VertexDr

APPLICATION MANUAL

Meaningful Use

Stage 3

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What is Meaningful Use?

Meaningful use refers to the program available for adopting an EMR in physician practices. It is part of the ARRA stimulus package. Through this program, an eligible professional who participates in either the Medicare or Medicaid programs can be eligible to receive additional monetary incentives if they are able to demonstrate the use of a certified EMR/EHR technology. In order to obtain the full amount of funding available, the eligible professional must continue to demonstrate the use of the EMR/EHR throughout the entire attestation period and beyond.

Meaningful Use Terms

Below are some of the terms used when discussing meaningful use.

ARRA – The American Recover and Reinvestment Act was passed on February 17, 2009 in order to stimulate the American economy. A portion of the act includes billions of dollars in Medicare and Medicaid incentive payments to providers and hospitals for the "Meaningful Use" of certified health IT products.

EMR / EHR – Electronic Medical Records / Electronic Health Records. Electronic charting and ordering systems which replace the need and use for paper records. Provides easier access to patient data, contains data and is stored in one place.

- Eligible Professional (EP) – Must be one of the following: MD or DO, Doctor of Podiatric Medicine, Doctor of Optometry, or a Chiropractor within a list of specialties. Eligible for only one incentive reimbursement a year, even if the eligible professional works at multiple locations or practices.

Meaningful Use Reports

There are 2 reports that must be run frequently by your practice in order to ensure that meaningful use measures for Stage 3 are being satisfied during the reporting period.

Meaningful Use Measures (Stage III) Report

The *Meaningful Use Measures (Stage III)* Report provides a per-provider list of the required meaningful use criteria and the expected percentage of satisfaction for each criterion within a given date range.

To generate the report:

1. Click the **Reports** Menu and then click **Meaningful Use**.
2. Click **Stage III**.
3. Click **Meaningful Use Measures (Stage III)**. The *Meaningful Uses Measures (Stage III) Report* Window displays.
4. When finished entering the report criteria, click the **OK** Button to generate the report.

Report Details by Measure

The results of the *Meaningful Use Measures (Stage III)* Report are divided into *Numerators* and *Denominators*. The *Numerators* and *Denominators* are used to calculate the percentage satisfied for each measure (*Numerator ÷ Denominator)*. Depending on the nature of the measure, there may be *Exclusions*. *Exclusions* are exceptions to the measure and are not used toward the calculation of the percentage.

This section will explain each *Numerator* and each *Denominator* in the order they appear on the VertexDr generated report.

Note: The % column indicates the minimum expected percentage of unique patients required during the reporting period in order to satisfy the measure.

Core Measures

***Objective 1**:* Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.	**NA**
Note – this measure is assumed to be 100% and is not included in the report.	

Objective 2: *More than 60 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.*	**60%**

Denominator

Any prescription generated during reporting period.

Numerator

Any prescription queried for drug formulary and transmitted electronically. If formulary data is not turned on automatically, users will need to click the "get eligibility" button in the script writer prior to sending the script:

Exclusions

Any provider who writes fewer than 100 prescriptions during the reporting period (e.g. a denominator less than 100).

Objective 4-1*: More than 60 percent of medications created by the EP during the EHR reporting period are recorded using CPOE.*	**60%**

Denominator

The number of prescriptions created by the provider during the reporting period.

Numerator

The number of prescriptions from the denominator which were submitted electronically, faxed, printed or marked as **Administered**.

Note: Prescriptions marked as **Hand Written** and/or **Phoned** In count toward the denominator, but do not satisfy the numerator for this measure.

Exclusions

Any provider who writes fewer than 100 prescriptions during the reporting period (e.g. a denominator less than 100).

Objective 4-2*: More than 60 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.*	**60%**

Denominator

The number of radiology orders created by the provider during the reporting period.

Numerator

The number of orders in the denominator recorded using CPOE.

Exclusions

Any provider who writes fewer than 100 radiology orders during the reporting period (e.g. a denominator less than 100).

Note: This measure should always be at 100%. An order cannot be created in the Suite without using CPOE.

***Objective 4-3**: More than 60 percent of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE.*	**60%**

Denominator

The number of lab orders created by the provider during the reporting period.

Numerator

The number of lab orders in the denominator recorded using CPOE.

Exclusions

Any provider writes fewer than 100 lab orders during the reporting period (e.g. a denominator less than 100).

Note: This measure should always be at 100%. An order cannot be created in the Suite without using CPOE.

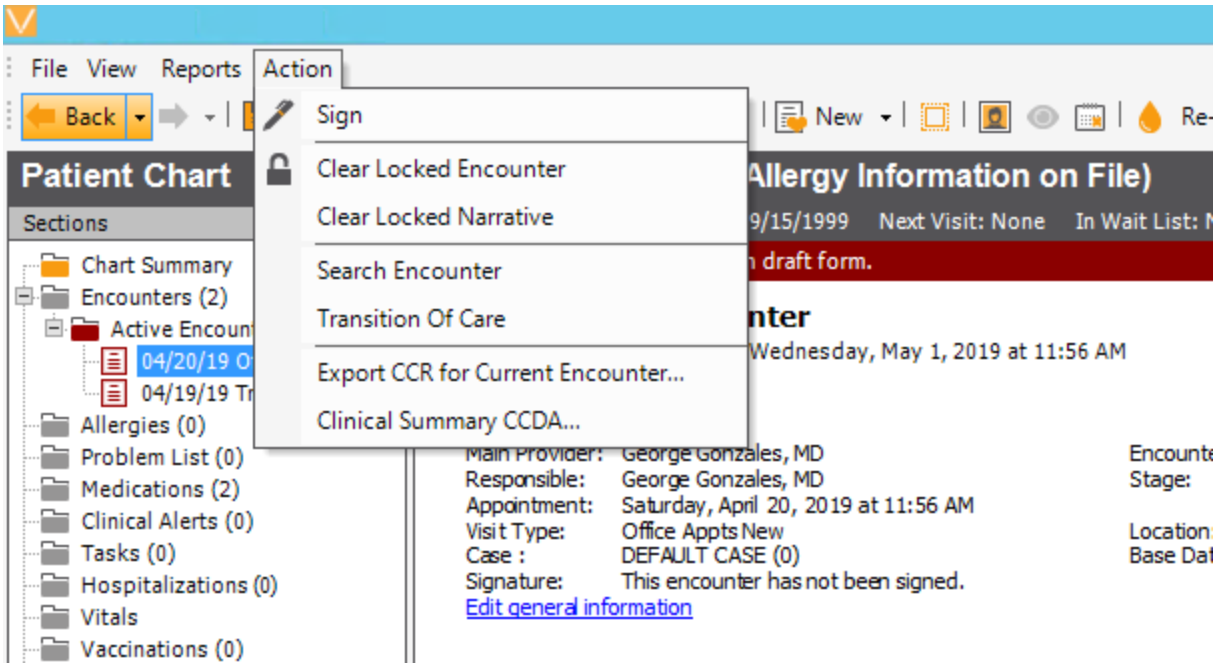
***Objective 5-1**: More than 80 percent of all unique patients seen by the EP: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access.*	**80%**

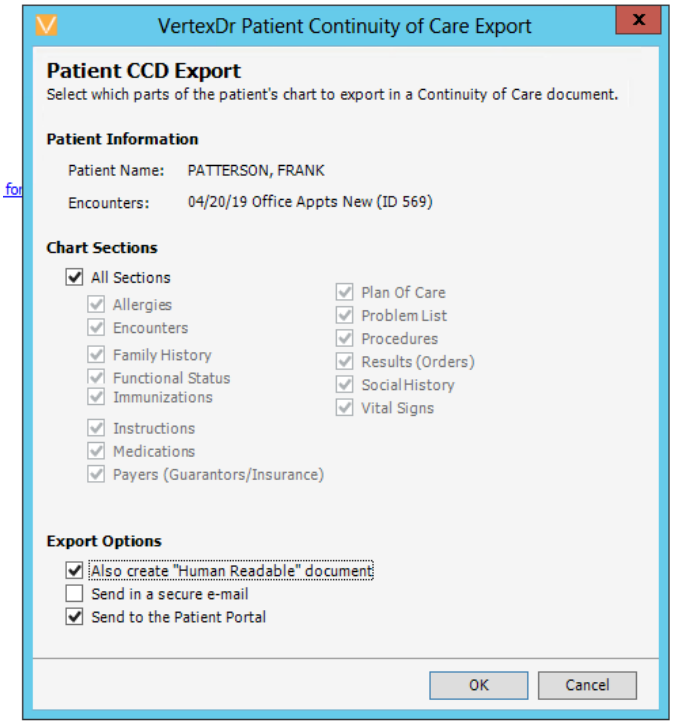
Denominator

Encounter generated during the reporting period.

