folder).
 - b. Click each clinical summary file to view it.

Core 16: Immunization Registries

For the objective, certification criteria, and Credible configuration and use information, refer to [Stage 1 Menu 8: Immunization Registries Data Submission](#).

Attestation: YES/NO

Measure	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.
Exclusion	Any EP that meets one or more of the following criteria may be excluded from this objective: <ol style="list-style-type: none">(1) the EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;(2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period;(3) the EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or(4) the EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

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

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

Core 17: Use Secure Electronic Messaging

Objective

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

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

§170.314(e)(3) Secure messaging

Enable a user to electronically send messages to, and receive messages from, a patient in a manner that ensures:

- (i) Both the patient (or authorized representative) and EHR technology user are authenticated; and
- (ii) The message content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at §170.210(f).

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

Settings Security Matrix: ClientNoteAdd, MessagingHubAnswerMessages

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 [Appendix A](#) for information on setting up the Client Portal.

Steps to Use For public client notes:

1. Notes on Client nav bar.
2. Enter the note in the text box, select the Is Public checkbox, and click Add Note.

3. Hover over the hash symbol to view the message hash. When the client user views the note in the Client Portal, they can compare the message hash with the received hash.

For client/employee messages:

1. Click the envelope icon in the banner or the Messaging Hub button on Employee nav bar.
2. 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: §170.302(n)

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

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

Menu 1: Syndromic Surveillance Data Submission

Objective	Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.
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Certification criteria: §170.314(f)(3) Transmission to public health agencies – syndromic surveillance

§170.314(f)(3) Transmission to public health agencies – syndromic surveillance	<p>EHR technology must be able to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with:</p> <ul style="list-style-type: none"> C. The standard specified in §170.205(d)(2). D. Optional. The standard (and applicable implementation specifications) specified in §170.205(d)(3).
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For Credible configuration and use information, refer to [Stage 1 Menu 9: Syndromic Surveillance Data Submission](#).

Attestation: YES/NO

Measure	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.
Exclusion	<p>Any EP that meets one or more of the following criteria may be excluded from this objective:</p> <ul style="list-style-type: none"> (1) the EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period; (2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period; (3) the EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or (4) the EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

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

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

Menu 2: Electronic Notes

Objective

Record electronic notes in patient records.

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

§170.314(a)(9) Electronic notes

Enable a user to electronically record, change, access, and search electronic notes.

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

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

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

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

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

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

Attestation: §170.314(g)(2)

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

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

Menu 3: Imaging Results

Objective

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

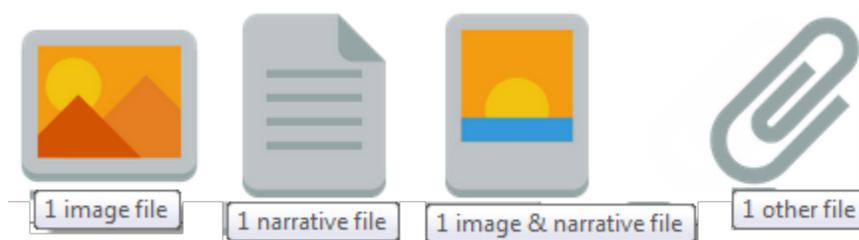
Certification criteria: §170.314(a)(12) Image results

§170.314(a)(12) Image results

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

In Credible, when entering a manual lab result or editing an existing one, you can upload one or more attachments. You have to specify the attachment type as Image, Narrative, Image & Narrative, or Other. Note that there is no file type validation so you must select the appropriate type based on what is in the file. To count towards this measure, the lab attachment must be Image or Image & Narrative.

Once attached, a corresponding icon is added to the lab results list for the order and the overall Results list; hovering over the icon displays the number of attachments and attachment type.



Settings Security Matrix: eLabs

Separate contracting is required to use the Credible eLabs module. Please contact contracts@credibleinc.com if you would like to add this module to your Agency's domain. Once purchased, your IM/PSC needs to turn on the eLabs Result Entry feature.

Steps to Configure In Credible Help, refer to *Setting Up eLabs*.

- Steps to Use**
1. eLabs button on Client nav bar.
 2. Edit an existing lab result (click edit button > Save Result Header button) or add a new one (click Add Manual Result tab, fill out the Lab Results Header screen, and click Save Result Header.)
 3. Edit an existing lab result or add a new one (make sure the required fields Test Code, Test Name, and Result Date are filled out).
 4. In the Attachments section, click Choose File and find/select the file (see Credible Help for supported file types). Select the attachment type Image or Image & Narrative as appropriate and click Attach File.
 5. If you need to delete an attachment, use the delete button in the Attachments section.
 6. When done adding attachments, click Save Lab Result and then click Return to Labs.

Attestation: §170.302(n)

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

	CMS	Credible
Denominator	Number of tests whose result is one or more images ordered by the EP during the EHR reporting period	Number of physician orders where type is 'Radiology' and the Order Date in is the reporting period
Numerator	Number of results in the denominator that are accessible through CEHRT	Number of orders in Credible denominator where eLab result has an attachment with Image or Image & Narrative as the attachment type AND the test type specifically is the word 'Radiology' AND the ordered date is in the date range

 Stored procedure in Credible
[spc_export_mu_imaging_summary](#)

Menu 4: Family Health History

Objective	Record patient family health history as structured data.
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Certification criteria: §170.314(a)(13) Family health history

§170.314(a)(13) Family health history	Enable a user to electronically record, change, and access a patient's family health history according to: <ul style="list-style-type: none">(i) At a minimum, the version of the standard specified in §170.207(a)(3); or(ii) The standard specified in §170.207(j).
--	--

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

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

Settings Security Matrix: ClientUpdateContactsFamily

Partner Config: Use Client Family

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

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

Steps to Use To record the health history of an “existing client” family member, use the Diagnosis button on his/her Client nav bar. For more information, refer to the Steps to Use for [Stage 1 Menu 3: Maintain Problem List](#).

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

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

Attestation: §170.302(n)

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

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

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

All eligible professionals (EPs) are required to report on CQMs to demonstrate meaningful use. As of 2014, all EPs, *regardless of their stage of meaningful use*, report on CQMs in the same way and must report on 9 of the 64 approved CQMs. When reporting CQMs, it is only required that you report on them – there is no minimum threshold that must be met. As shown below, a zero in the denominator is acceptable as long as it was produced by certified EHR technology.