Numerator

A Clinical Summary CCDA is generated and sent to the patient's portal account. This is done by selecting an encounter and clicking Action→Clinical Summary CCDA:


File View Reports Action
Back
New
Sign
Clear Locked Encounter
Clear Locked Narrative
Search Encounter
Transition Of Care
Export CCR for Current Encounter...
Clinical Summary CCDA...
Patient Chart
Sections
Chart Summary
Encounters (2)
Allergies (0)
Problem List (0)
Medications (2)
Clinical Alerts (0)
Tasks (0)
Hospitalizations (0)
Vitals
Vaccinations (0)
Allergy Information on File)
draft form.
Wednesday, May 1, 2019 at 11:56 AM
Main Provider: George Gonzales, MD
Responsible: George Gonzales, MD
Appointment: Saturday, April 20, 2019 at 11:56 AM
Visit Type: Office Appts New
Case : DEFAULT CASE (0)
Signature: This encounter has not been signed.
Edit general information


VertexDr Patient Continuity of Care Export
Patient CCD Export
Select which parts of the patient's chart to export in a Continuity of Care document.
Patient Information
Patient Name: PATTERSON, FRANK
Encounters: 04/20/19 Office Appts New (ID 569)
Chart Sections
All Sections
Allergies
Encounters
Family History
Functional Status
Immunizations
Instructions
Medications
Payers (Guarantors/Insurance)
Plan Of Care
Problem List
Procedures
Results (Orders)
Social History
Vital Signs
Export Options
Also create "Human Readable" document
Send in a secure e-mail
Send to the Patient Portal
OK
Cancel

Exclusions

An EP may exclude from the measure if they have no office visits during the EHR reporting period.

Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

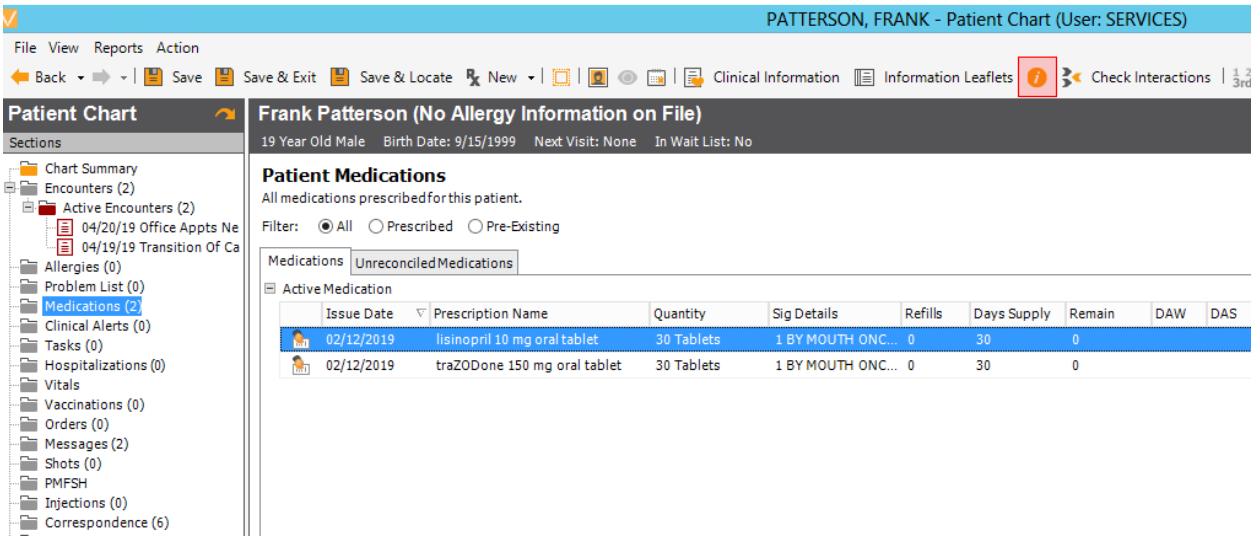
***Objective 5-2**: Use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the EHR reporting period.*	**35%**

Denominator

Encounter generated during the reporting period.

Numerator

Education Resources provided electronically, via Patient Portal. With use of the Info Button within the Problem List, and Medication section of the patients chart.



On the patient education window that loads, click the "Send to portal" button:

Exclusions

An EP may exclude from the measure if they have no office visits during the EHR reporting period.

Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

Objective 6-1*: During the EHR reporting period, more than 10 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) view, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).*	**10%**

Denominator

Encounter generated during the reporting period.

Numerator

Patients who view, download or transmit a CCDA via the patient portal. This is done when the patient accesses their portal and either views or downloads their clinical summary.

Exclusions

An EP may exclude from the measure if they have no office visits during the EHR reporting period.

Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

Objective 6-2*: For more than 25 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative. For an EHR reporting period in 2017, the threshold for this measure is 5 percent rather than 25 percent.*	**25%**

Denominator

Encounter generated during the reporting period.

Numerator

Any message from the provider sent to the patient's portal account either in reply to an "ask a staff' message, or sent directly from the patient's chart.

Exclusions

An EP may exclude from the measure if they have no office visits during the EHR reporting period.

Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

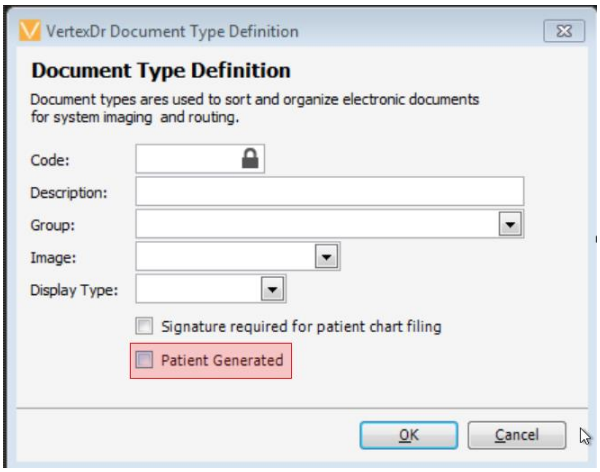
Objective 6-3*: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.*	**5%**

Denominator

Encounter generated during the reporting period.

Numerator

When the practice receives patient generated health data via the patient portal. A document is populated in the patient's chart and noted as patient generated health data. This needs to be defined in the definition for documents under Definition→Office→Document Types:



Exclusions

An EP may exclude from the measure if they have no office visits during the EHR reporting period.

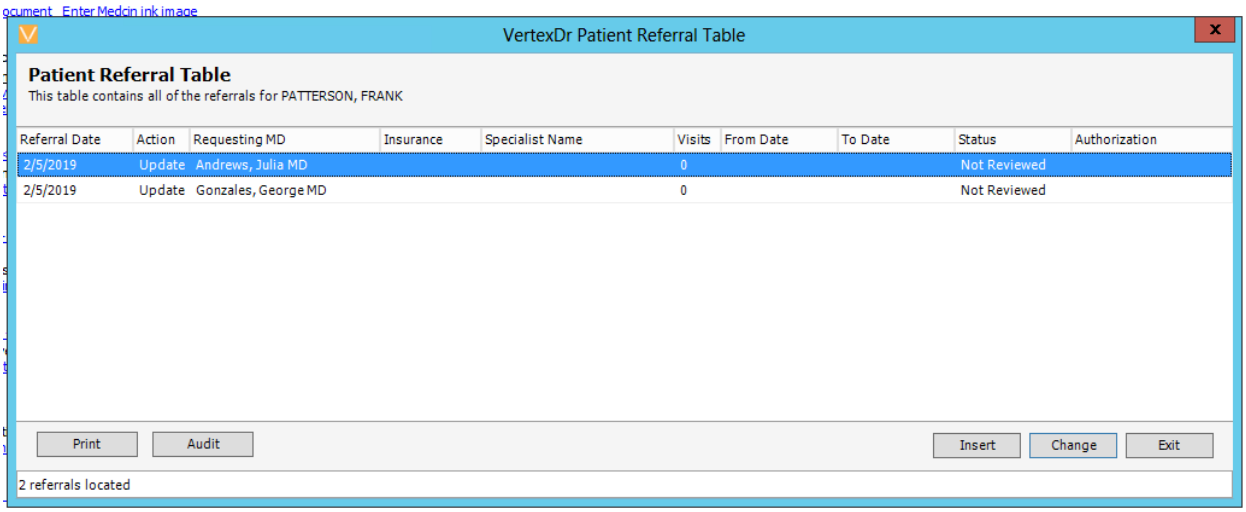
Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

Note: There is additional portal set up required. Please reference Patient Portal Manual.

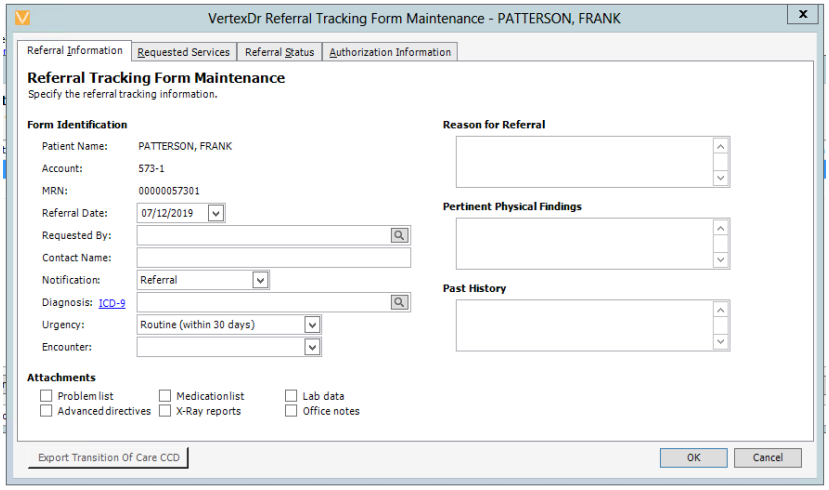
***Objective 7-1**: For more than 50% of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.*	**50%**

Denominator

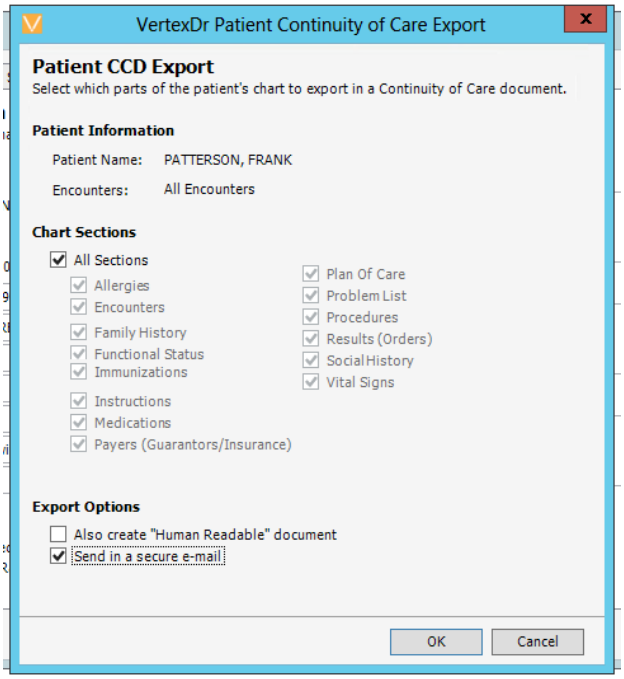
Any patient seen during the reporting period that has a transition of care to another provider. Transitions of care are created by selecting the encounter, then clicking View→Referral Tracking



From here, a new Referral/Transition of care can be created:

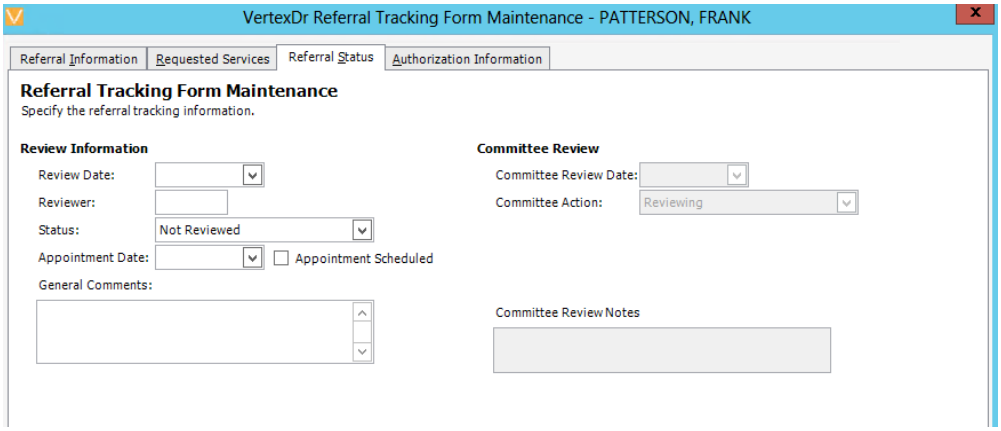


Note, "Reason for Referral" and "Diagnosis" are required fields to continue. After selecting any additional optional fields, selecting the "Export Transition of Care CCD" button will generate the CCD and give the user the option to send the CCD to the provider the patient is being transitioned to:



Numerator

A transition of care that is generated during the reporting period and sent via Direct Message with confirmed receipt. Confirming receipt is done by again selecting the transition of care that was created for the denominator, navigating to "Referral Status" and filling out the review date and Status under "Review Information":



Exclusions

***Objective 7-2**: For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.*	**40%**

Denominator

Any patient with only one encounter (for the EP) in their chart generated during the reporting period.

Numerator

Any patient that has incorporated a CCD into the patient's chart received via secure messaging. This is accomplished automatically when a CCD for a patient is received via Secure Messaging.

Exclusions

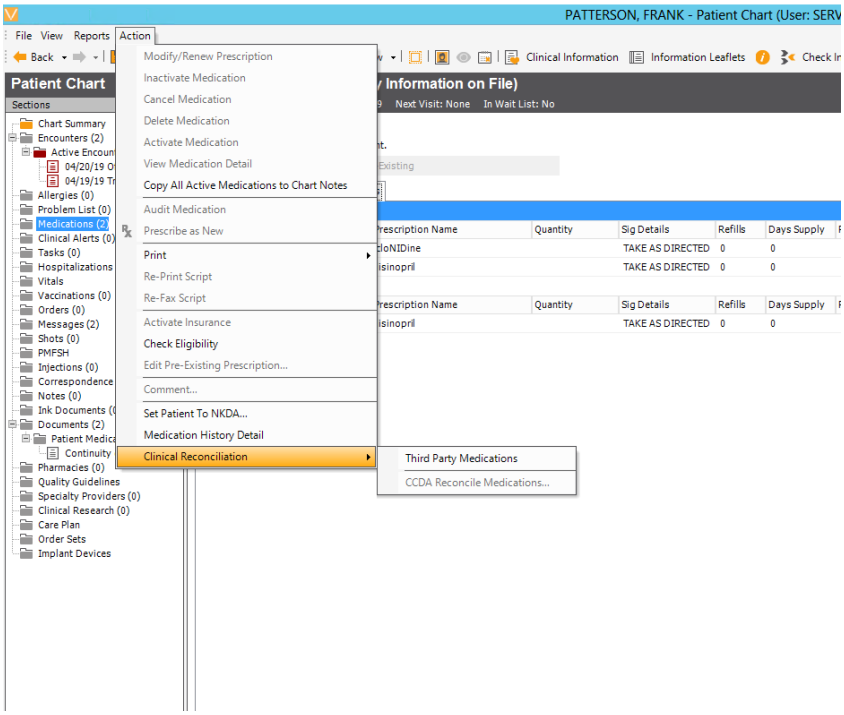
***Objective 7-3**: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies. (3) Current Problem list. Review of the patient's current and active diagnoses.*	**80%**

Denominator

Any patient with only one encounter (for the EP) in their chart generated during the reporting period.