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FOR ELIGIBLE PROFESSIONALS

<https://ehrincentives.cms.gov>

Step 24 – Clinical Quality Measures (CQMs 1 of 9)

Each EP must report on nine CQMs. Zero is an acceptable denominator provided that this value was produced by certified EHR technology.

Credible developed reporting functionality for 9 CQMs that meet the requirement of covering at least three of the National Quality Strategy domains.

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

The CQM reports are generated using the HL7 Quality Reporting Document Architecture (QRDA), a standard document format for exchanging electronic CQM data. Each time you request the CQM reports, the system generates a:

1. Category III zip file that contains the summary results from all nine measures with no patient-identifiable information and an XSL style sheet for viewing purposes
2. Zip file for each measure that contains Category I client files – one for each client included in the measure results

Important: Category I files contain protected health information (PHI) – follow HIPAA guidelines to protect it.

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

Settings and General Configuration

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

Important: access to the CQM reports can give employees access to client data they may not usually have access to. For this reason, you should only give the ClinicalQualityMeasurements right to Admin-level staff.

Category I files contain protected health information (PHI) – follow HIPAA guidelines to protect it.

General configuration steps:

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

Understanding the Components of a CQM

CMS defines the five components of a CQM as follows:¹⁴

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

In Credible:

- Any client that has been flagged as DUPLICATE (via Manage Client Duplicates) or DELETED will not be included in an IPP.
- If inclusion in an IPP is based on having received a service (encounter), a client must have had at least one *approved* visit where the visit date is in the measurement period AND the CPT or HCPCS code is in the “value set” (list of valid codes) for the measure. If there are multiple visits that meet this criteria, the most recent visit that occurs in the measurement period will be used to determine the Denominator and Numerator. This visit is referred to as the “IPP Visit.”¹⁵
- If an IPP has an age requirement (for example, must be 12 or older), a client will only be included if he/she meets the requirement as of the measurement period Start Date AND his/her date_of_death field is blank (null) or has a date that is after the measurement period Start Date.

¹⁴ http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/CQM_Webinar_Slides.pdf

¹⁵ CPT stands for Current Procedural Terminology and HCPCS stands for Healthcare Common Procedure Coding System.

Search 

- (Select All)
- Attribute
- Condition-Diagnosis-Problem
- Encounter
- Individual Characteristic
- Intervention
- Medication
- Procedure
- Risk Category-Assessment

D	E	F	G	H
qdm category	value_set_oid	value_set_name	code system	code
Encounter	2.16.840.1.113883.3.464.1003.101.12.1047	HIV Visit	CPT	99201
Encounter	2.16.840.1.113883.3.464.1003.101.12.1047	HIV Visit	CPT	99202
Encounter	2.16.840.1.113883.3.464.1003.101.12.1047	HIV Visit	CPT	99203

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

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

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

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

CQM Component	In Credible
<p>Initial Patient Population (IPP): all patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period</p>	<ol style="list-style-type: none"> 1. Click here for age requirement information. 2. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (<code>SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS2V3'</code>) and filter the <code>qdm_category</code> column by Encounter. Refer to the <code>code_system</code>, <code>code</code>, and <code>description</code> columns. 3. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides. 4. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with the required questions and answers.
<p>Denominator: equals IPP</p>	N/A

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

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

Effective Date: 2/11/2014 Date Created: 2/11/2014

Axis I: Clinical Disorders; Other Conditions That May be a Focus of Clinical Attention

First 290.10 - PRESENILE DEMENTIA, UNCOMPLICATED

Diagnosed By: [] Diagnosed: 01/01/2014 Resolved: 03/10/2014

Onset Prior to Admission: --Select-- Onset Date: [] Previous Onset Date: []

Default for Programs: [] Notes: []

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

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

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

Adolescent Depression Screening (LOINC 73831-0)

---SELECT---

---SELECT---

Depression Screening Negative (finding) (SNOMEDCT 428171000124102)

Depression Screening Positive (situation) (SNOMEDCT 428181000124104)

Not performed due to Medical Reason: Procedure contraindicated (situation) (SNOMEDCT 428191000124104)

Adult Depression Screening (LOINC 73832-8)

---SELECT---

---SELECT---

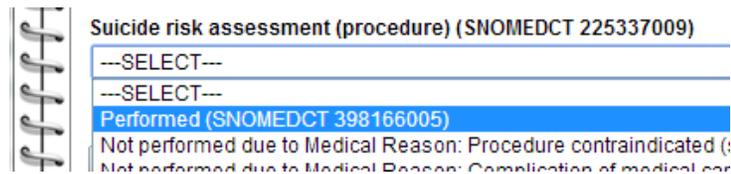
Depression Screening Negative (finding) (SNOMEDCT 428171000124102)

Depression Screening Positive (situation) (SNOMEDCT 428181000124104)

Not performed due to Medical Reason: Procedure contraindicated (situation) (SNOMEDCT 428191000124104)

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

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



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

Numerator Exclusions: N/A

N/A

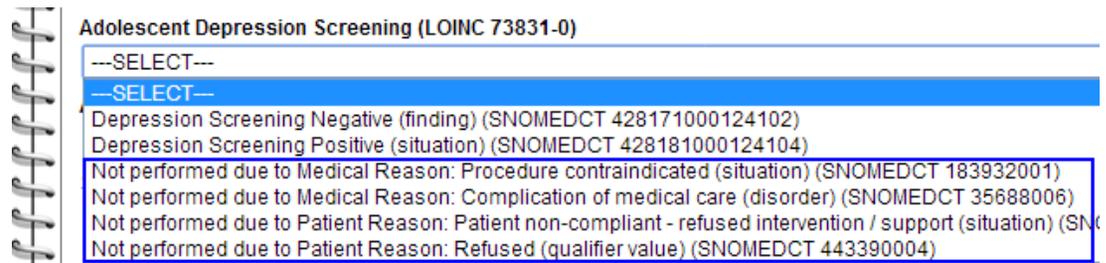
Denominator Exceptions:

Patient Reason(s): Patient refuses to participate

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

OR

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



OR

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

Adult Depression Screening (LOINC 73832-8)
--SELECT--
--SELECT--
Depression Screening Negative (finding) (SNOMEDCT 428171000124102)
Depression Screening Positive (situation) (SNOMEDCT 428181000124104)
Not performed due to Medical Reason: Procedure contraindicated (situation) (SNOMEDCT 183932001)
Not performed due to Medical Reason: Complication of medical care (disorder) (SNOMEDCT 35688006)
Not performed due to Patient Reason: Patient non-compliant - refused intervention / support (situation) (SNOMEDCT 443390004)
Not performed due to Patient Reason: Refused (qualifier value) (SNOMEDCT 443390004)

Form Configuration for the Numerator and the Denominator Exception

Update the appropriate form(s) as follows:

- Optional: add a label only question that identifies the measure.
- Add separate dropdown questions for Adolescent Depression Screening and Adult Depression Screening, coding the Adolescent one to LOINC 73831-0 and the Adult one to LOINC 73832-8.¹⁶

include in summary: False ▼

External Code:

SNOMED Code:

LOINC Code:

- Add Negative and Positive answers to each depression screening question, coding the Negative one to SNOMED CT 428171000124102 for “Depression screening negative (finding)” and the Positive one to SNOMED CT 428181000124104 for “Depression screening positive (situation)”.

Answer:

External Code:

SNOMED Code:

LOINC Code:

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

¹⁶ LOINC stands for Logical Observation Identifiers Names and Codes, a standard for identifying medical laboratory observations.

5. For Positive screening follow-up, do one or both of the following:

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

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

CMS50v2 Closing the Referral Loop: Receipt of Specialist Report

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

Closing the referral loop: receipt of specialist report

Referral Received (indicate type)
---SELECT---

Provider to Provider Communication (indicate type)
---SELECT---

CQM Component	In Credible
<p>Initial Patient Population (IPP): number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period</p>	<ol style="list-style-type: none"> To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (<code>SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS50V2'</code>) and filter the <code>qdm_category</code> column by Encounter. Refer to the <code>code_system</code>, <code>code</code>, and <code>description</code> columns. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with the required questions and answers. To be included in the IPP, the client must also have a referral documented. In the same visit, or another approved visit in the measurement period, a question has an answer coded to an intervention in the value set. For example, the answer 'Referral to neurologist (procedure)' would be coded as 308474002. To view valid referral answers, view the value set and filter the <code>qdm_category</code> column by Intervention. Jot down the SNOMED CT codes that correspond to the referrals that your Agency makes.

Denominator: equals IPP N/A

Denominator Exclusions: none N/A

Numerator: number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred
Receiving the referral report is considered 'Communication from Provider to Provider' and is documented by having an approved visit with an answer coded to one the three Communications in the value set (see below). The visit documenting the communication must start after the referral visit ends.

Numerator Exclusions: N/A N/A

Denominator Exceptions: none N/A

Form Configuration for the IPP and the Numerator

Update the appropriate form(s) as follows:

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

Referral Received (indicate type)

--SELECT--
--SELECT--
Patient referral for dental care (procedure) (SNOMEDCT 103697008)
Patient referral to dietitian (procedure) (SNOMEDCT 103699006)
Referral to physician (procedure) (SNOMEDCT 183515008)
Referral to psychiatrist for the elderly mentally ill (procedure) (SNOMEDCT 183528001)

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

Provider to Provider Communication (indicate type)

---SELECT---

---SELECT---

Clinical consultation report (record artifact) (SNOMEDCT 371530004)

Report of clinical encounter (record artifact) (SNOMEDCT 371531000)

Confirmatory consultation report (record artifact) (SNOMEDCT 371545006)

CMS62v2 HIV/AIDS: Medical Visit

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

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

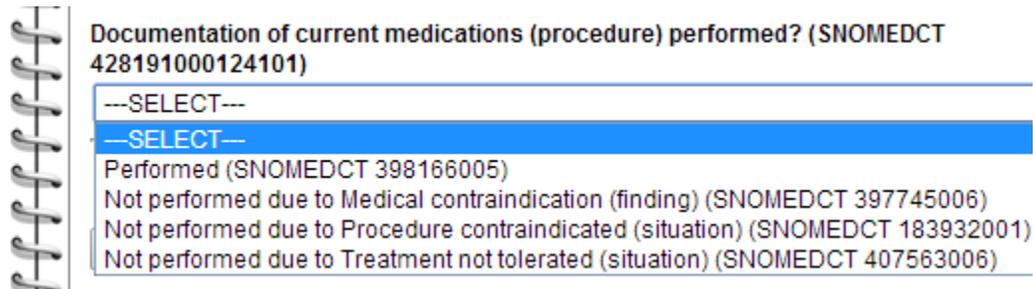
- Example 2: Visit A on 1/1/13, Visit B on 1/15/13, and Visit C on 6/20/13. Client has three visits and Visits B and C are more than 90 days apart. Client counts towards the numerator.

Numerator Exclusions: N/A N/A

Denominator Exceptions: none N/A

CMS68v3 Documentation of Current Medications in the Medical Record

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



Measure Notes

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

CQM Component	In Credible
Initial Patient Population (IPP): all visits occurring during the 12 month reporting period for	1. Click here for age requirement information.

patients aged 18 years and older before the start of the measurement period

2. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (`SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS68V3'`) and filter the `qdm_category` column by Encounter.
3. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides.
4. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with a required question and answers.

The documentation for every visit identified in the IPP must contain a question asking whether Medication Reconciliation was performed. You need to code the question to SNOMED CT 428191000124101 for “Documentation of current medications (procedure)” and code the answers as specified below. The answer selected determines whether the visit counts toward the numerator or is a denominator exception (see below).

If the completed form data for an IPP visit does not contain BOTH a Medication Reconciliation question and answer with the required SNOMED codes, medication reconciliation will be considered not performed.

Denominator: equals IPP

N/A

Denominator Exclusions: none

N/A

Numerator: eligible professional attests to documenting, updating or reviewing the patient’s current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions,

To count towards the numerator, the selected answer to the Medication Reconciliation question has to have a SNOMED code of 398166005 for “Performed (qualifier value)” – this indicates that the medication list was reviewed and found to be complete.

It is the responsibility of the employee completing the visit to review the list of medications at each visit and attest to its completeness.

over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration

Numerator Exclusions: N/A

N/A

Denominator Exceptions:

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

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

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

Form Configuration for the IPP, Numerator, and Denominator Exception

Update the appropriate form(s) as follows:

1. Optional: add a label only question that identifies the measure.
2. Add a dropdown question for "Documentation of current medications (procedure) performed?" and enter 428191000124101 in the SNOMED Code field.
3. Add the following answers to the question, entering the codes indicated in the SNOMED Code field:
 - a. Performed (qualifier value) – 398166005
 - b. Procedure contraindicated (situation) – 183932001
 - c. Medical contraindication (finding) – 397745006

d. Treatment not tolerated (situation) – 407563006

CMS139v2 Falls: Screening for Future Fall Risk

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

Falls risk assessment (LOINC 73830-2)

- SELECT--
- Performed (SNOMEDCT 398166005)**
- Not performed due to History of - drug allergy (situation) (SNOMEDCT 161590003)
- Not performed due to Procedure contraindicated (situation) (SNOMEDCT 183932001)
- Not performed due to Drug treatment not indicated (situation) (SNOMEDCT 183966005)
- Bed-ridden (finding) (SNOMEDCT 160685001)

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

Numerator: patients who were screened for future fall risk at least once within the measurement period

To count towards the numerator, the selected answer to the Fall Risk Screening question has to have a SNOMED CT code of 398166005 for “Performed (qualifier value)” – this indicates that the Fall Risk Screen was done.