Numerator

Any patient who has received a CCD from a Transition of Care via Direct Messaging and consequently reconciles the received meds, allergies, and problems (NOTE – all three areas need to be reconciled in order to numerate). This is accomplished by going to each area of the patients chart (Meds, Allergies, and problems and selecting Action→Clinical Reconciliation→CCDA Reconcile:



Exclusions

Any transitioned encounter where the EP requests a CCDA from the referring physician and does not receive one. The request is noted as a task in the patient's chart. The task is defined under Definition→Parameters→MIPS Use

ACI Measures

ACI Objective 2
Electronic Prescribing
ACI EC Measure 1: At least one permissible prescription written by the MIPS EC is queried for a drug formulary and transmitted electronically using certified EHR technology.

Denominator

Any patient receiving a prescription during the reporting period

Numerator

Any prescription queried for drug formulary and transmitted electronically. If formulary data is not turned on automatically, users will need to click the "get eligibility" button in the script writer prior to sending the script:

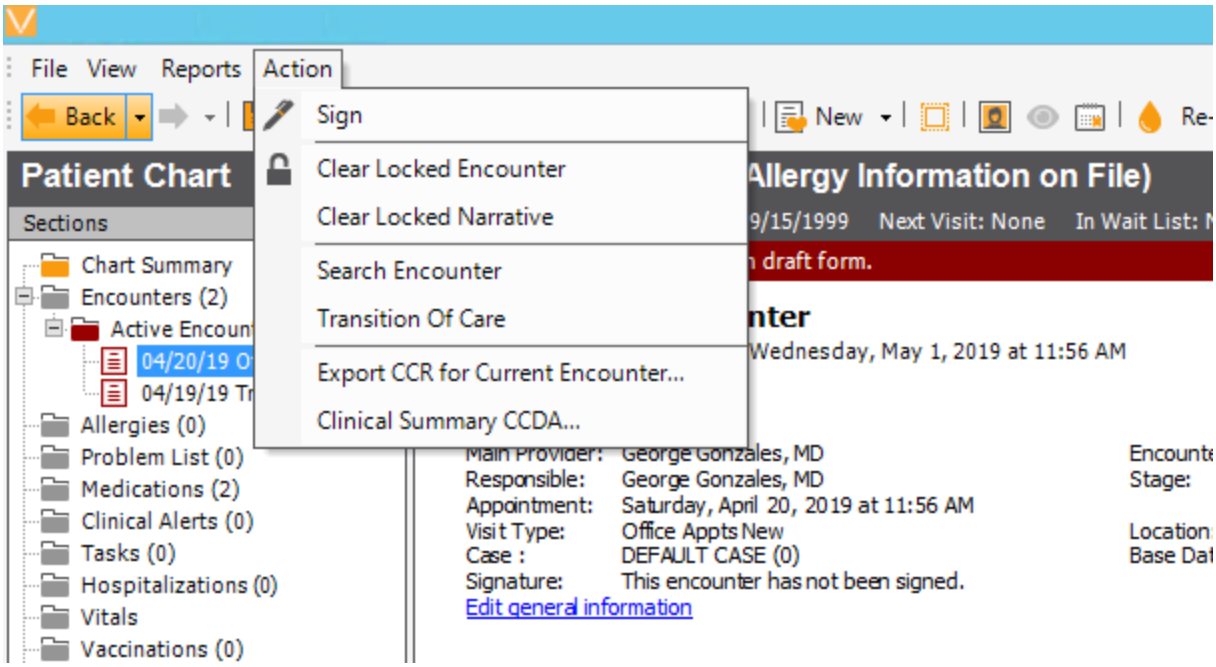
ACI Objective 5 (Measure 1)
Patient Electronic Access
ACI EC Measure 1: At least one patient seen by the MIPS EC during the performance period is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS EC's discretion to withhold certain information.

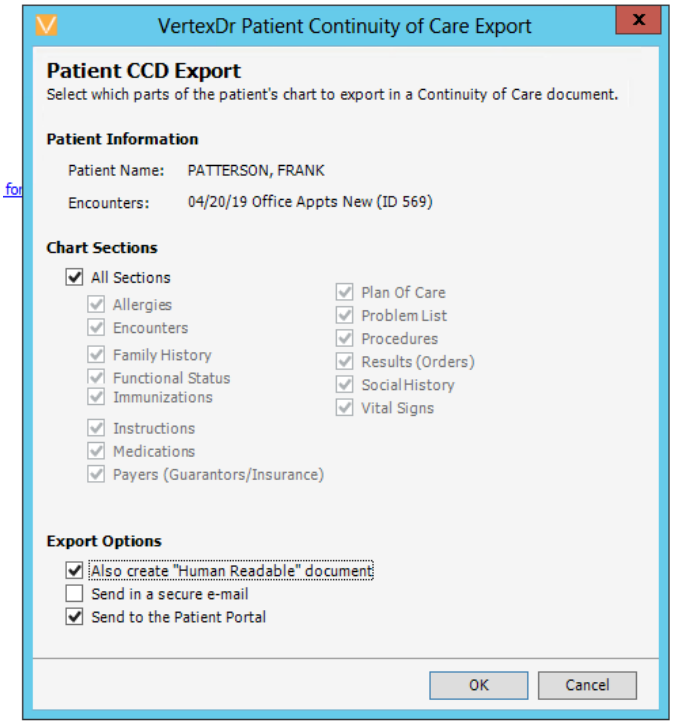
Denominator

Patient seen during the reporting period.

Numerator

A Clinical Summary CCDA is generated and sent to the patient's portal account. This is done by selecting an encounter and clicking Action→Clinical Summary CCDA:


File View Reports Action
Back
New
Sign
Clear Locked Encounter
Clear Locked Narrative
Search Encounter
Transition Of Care
Export CCR for Current Encounter...
Clinical Summary CCDA...
Patient Chart
Sections
Chart Summary
Encounters (2)
Allergies (0)
Problem List (0)
Medications (2)
Clinical Alerts (0)
Tasks (0)
Hospitalizations (0)
Vitals
Vaccinations (0)
Allergy Information on File)
draft form.
Wednesday, May 1, 2019 at 11:56 AM
Main Provider: George Gonzales, MD
Responsible: George Gonzales, MD
Appointment: Saturday, April 20, 2019 at 11:56 AM
Visit Type: Office Appts New
Case : DEFAULT CASE (0)
Signature: This encounter has not been signed.
Edit general information


VertexDr Patient Continuity of Care Export
Patient CCD Export
Select which parts of the patient's chart to export in a Continuity of Care document.
Patient Information
Patient Name: PATTERSON, FRANK
Encounters: 04/20/19 Office Appts New (ID 569)
Chart Sections
All Sections
Allergies
Encounters
Family History
Functional Status
Immunizations
Instructions
Medications
Payers (Guarantors/Insurance)
Plan Of Care
Problem List
Procedures
Results (Orders)
Social History
Vital Signs
Export Options
Also create "Human Readable" document
Send in a secure e-mail
Send to the Patient Portal
OK
Cancel