Clients will count towards the numerator when they have at least one visit where a fall risk screening was performed. Multiple fall risk screenings for the same client will not be counted.

Numerator Exclusions: N/A

N/A

Denominator Exceptions: documentation of medical reason(s) for not screening for fall risk (e.g., patient is not ambulatory)

To indicate a valid reason for NOT doing the fall risk screening, the selected answer to the Fall Risk Screening question has to have a SNOMED CT code from the value set OR the SNOMED CT code of 160685001 for “Bed-ridden (finding).”

Form Configuration for Numerator and Denominator Exception

Update the appropriate form(s) as follows:

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

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

- c. Bed-ridden (finding) – 160685001

CMS149v2 Dementia: Cognitive Assessment

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

Dementia: Cognitive Assessment	
<hr/>	
Assessment and interpretation of higher cerebral function, cognitive testing (procedure) performed? (SNOMEDCT 113024001)	
<input type="radio"/> Yes (SNOMEDCT 398166005)	
<input type="radio"/> No (SNOMEDCT 262008008)	
Psychologic cognitive testing and assessment (procedure) performed? (SNOMEDCT 113024001)	
<input type="radio"/> Yes (SNOMEDCT 398166005)	
<input type="radio"/> No (SNOMEDCT 262008008)	
Palliative care (regime/therapy) performed? (SNOMEDCT 103735009)	
<input type="radio"/> Yes (SNOMEDCT 398166005)	
<input type="radio"/> No (SNOMEDCT 262008008)	
Hospice care (regime/therapy) performed? (SNOMEDCT 385763009)	
<input type="radio"/> Yes (SNOMEDCT 398166005)	
<input type="radio"/> No (SNOMEDCT 262008008)	
<hr/>	
Brief Interview for Mental Status (BIMS)	
BIMS Result (LOINC 58151-2)	<input type="text"/>
BIMS Not performed due to	
<input type="text" value="---SELECT---"/>	

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

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

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

Numerator Exclusions: N/A

N/A

Denominator Exceptions:

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

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

Documentation of patient reason(s) for not assessing cognition

To document NOT performing the cognitive assessment:

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

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

Form Configuration for the Numerator and the Denominator Exceptions

Update the appropriate form(s) as follows:

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

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

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

OR

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

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

code	description
161590003	History of - drug allergy (situation)
183932001	Procedure contraindicated (situation)
183961008	Treatment not indicated (situation)

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

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

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

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

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

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

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

Complete Medical Profile Vital Signs (height/weight) [numerator 1]

Counseling for Nutrition Performed [numerator 2]

--SELECT--

Counseling for Physical Activity [numerator 3]

--SELECT--

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

- Stratum 1 – Patients age 3-11
- Stratum 2 – Patients age 12-17

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

CQM Component	In Credible
<p>Initial Patient Population (IPP): patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period</p>	<ol style="list-style-type: none"> Click here for age requirement information. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (<code>SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS155V2'</code>) and filter the qdm_category column by Encounter. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides.

- Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with required questions and answers.

Denominator: equals IPP

N/A

Denominator Exclusion: patients who have a diagnosis of pregnancy during the measurement period

To be considered active, the diagnosis must start prior to the end of the measurement period and end after the start of the measurement period (or not end at all). The diagnosis of starts on the Diagnosed Date; if blank, the Effective Date for the assessment is used. The Resolved Date indicates when that diagnosis is no longer active.

If you want to see which Pregnancy diagnoses are valid for the measure, view the value set and filter the qdm_category column by Condition-Diagnosis-Problem; the valid diagnoses have ICD9CM or SNOMEDCT in the code_system column.

Numerator 1: patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period

To count towards Numerator 1, the client must have a complete height and weight in the same medical profile and the effective date of the medical profile must be in the measurement period. BMI is automatically calculated.

Height and weight must be recorded using the standard fields (ClientMedicalProfile.height_ft, ClientMedicalProfile.height_in, ClientMedicalProfile.weight); using any other fields will not calculate a BMI.

Numerator 2: patients who had counseling for nutrition during the measurement period

To count towards Numerator 2, the client needs at least one approved visit during the measurement period where Nutrition Counseling is documented. As there are multiple types of counseling, only the answers need to be coded with the SNOMED CT codes in the value set.

Numerator 3: patients who had counseling for physical activity during the measurement period

To count towards Numerator 3, the client needs at least one approved visit during the measurement period where Physical Activity Counseling is documented. As there are multiple types of counseling, only the answers need to be coded with the SNOMED CT codes in the value set.

Numerator Exclusion: N/A

N/A

Denominator Exceptions: none

N/A

Form Configuration for Numerators 2 and 3

Update the appropriate form(s) as follows:

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

code	description
103699006	Patient referral to dietitian (procedure)
11816003	Diet education (procedure)
183059007	High fiber diet education (procedure)
183062005	Low cholesterol diet education (procedure)

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

code	description
103736005	History and physical examination, sports part
183073003	Patient advised about exercise (situation)
183075005	Recommendation to mobilize part (procedure)
223440005	Recommendation to undertake activity (proce

CMS156v2 Use of High-Risk Medications in the Elderly

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

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

Calculation Notes

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

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

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

The duration of the prescription is calculated by as follows:

$(\text{Quantity} \times \text{Number of Refills}) / (\text{Dosage} \times \text{Route Per} \times \text{Route Time Multiplier})$

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

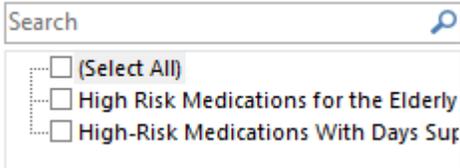
Route Time Multiplier = 1 or 3; see below