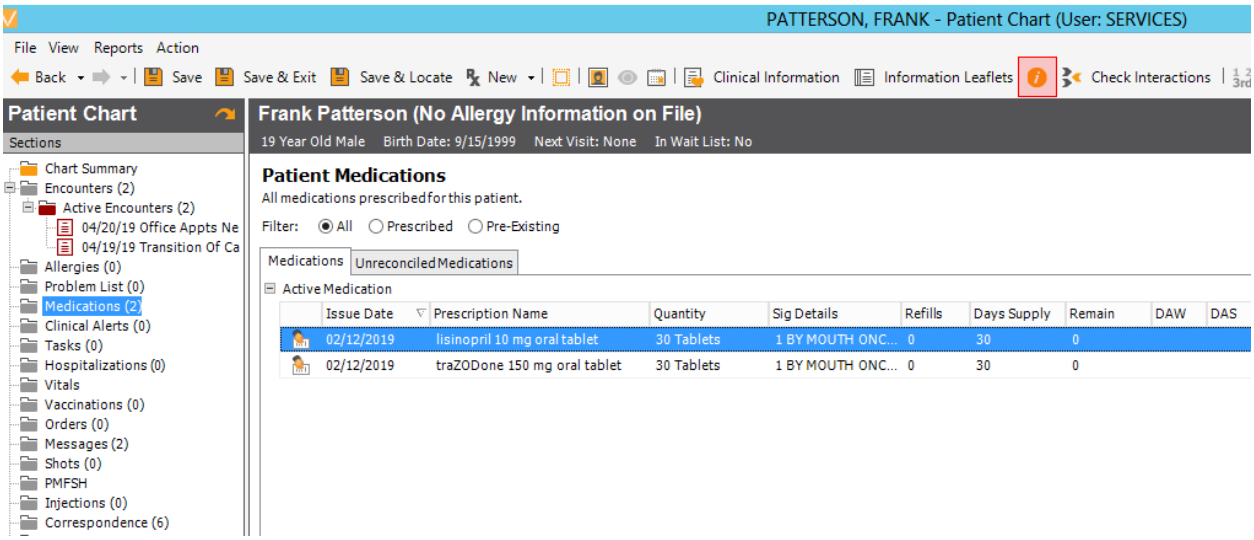
ACI Objective 3 (Measure 2)
Patient-Specific Education
ACI EC Measure 2: The MIPS EC must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide access to those materials to at least one unique patient seen by the MIPS EC.

Denominator

Patient seen within the reporting period.

Numerator

Education Resources provided electronically, via Patient Portal. With use of the Info Button within the Problem List, Medication section of the patients chart.



On the patient education window that loads, click the "Send to portal" button:

ACI Objective 4
Secure Messaging
For at least one patient seen by the MIPS EC during the performance period, a secure message was sent using the electronic messaging function of certified EHR technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative) during the performance period.

Denominator

Patient who was seen within the reporting period.

Numerator

Any patient where a secure message has been sent to the patient portal (either from the chart of in response to a message received via "ask a staff").

ACI CMS Objective 5
Health Information Exchange
ACI Measure 2: For at least one transition of care or referral received or patient encounter in which the MIPS EC has never before encountered the patient, the MIPS EC receives or retrieves and incorporates into the patient's record an electronic summary of care document.

Denominator

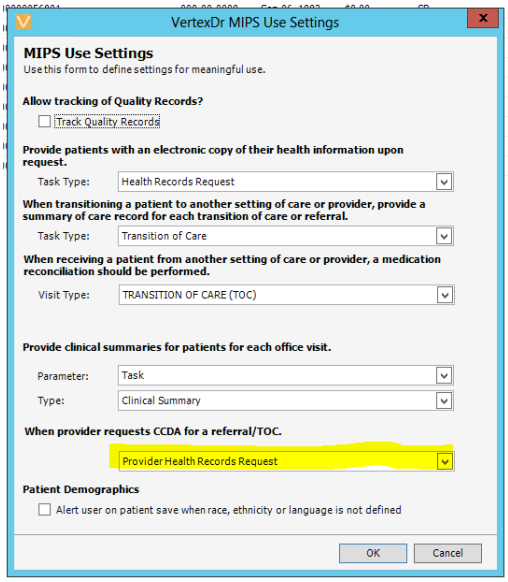
Any patient with only one encounter in their chart in the reporting period.

Numerator

Any patient where a CCD is retrieved via Direct Messaging and mapped into the patient's chart. (Note, the CCD is mapped into the chart automatically upon receipt via secure messaging)

Exceptions

If a provider "requests" a CCD (via task, which is defined within the MIPS definition menu) and does not receive a CCD, they will be removed from the denominator:



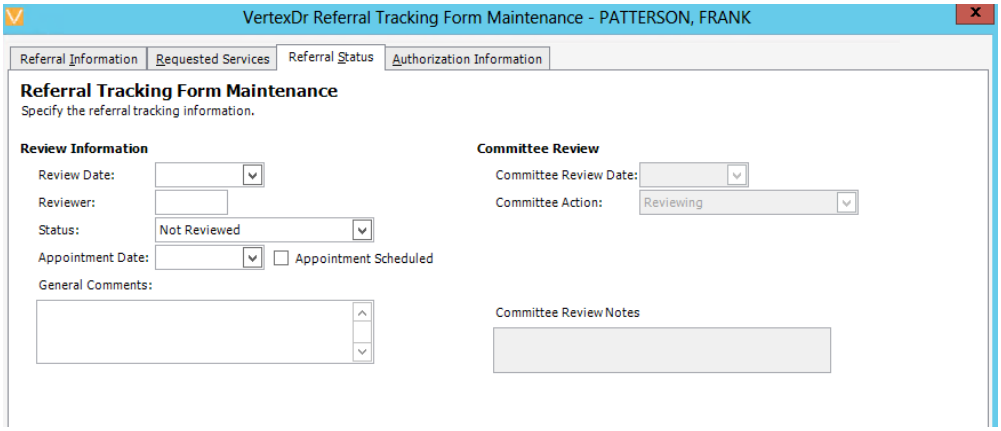
ACI Objective 6
Health Information Exchange
ACI Measure 1: The MIPS EC that transitions or refers their patient to another setting of care or health care provider (1) uses certified EHR technology to create a summary of care record; and (2) electronically transmits such summary to a receiving health care provider for at least one transition of care or referral.

Denominator

Any patient with a referral out to an external provider (sent out as a transition of care)

Numerator

A transition of care that is generated during the reporting period and sent via Direct Message with confirmed receipt. Confirming receipt is done by again selecting the transition of care that was created for the denominator, navigating to "Referral Status" and filling out the review date and Status under "Review Information":



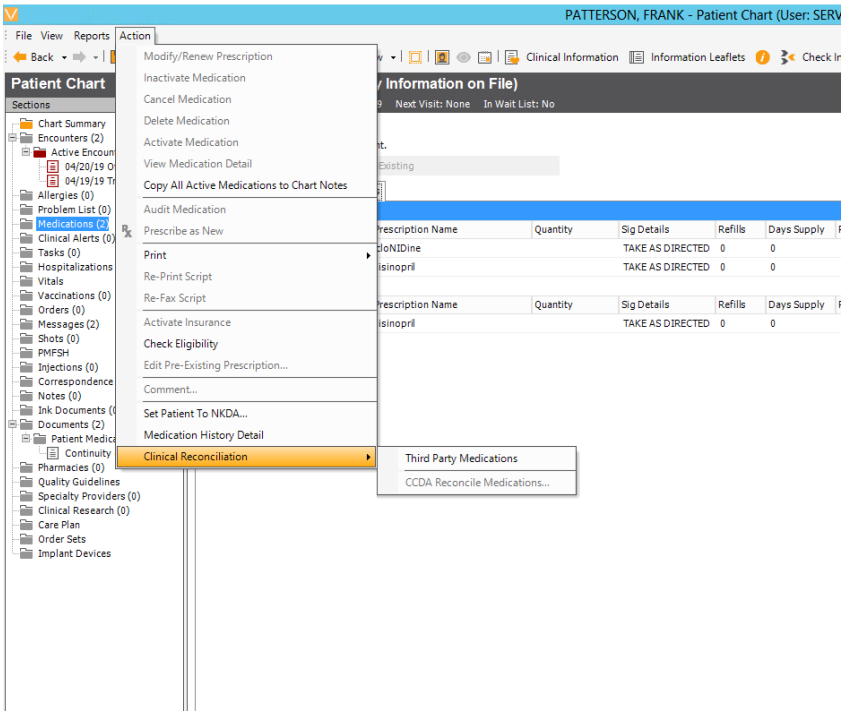
ACI Objective 7
Medication Reconciliation
ACI EC Measure 1: The MIPS EC performs medication reconciliation for at least one transition of care in which the patient is transitioned into the care of the MIPS EC.

Denominator

Any patient seen as a Transition of care from another provider (this is tracked by encounter type in Definition->Office->Meaningful Use)

Numerator

Any patient who has received a CCD from a Transition of Care via Direct Messaging and consequently reconciles the received meds, allergies, and problems (NOTE – all three areas need to be reconciled in order to numerate). This is accomplished by going to each area of the patients chart (Meds, Allergies, and problems" And selecting Action→Clinical Reconciliation→CCDA Reconcile:


PATTERSON, FRANK - Patient Chart (User: SERV
File View Reports Action
Back
Clinical Information
Information Leaflets
Patient Chart
Sections
Chart Summary
Encounters (2)
Allergies (0)
Problem List (0)
Medications (2)
Clinical Alerts (0)
Tasks (0)
Hospitalizations
Vitals
Vaccinations (0)
Orders (0)
Messages (2)
Shots (0)
PMFSH
Injections (0)
Correspondence
Notes (0)
Documents (2)
Continuity
Pharmacies (0)
Quality Guidelines
Specialty Providers (0)
Clinical Research (0)
Care Plan
Order Sets
Implant Devices
Information on File)
Next Visit: None
In Wait List: No
Existing
Prescription Name
Quantity
Sig Details
Refills
Days Supply
TAKE AS DIRECTED
Modify/Renew Prescription
Inactivate Medication
Cancel Medication
Delete Medication
Activate Medication
View Medication Detail
Copy All Active Medications to Chart Notes
Audit Medication
Prescribe as New
Print
Re-Print Script
Re-Fax Script
Activate Insurance
Check Eligibility
Edit Pre-Existing Prescription...
Comment...
Set Patient To NKDA...
Medication History Detail
Clinical Reconciliation
Third Party Medications
CCDA Reconcile Medications...

Clinical Quality Measures by Provider (Stage III) Report

The *Clinical Quality Measures by Provider (Stage III)* Report tracks the clinical quality measures (CQM's) each provider/practice has chosen to report on. Regardless of the measures selected, the report structure is the same:

- *Initial – Refers to the source of patient's used for reporting clinical quality measures.*
- *Denominator – Refers to the total number of patients seen during the specified date range.*
- *Numerator – Refers to the number of qualifying patients seen during the specified time frame.*
- *Exclusions – The total number of non-qualifying patients seen during the same period.*

The following CQMs are available for Stage III:

CMS 2 – Preventive care and screening – Screening for depression and follow-up

CMS 22 – Preventive are and screening – Screening for high blood pressure and follow-up

CMS 50 – Closing the referral loop: receipt of specialist report

CMS 65 – Hypertension: Improvement in blood pressure

CMS 68 – Documentation of current medications in the medical record

CMS 69 – Preventive care and screening: BMI screening and follow-up

CMS 75 – Children who have dental decay or cavities

CMS 90 – Functional status assessment for congestive heart failure

CMS 117 – Childhood immunization status

CMS 138 – Preventive care and screening: tobacco use, screening and cessation intervention

CMS 146 – Appropriate testing for children with pharyngitis

CMS 153 – Chlamydia screening for women

CMS 155 – Weight assessment and counseling for nutrition and physical activity for children

CMS 156 – Use of high-risk medications in the elderly

CMS 165 – Controlling high blood pressure

CMS 166 – Use of imaging studies for low back pain

Patient Definition

Personal Section

The size of the *Race(s)* field has been increased.

The following options can be selected from the **Name Type** Dropdown:

Note: The **Name Type** Dropdown is not a required field in Patient Definition.

- Alias **Name**
- Name **at Birth**
- Adopted Name
- **Display Name**
- **Legal Name**
- **Maiden Name**
- **Name of Partner/Spouse**

The option selected will be used when transmitting to immunization registries. **Legal Name** is the default selection.

Note: The options within the dropdown are defined by CMS and cannot be changed. Also if you would like the

The following options can be selected from the **Address Type** Dropdown:

Note: The **Address Type** Dropdown is not a required field in Patient Definition.

- **Bad Address**
- **Birth Address**
- **Birth Delivery Location**
- **Country of Origin**
- **Current or Temporary**
- **Firm/Business**
- **Home**
- **Legal Address**
- **Mailing**
- **Office**
- **Permanent**
- **Registry Home**

Note: This option refers to the public health agency location responsible for storing patient information.

- **Residence at birth**

The option selected will be used when transmitting to immunization registries. **Home** is the default selection.

Note: The options within the dropdown are defined by CMS and cannot be changed.

An additional *Race* field is available to satisfy a requirement of Meaningful Use, Stage II.

The following options can be selected from the **Equip Type** Dropdown:

Note: The **Equip Type** Dropdown is not a required field in Patient Definition.

- **Beeper**
- **Cellular Phone**
- **Fax**
- **Internet Address**
- **Modem**
- **Telecommunications Device for the Deaf**
- **Telephone**
- **Teletypewriter**
- **X.400 email address**

The option selected will be used when transmitting certified phone types to immunization registries. **Telephone** is the default selection.

Note: The options within the dropdown are defined by CMS and cannot be changed.

Select the appropriate code from the **Other ID** field. The **Other ID** text box can be used to enter additional information. For example, select **License Number** from the dropdown and then enter the driver's license number in the text box.

Note: The **Other ID** dropdown and text box are not a required fields in Patient Definition.

Note: The options within the dropdown are defined by CMS and cannot be changed.

The following fields have been added to the demographics section:

- **Sexual Orientation**
- **Gender Identity**
- **Birth Sex**
- **Multiple Birth**
- **Birth Order**

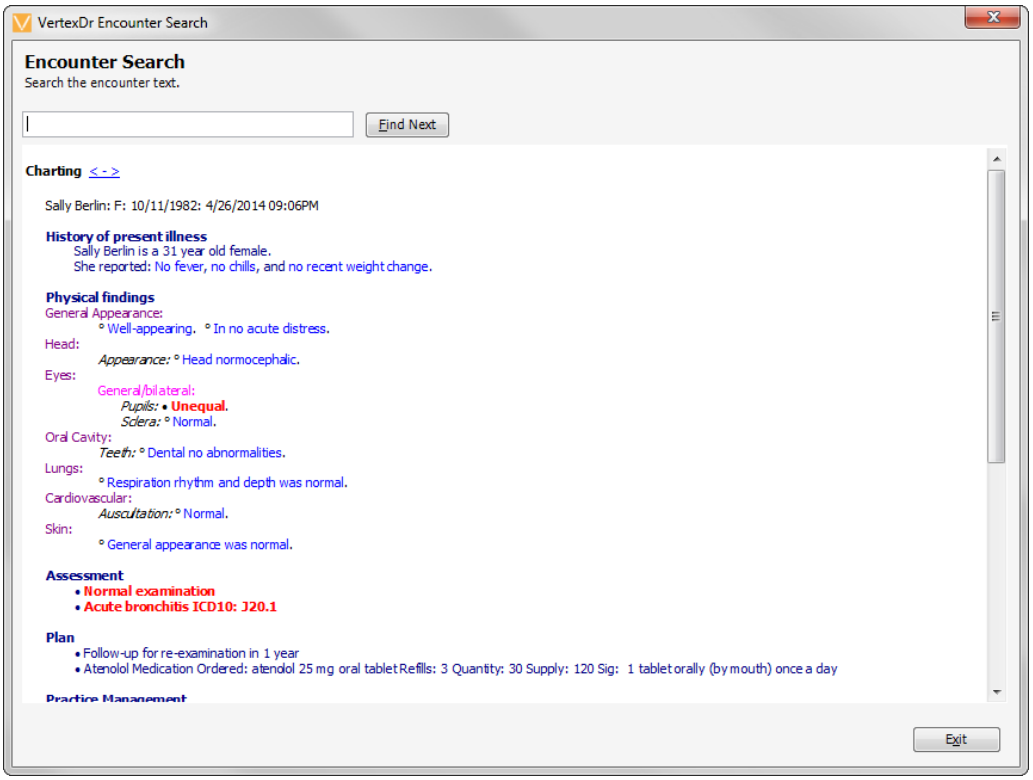
Patient Chart

Encounters

Specific text can be located within an encounter. To do so:

Note: This can also be done when viewing encounters from the Encounters Area.

1. When highlighted on an encounter, click the **Actions** Menu and then click **Search Encounter**. The *Encounter Search* Window displays.



2. Enter the text to search for in the *Search* Field and then click the **Find Next** Button.
3. Continue clicking the **Find Next** Button to move through the encounter locating the defined text.
4. Click the **Exit** Button when finished.

Allergies

When entering allergies, a Medcin findings can be selected from the *Reaction Code* Field.