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

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

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

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

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

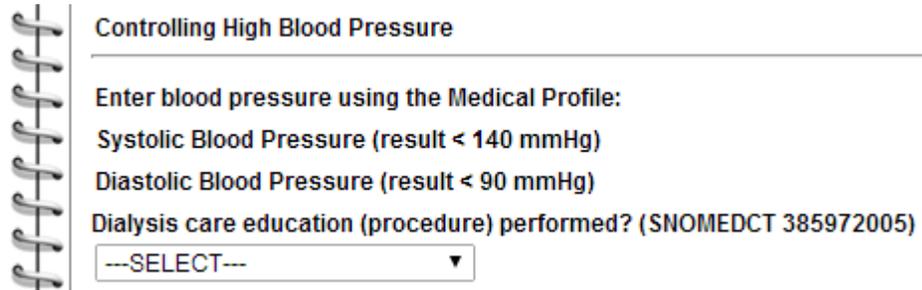
- High-Risk Medications With Days Supply Criteria – these only count towards the numerator when the prescription exists AND the Cumulative Medication Duration is 90 days or greater (high risk for the client exists if 90 or more days worth of the medication has been ordered)

Numerator Exclusion: N/A N/A

Denominator Exception: N/A N/A

CMS165v2 Controlling High Blood Pressure

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



The screenshot shows a data entry form with a spiral binding on the left. The title is 'Controlling High Blood Pressure'. Below the title, there is a horizontal line. The instructions are: 'Enter blood pressure using the Medical Profile:'. There are three text input fields: 'Systolic Blood Pressure (result < 140 mmHg)', 'Diastolic Blood Pressure (result < 90 mmHg)', and 'Dialysis care education (procedure) performed? (SNOMEDCT 385972005)'. The last field has a dropdown menu with the text '--SELECT--' and a downward arrow.

Measure Notes

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

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

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

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

The following are used only for the denominator exclusions:

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

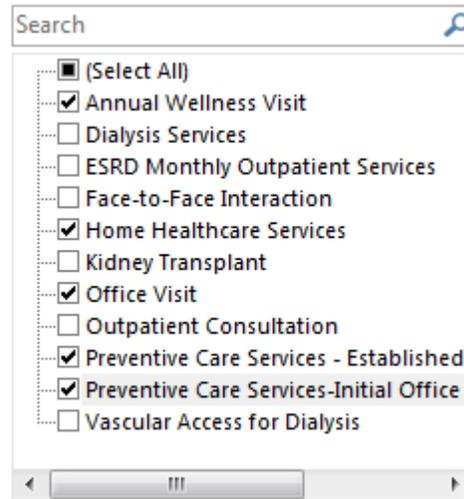
CQM Component

In Credible

Initial Patient Population (IPP):

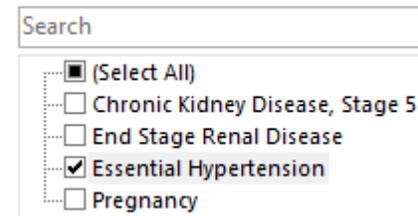
patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

1. Click [here](#) for age requirement information.
2. To view CPT/HCPCS codes of IPP visits, export value set to a spreadsheet (`SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS165V2'`), filter qdm_category column by Encounter, and then filter value_set_name by the names below.



To be included in the IPP, a client must have a diagnosis of Essential Hypertension that starts no later than 6 months after the start of the measurement period. If the diagnosis started prior to the start of the measurement period, the Resolved Date must be empty or after the start of the measurement period. In essence, the client has a diagnosis of hypertension during the first six months of the period.

The ICD9CM or SNOMEDCT code of the diagnosis must be in the value set. To view the valid codes: view the value set, filter qdm_category by Condition-Diagnosis-Problem, and then filter value_set_name by Essential Hypertension.



Denominator: equals IPP

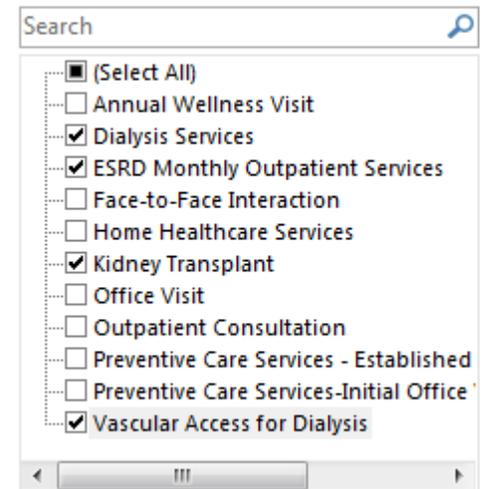
Denominator Exclusions: patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.

N/A

Diagnosis-based exclusions are where the diagnosis code is in the value set AND the value_set_name is NOT Essential Hypertension. The diagnosis has to start on/before the end of the measurement period and either have no resolved date or be resolved during/after the measurement period. In essence, during the measurement period the client has to have that diagnosis.

There are two approaches to documenting non-diagnosis-based exclusions:

- The client has an approved visit where the CPT code is in the Denominator Exclusion value set (shown on right) and the visit date is before the end of the measurement period (this can include visits prior to the measurement period).
- An intervention is performed as documented in a SNOMED CT-coded question/answer pair. The approved visit associated with the intervention has a visit date before the end of the measurement period (this can include visits prior to the measurement period).

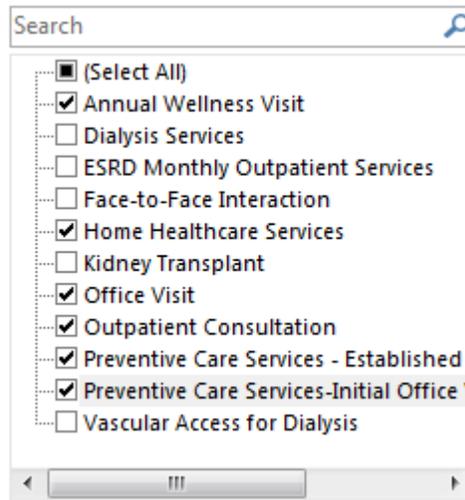


Search

- (Select All)
- Annual Wellness Visit
- Dialysis Services
- ESRD Monthly Outpatient Services
- Face-to-Face Interaction
- Home Healthcare Services
- Kidney Transplant
- Office Visit
- Outpatient Consultation
- Preventive Care Services - Established
- Preventive Care Services-Initial Office
- Vascular Access for Dialysis

Numerator: patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

To count towards the numerator, the date of the most recent numerator visit that occurs during the measurement period is obtained; see below for the different numerator visit types. The client must have a medical profile with an Effective Date matching this most recent date AND that profile must have a blood pressure pairing where the top (Systolic) value is less than 140 AND the bottom (Diastolic) value is less than 90.