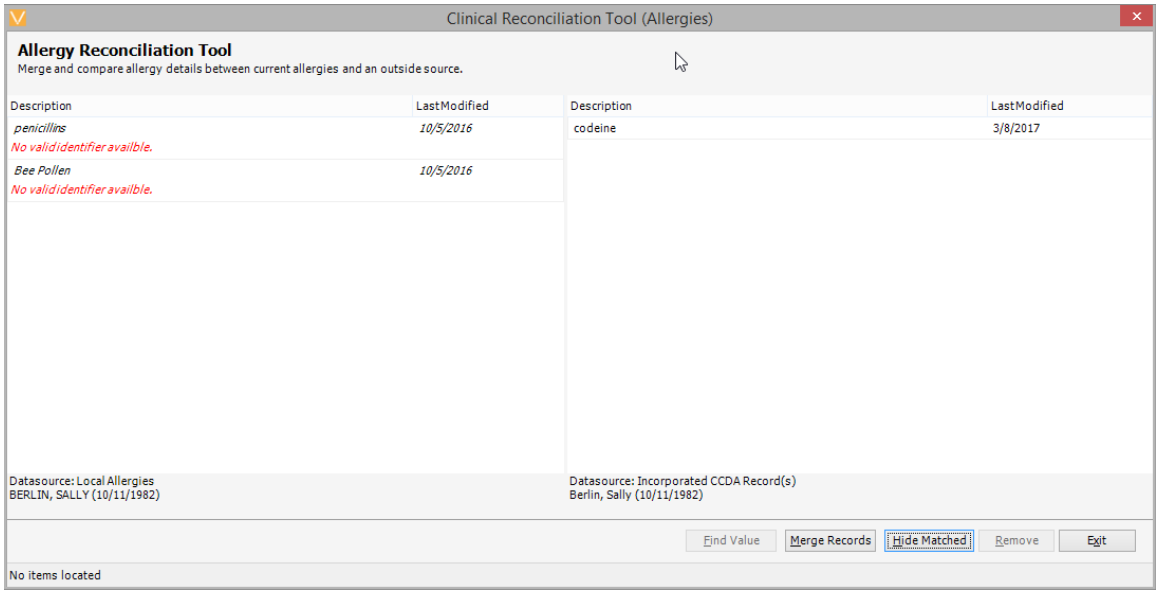
The following options are available from **Type** Dropdown when entering allergies:

- **Drug Intolerance**
- **Food Intolerance**
- **Allergy to Substance**
- **Propensity to adverse reactions**
- **Propensity to adverse reactions to drug**
- **Propensity to adverse reactions to food**

Allergy Reconciliation

When CCDs are imported, any new allergies are added to the *Allergies* Section of the Patient Chart.

1. To view the unreconciled allergies, click the **Actions** Menu and then click **CDA Reconcile Allergies** or right-click on an allergy record and select **CCDA Reconcile Allergies**.



2. Click the **Hide Matched** Button to hide the allergies that were on the imported CCD and are listed in the Patient Chart.
3. Click the **Show All** Button to view the hidden records.
4. Click the **Remove** Button to omit any allergy record that should not be added to the Patient Chart.
5. Click the **Merge** Button to add the unreconciled allergies to the Patient Chart.
6. A preview is displayed. Allergies can still be removed from this window if necessary. When ready, click the **Save** Button.

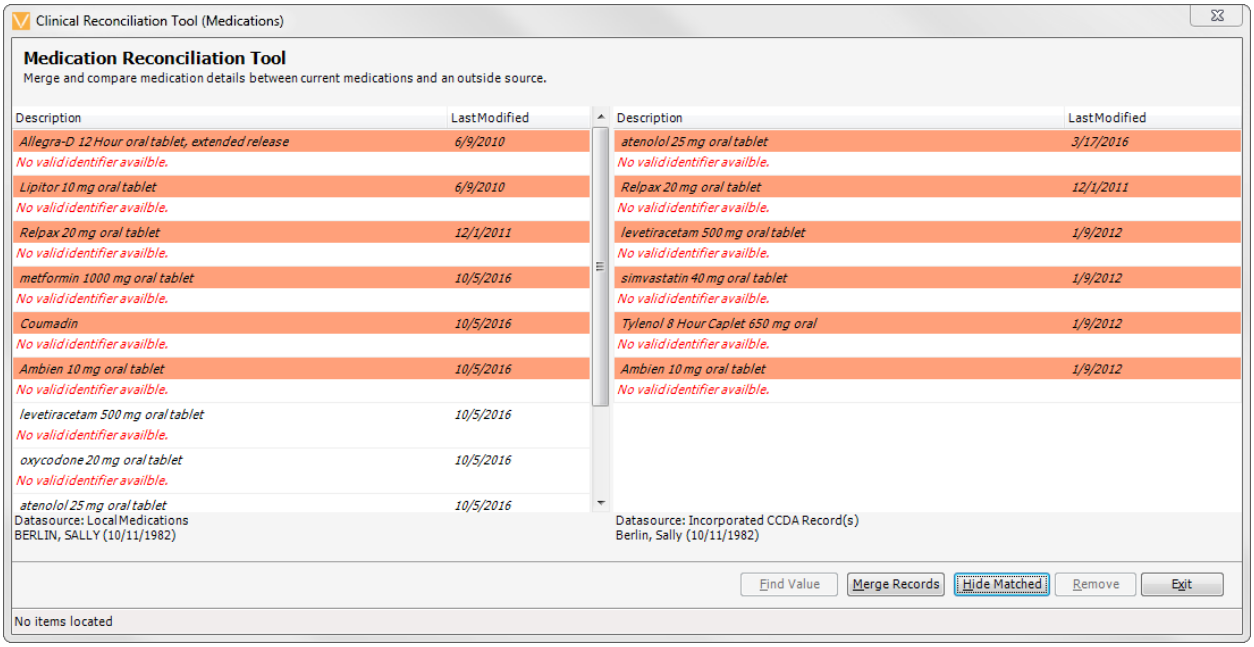
Note: Allergies added to the Patient Chart from the Allergy Reconciliation Tool will have a comment indicating such.

Medications

Medication Reconciliation

When CCDs are imported, any new allergies are added to the *Medications* Section of the Patient Chart.

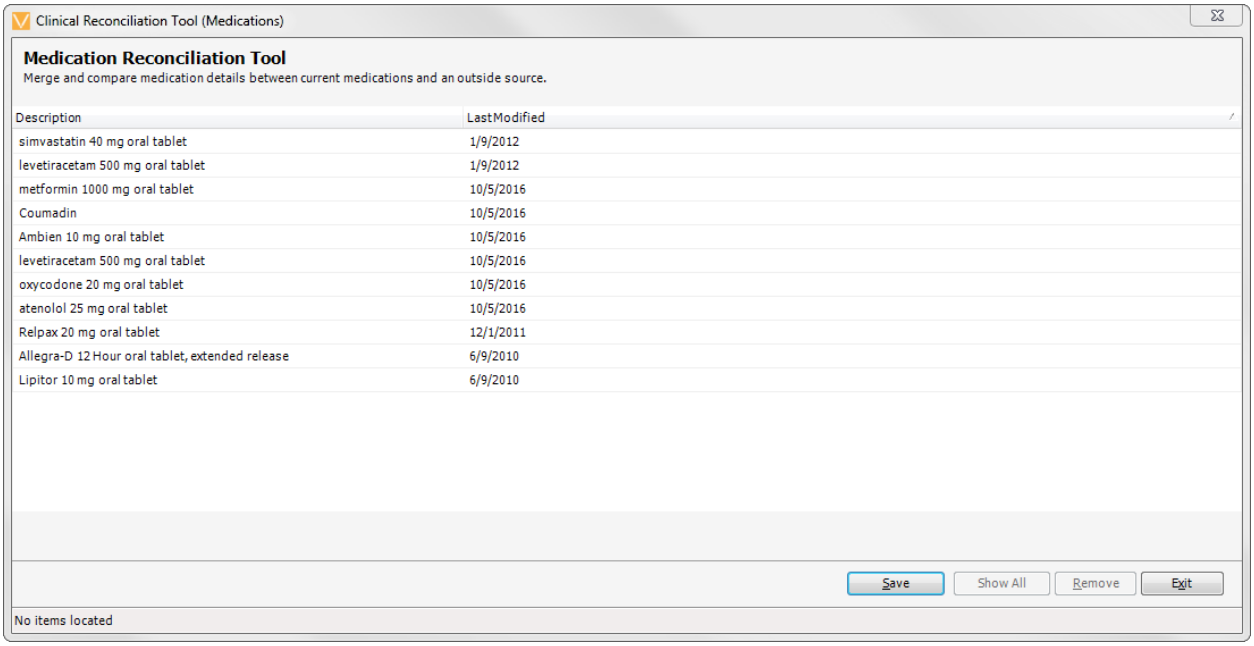
1. To view the unreconciled allergies, click the **Actions** Menu and then click **CDA Reconcile Medications** or right-click on an allergy record and select **CCDA Reconcile Medications**.