There are three pairs of blood pressure fields in the medical profile: resting (bloodpressure_top and bloodpressure_bottom), standing (standing_bp_top and standing_bp_bottom), and lying (lying_bp_top and lying_bp_bottom). These are the only fields that can be used to record blood pressure. Both top (Systolic) and bottom (Diastolic) for the pair must be used.

Numerator Exclusions: N/A N/A

Denominator Exceptions: N/A N/A

Form Configuration for Denominator Exclusion Intervention Method

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

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

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

Generating the Nine CQM Reports

To generate the nine CQM reports, the system has to process a large amount of data. To avoid system performance degradation, the CQM reports are queued up after you request them and are generated during non-peak hours. Note that CQM reports are only available for download for 30 days. To keep a report, you need to download and save it before the 30-day time frame is up.

1. Reports tab >  CQM on nav bar.
2. Select an Agency-level provider for the NPI and address information. Note that this selection is not a filter – the CQM reports pull data from all clients and visits that meet the criteria.

Clinical Quality Measurements

Select Provider:

Start Date: 

End Date: 

3. Enter the start and end date of the reporting period; the default is 12 months prior to the current date.
4. Click . A “successfully queued” popup displays with the date when the CQM reports will be available.
5. Click OK to close the popup. The Report Inbox screen displays.

Report Inbox

Deliverable Name	Parameters	Date Requested	Status	Date Completed
 CQM	<p>CMS2v3, CMS50v2, CMS82v2, CMS88v3, CMS139v2, CMS149v2, CMS155v2, CMS156v2, CMS185v2</p> <p>Provider: Credible Behavioral Health Start Date: 10/7/2013 End Date: 10/7/2014</p>	10/7/2014 9:21:31 AM	Pending	<i>Report is not ready for viewing</i>

- On the specified “available by” date, use the corresponding button on the Reports nav bar to access the Report Inbox.



When the CQM reports are available, the red circle changes to green, the status changes to Completed, and the date/time the reports were completed is indicated.

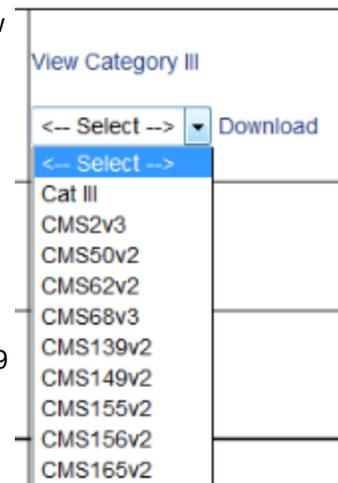
Report Inbox						
Deliverable Name	Parameters	Date Requested	Status	Date Completed		
● CQM	CMS2v3, CMS50v2, CMS62v2, CMS68v3, CMS139v2, CMS149v2, CMS155v2, CMS156v2, CMS165v2 Provider: Credible Behavioral Health Start Date: 10/7/2013 End Date: 10/7/2014	10/7/2014 9:21:31 AM	Completed	10/9/2014 5:17:14 PM	View Category III <-- Select --> Download	

Do one of the following:

- Click the View Category III link to display the summary results from all nine CQMs in a new tab/window. A Category III file does not contain patient-identifiable information.
- Use the dropdown and Download link to select/download a zip file of the Category III summary file (for attestation purposes) or the zip file for an individual CQM.

Important: the zip file for each CQM contains a Category I file for each client included in the measure. Category I files contain PHI – follow HIPAA guidelines to protect it.

Category I files use the following naming convention: cqm_measure name_client id_datetimestamp. For example, cqm_CMS2v3_1489_201430071550.xml is for client 1489 for measure CMS2v3, generated at 3:50pm on July 30, 2014. While an individual measure zip file does not contain a style sheet, you can use the same style sheet provided for clinical summaries (cda.xml) to view a Category I file.



- For attestation purposes, upload the Category III zip file to the appropriate third party – this process occurs outside of Credible. Provide the third party with the following view instructions:
 - Extract the files from the zip file into a folder (the XSL style sheet and Category III file have to be in the same folder).
 - Click the cqm_CategoryIII file to view it.

Appendix A: Credible Client Portal Configuration

Setting up the Credible Client Portal

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

Giving Client User Access to the Client Portal

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

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

Appendix B: 2013 CQMs

Objective

(1) Calculate

- (i) Electronically calculate all of the core clinical measures specified by CMS for EPs
- (ii) Electronically calculate, at a minimum, three clinical quality measures specified by CMS for EPs, in addition to those clinical quality measures specified in paragraph (1)(i)

(2) Submit. Electronically submit calculated clinical quality measures in accordance with the standard and implementation specifications specified in §170.205(f)

Measure

Credible has been certified for the following ambulatory clinical quality measures endorsed by the [National Quality Forum](#) (NQF):

- [NQF 0004](#) Alcohol and Drug Dependence (CMS – EP)
- [NQF 0013](#) Hypertension: Blood Pressure Measurement (Core)
- [NQF 0024](#) Youth Weight Assessment (Core)
- [NQF 0027](#) Tobacco Use Cessation (CMS – EP)
- [NQF 0028](#) Preventive Care: Tobacco Use Assessment & Tobacco Cessation (Core)
- [NQF 0038](#) Childhood Immunization Status (Core)
- [NQF 0041](#) (PQRI 110) Influenza Immunization (Core)
- [NQF 0105](#) Depression Management (CMS – EP)
- [NQF 0421](#) (PQRI 128) Adult Weight Screening (Core)

Calculating the clinical quality measures and submitting the results is how you demonstrate that you are using Credible in a meaningful way. The Physician Quality Reporting System (Physician Quality Reporting), formerly known as the Physician Quality Reporting Initiative (PQRI), requires that EPs report data on quality measures for covered professional services furnished to Medicare beneficiaries. For more information, visit the CMS website for PQRS: www.cms.gov/PQRS.

In Credible, you use the PQR Outcomes report to calculate the percentages for the different measures and generate an XML file for electronic submission. For 2011 Physician Quality Reporting, you can submit the data to “CMS on your Medicare Part B claims, a qualified Physician Quality Reporting registry, or CMS via a qualified electronic health record (EHR) product.”

You use custom exports to calculate all of the clinical quality measures. For some of the measures, you need to use web forms to capture the data. Credible has built forms and queries to help you in this effort – you can copy them from the Credible Library. The National Quality Forum (www.qualityforum.org) maintains the clinical details for the outcomes measures. To access the details, you need to register for a free membership with NQF.

Disclaimer: the exports and forms referenced in the measures below are based on Credible’s understanding of each measure. Having our software certified by an ONC-ATCB is not a verification of our understanding or that the exports are calculating raw clinical data correctly according to the NQF outcome specifications. You are responsible for understanding each NQF measure, reviewing Credible’s approach, and modifying if necessary. If you need additional detail about a measure, contact your PQR registry or the steward for the measure (listed in the summary of each measure), review the documentation at the NQF website, and/or review the PQRS documentation at CMS.

Settings Security Matrix: FormBuilder, FormBuilderEdit, ClientFormsUpdate, DataDictionary, ClientUpdate, ReportList, ExportBuild, ExportRun, AdvSearch

Report Security: PQR Outcomes

You need to have the Form Builder module and your IM/PSC needs to turn it on in your system.

- Steps to Configure**
1. Add the NPI, tin, and pqri_waiver_signed fields to the Employee Profile:
 - a. Admin tab > **Data Dictionary** > Table source = Employee | Type = View.
 - b. Insert the npi field with a max length of 50.
 - c. Insert the tin field with a max length of 9.
 - d. Insert the pqri_waiver_signed field and set it as a Boolean field with a max length of 1.
 - e. Click **Match Update to View** or add the field to the Update screen manually.
 2. Copy the forms referenced in the measures below from the Credible Library to your system.
 - a. For each form copied, click **New Version** and then **Build** and **Activate**.
 - b. Add a visit type for each form and link the form to it.
 3. Copy the queries referenced in the measures below from the Credible Library or create your own to build the custom exports that will perform the necessary calculations. The queries are attachments in reference ID 33111, Clinical Quality Measures (PQRS).

Steps to Use For each provider you are going to report on:

1. Verify that the PQR waiver has been signed and then update the Employee Profile so the corresponding field = True.
2. Update the Employee Profile with the provider's tax identification number.

To calculate: when running an export to calculate the measure, select the Header Row checkbox and enter the appropriate dates in the Start Date and End Date fields.

To report on the quality measures and generate a PQR XML file:

1. Reports tab > **Employee** on nav bar > **PQR Outcomes** > **Run Report**. Any existing PQRs will be listed. You can view, edit, or delete an existing PQR with the corresponding buttons.
2. To create a new PQR:
 - a. Click **Start New PQR**.
 - b. Select the submission type and method and click **Save**.
 - Select Test and the 6 months method if you are submitting a test file to the registry.
 - Select Payment and the 12 months method if you are submitting a real production file for an incentive payment.
 - c. Select the Billing Provider/Employee and enter the date range you want to report on.
 - d. Enter the PQR number for the quality measure. If the measure does not have one, use the last three digits of the NQF number.
 - e. Fill in the appropriate values for Eligible Instances, Meet Performance Instances, and Exclusions (Meet Performance Instances must be less than the Eligible Instances).
 - Eligible instances is the denominator for the percentage – how many clients did you see that met the basic criteria (age, visit type, and so on)
 - Meet Performance is part of the numerator – of the clients meeting the basic criteria in the Eligible Instances, how many of them met the outcome measure (they had the right number of vaccinations, were asked about smoking, and so on)

- Exclusions do not apply to every outcome and for outcomes with exclusions, you might not have any clients that meet the exclusion criteria. If you enter a value in the Exclusions field, the system will subtract the value from the Meet Performance Instances value for the numerator. Exclusion example: for the flu vaccine, the exclusions are people aged 50 years and older who cannot take a flu vaccine due to allergies, bad reaction in the past, or personal reasons.
- f. Click **Save PQR Outcome**. The outcome is displayed. You can edit or delete it with the buttons provided.
 3. You can edit or delete the outcome results with the buttons provided. If you delete the results, the header information you set up in step 2b will be retained.
 4. After you have generated the outcomes for the appropriate providers and measures, click **Create PQR XML** and save the file locally.
 5. Upload the file to CMS or a qualified PQR registry – this process occurs outside of Credible.

0004	Title Alcohol and Drug Dependence (CMS – EP)	Description
	Initiation and engagement of alcohol and other drug dependence (AOD) treatment: a. Initiation, b. Engagement	Percentage of adults aged 18 and over diagnosed with AOD abuse or dependence and receiving a related service who initiate treatment Assessment of the degree to which members engage in treatment with two additional AOD treatments within 30 days after initiating treatment
	Steps to Use	1. Complete a chart review for each client aged 18 years and older with AOD and then complete the web form (#1093 NQF 0004 CHART REVIEW). 2. Run the export to measure (*NQF 0004 Initiation and Engagement AOD Treatment).

	Title	Description
0013	Hypertension: Blood Pressure Measurement (Core)	<p>Percentage of patients aged 18 years and older with a diagnosis of hypertension with blood pressure <140/90 mm Hg OR patients with blood pressure >= 140/90 mm Hg and prescribed 2 or more anti-hypertensive medications during most recent office visit within a 12-month period</p> <p>Denominator: all patients 18 years and older with a diagnosis of hypertension</p> <p>Numerator: all patients in denominator with blood pressure <140/90 mm Hg OR >= 140/90 mm Hg and prescribed 2 or more anti-hypertensive medications during the most recent office visit within a 12-month period</p>
Steps to Use	<ol style="list-style-type: none"> 1. Use the Medical Profile to record a client's blood pressure (see §170.302(f) Record and Chart Vital Signs). 2. Use the Diagnosis function to record a diagnosis of hypertension (Axis III, 401 to 405). 3. Use Create Prescription to prescribe the medications (see §170.304(b) Electronic Prescribing). 4. Run the export to measure (*NQF 0013 Blood pressure measurement). 	

	Title	Description
0024	Youth Weight Assessment (Core) Body mass index (BMI) 2 through 18 years of age	<p>Percentage children, 2 through 18 years of age, whose weight is classified based on BMI percentile for age and gender</p> <p>Denominator: all clients 2 through 18 years of age with a well child visit in the measurement period month</p> <p>Numerator: all clients in the denominator who were classified based on BMI percentile for age and gender</p>
Steps to Use	<ol style="list-style-type: none"> 1. Use the Medical Profile to record a client's height and weight (see §170.302(f) Record and Chart Vital Signs). 2. Add a visit for each client aged 2 to 18 and complete the web form to document BMI percentile (#1097 WELL CHILD VISIT). (CDC BMI Percentile Calculator for Child and Teen) 3. Run the export to measure (*NQF 0024 Body Mass Index (BMI) 2 through 18 years). 	

	Title	Description
0027	<p data-bbox="289 280 829 321">Tobacco Use Cessation (CMS – EP)</p> <p data-bbox="289 354 953 451">Smoking cessation, medical assistance: a. Advising smokers to quit, b. Discussing smoking cessation medications, c. Discussing smoking cessation strategies</p>	<p data-bbox="1016 297 1816 394">Number of patients 18 and older who responded to the survey and indicated that they were current smokers and had one or more visits during the measurement year</p> <p data-bbox="1016 418 1887 548">a: Advising Smokers to Quit: The number of patients in the denominator who responded to the survey and indicated that they had received advice to quit smoking from a doctor or other health provider during the measurement year.</p> <p data-bbox="1016 573 1887 703">b: Discussing Smoking Cessation Medications: The number of patients in the denominator who responded to the survey and indicated that their doctor or other health provider recommended or discussed medications to assist with quitting smoking during the measurement year.</p> <p data-bbox="1016 727 1887 881">c: Discussing Smoking Cessation Strategies: The number of patients in the denominator who responded to the survey and indicated that their doctor or health care provider recommended or discussed methods and strategies other than medication to assist with quitting smoking during the measurement year.</p>
Steps to Use	<ol data-bbox="462 914 1711 990" style="list-style-type: none"> <li data-bbox="462 914 1711 946">1. Add a visit for each client aged 18 and older and complete the web form (#1102 SMOKING SURVEY). <li data-bbox="462 963 1711 990">2. Run the export to measure (*NQF 0027 Smoking Cessation). 	

	Title	Description
0028	<p>Preventive Care: Tobacco Use Assessment and Cessation (Core)</p> <p>Measure pair: a. Tobacco use assessment, b. Tobacco cessation intervention</p>	<p>Percentage of patients who were queried about tobacco use one or more times during two-year measurement period</p> <p>Percentage of patients identified as tobacco users who received cessation intervention during two-year measurement period</p> <p>Denominator:</p> <p>a: All patients > 18 years of age at the beginning of the two-year measurement period Patient Selection:</p> <p>CPT codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404</p> <p>And Patient's age is > 18 years</p> <p>b: All patients > 18 years of age identified as tobacco users at the beginning of the two-year measurement period</p> <p>Numerator:</p> <p>a: Patients who were queried about tobacco use one or more times</p> <p>b: Patients identified as tobacco users who received cessation intervention</p> <p>Cessation intervention may include smoking cessation counseling (for example, advise to quit or referral for counseling) and/or pharmacologic therapy</p>
	<p>Steps to Use</p> <ol style="list-style-type: none"> 1. Add a visit for each client aged 18 and older and complete the web form (#1103 OFFICE VISIT). 2. Run the export to measure (*NQF 0028 Tobacco Use / Cessation). 	

	Title	Description
0038	Childhood Immunization Status (Core)	<p>Percentage of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV), and four pneumococcal conjugate vaccines by their second birthday</p> <p>Denominator: a systematic sample drawn from children who turn two years of age during the measurement year</p> <p>Numerator:</p> <p>For each antigen/vaccination, the number of children having the specified number of vaccinations (number of children having 4 DtaP/DT vaccinations, number of children having 3 IPV vaccinations, and so on)</p>
Steps to Use	<ol style="list-style-type: none"> 1. Record immunizations for children who turn two years of age during the measurement year in their Medical Profile. 2. Run the export to measure (*NQF 0038 Childhood Immunization Status). 	

	Title	Description
0041	<p>Influenza Immunization (Core)</p> <p>Preventive care and screening: influenza immunization for patients \geq 50 years old</p>	<p>Patients who received influenza vaccination from September through February of the year prior to the measurement period</p> <p>Denominator: all clients => 50 years of age at the beginning of the one-year measurement period</p> <p>Patient Selection: CPT codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99386-99387, 99396-99397, 99401-99404, 90471-90474 And Patient's age is > 50 years at the beginning of the one-year measurement period</p> <p>Numerator: clients in the denominator who received influenza vaccination from September through February of the year prior to the measurement period</p> <p>ICD-9-CM codes for need vaccine: V04.81</p> <p>Or CPT procedure codes for adult influenza vaccine: 90656, 90657, 90658, 90660</p> <p>Or HCDCS code: G0008</p> <p>Or Medical record includes documentation of patient report of having received the vaccination</p>
Steps to Configure	Add a generic field to the Client Profile to record the reason for not receiving the vaccination.	
Steps to Use	<ol style="list-style-type: none"> 1. For each client older than 50 years, record immunizations clients older than 50 year in their Medical Profile. If a client did not receive the vaccination, update his or her Client Profile with the reason. 2. Run the export to measure (*NQF 0041 Influenza Vaccination). 	

	Title	Description
0105	<p>Depression Management (CMS – EP)</p> <p>New episode of depression: (a) Optimal practitioner contacts for medication management, (b) Effective Acute Phase treatment, (c) Effective Continuation Phase treatment</p>	<p>Percentage of patients diagnosed with new episode of depression and treated with antidepressant medication and who had at least three follow-up contacts with a practitioner during 84-day (12-week) Acute Treatment Phase</p>
	<p>Steps to Use</p> <ol style="list-style-type: none"> 1. Complete a chart review for each client diagnosed with a new episode of depression and treated with antidepressant medication and then complete the web form (#1094 NQF 0105 CHART REVIEW). 2. Run the export to measure (*NQF 0105 New Episode of Depression). 	

	Title	Description
0421	<p>Adult Weight Screening (Core)</p> <p>Adult weight screening and follow-up</p>	<p>Percentage of patients aged 18 years and older with a calculated BMI documented in the medical record AND a documented follow-up plan if the most recent BMI is outside the parameters</p> <p>Parameters: age 65 and older BMI > or = 30 or < 22; age 18-64 BMI > or = 25 or < 18.5</p>
	<p>Steps to Use</p> <ol style="list-style-type: none"> 1. Use the Medical Profile to record a client's height and weight (see §170.302(f) Record and Chart Vital Signs). 2. Add a visit for each client and complete the web form document the follow-up plan (#1094 NQF 0105 CHART REVIEW). 3. Run the export to measure (*NQF 0421 Adult Weight Screening). 	