2. Click the **Hide Matched** Button to hide the allergies that were on the imported CCD and are listed in the Patient Chart.
3. Click the **Show All** Button to view the hidden records.
4. Click the **Remove** Button to omit any medication record that should not be added to the Patient Chart.
5. Click the **Merge** Button to add the unreconciled medications to the Patient Chart.

6. A preview is displayed. Medications can still be removed from this window if necessary. When ready, click the **Save** Button.

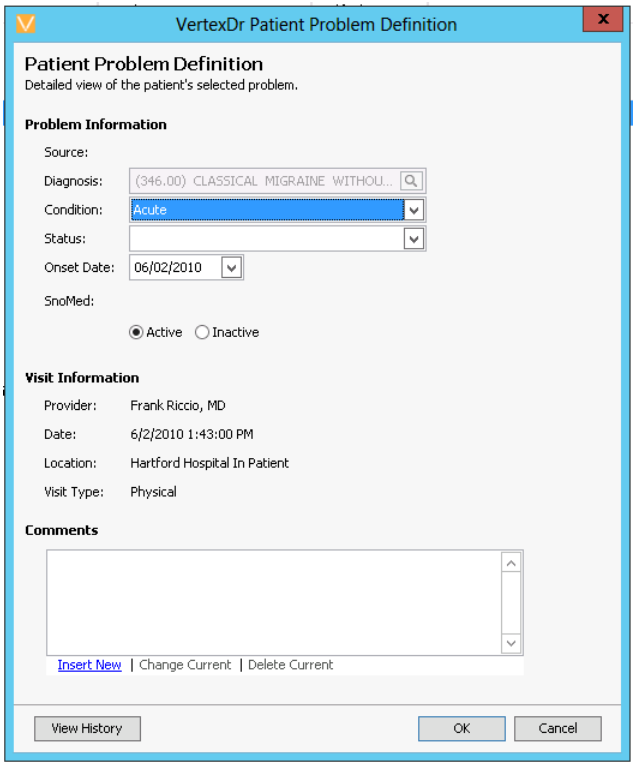
Note: Medications added to the Patient Chart from the Medication Reconciliation Tool will have a comment indicating such.



Problem List

- A status of **Cognitive Status** or **Functional Status** can be assigned to a problem.

Note: The assigned status will be included on the CCD export.



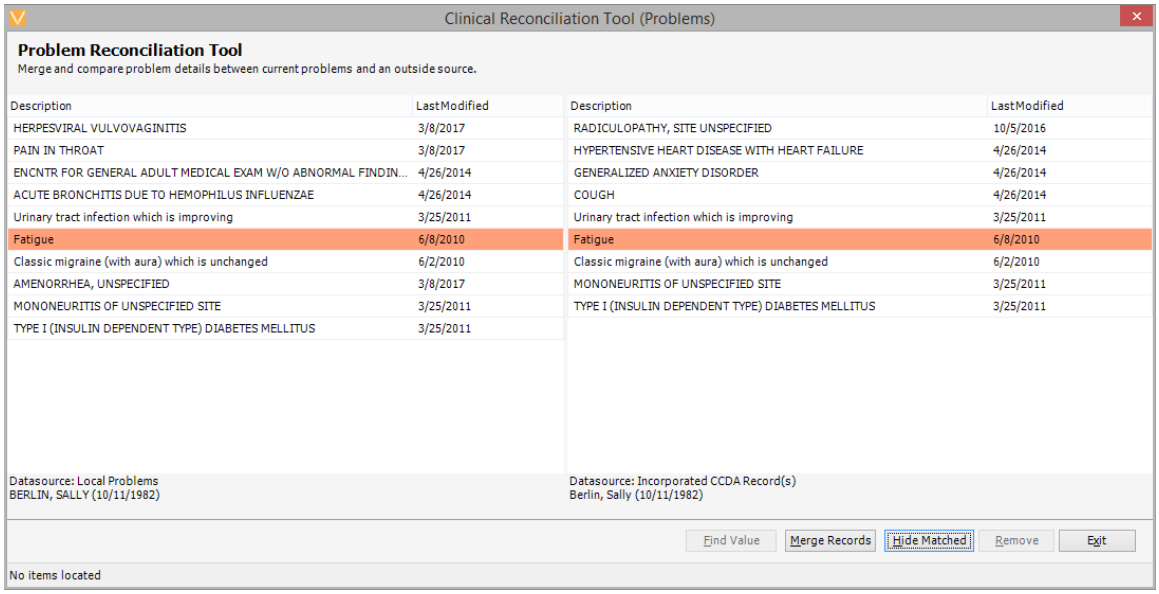
If a SnoMed code is linked to the problem, the SnoMed code displays in the *Patient Problem Definition* Window when viewing problems.

Note: The SnoMed code only displays if the problem was charted.

Problem List Reconciliation

When CCDs are imported, any new allergies are added to the *Problem List* Section of the Patient Chart.

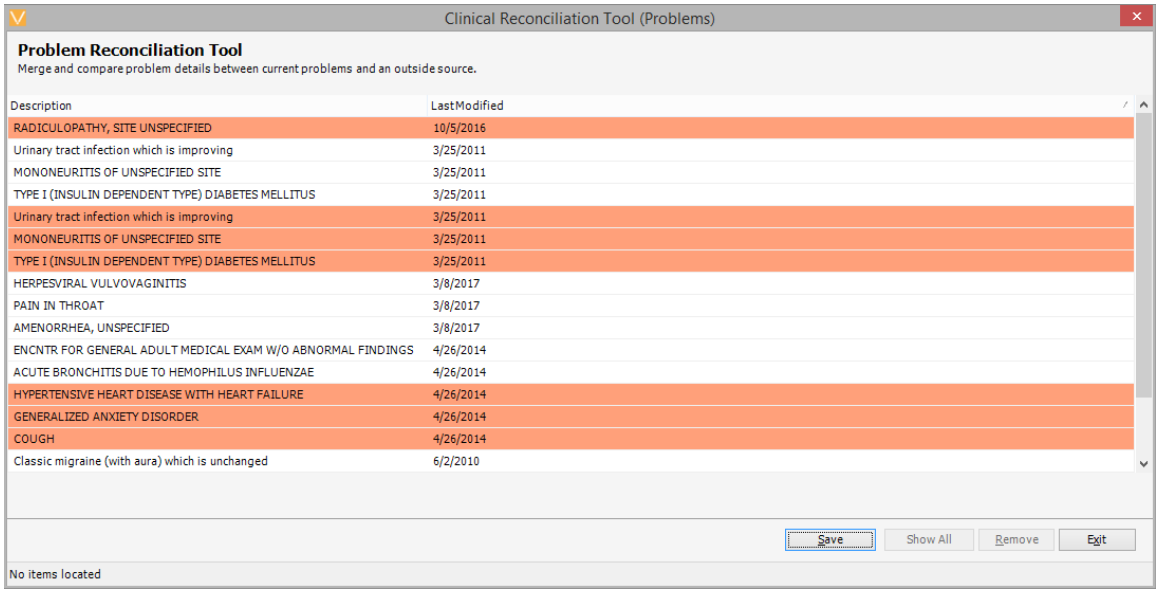
1. To view the unreconciled problems, click the **Actions** Menu and then click **CDA Reconcile Problems** or right-click on a problem record and select **CCDA Reconcile Problems**.



2. Click the **Hide Matched** Button to hide the problem that were on the imported CCD and are listed in the Patient Chart.
3. Click the **Show All** Button to view the hidden records.
4. Click the **Remove** Button to omit any problem record that should not be added to the Patient Chart.
5. Click the **Merge** Button to add the unreconciled problems to the Patient Chart.

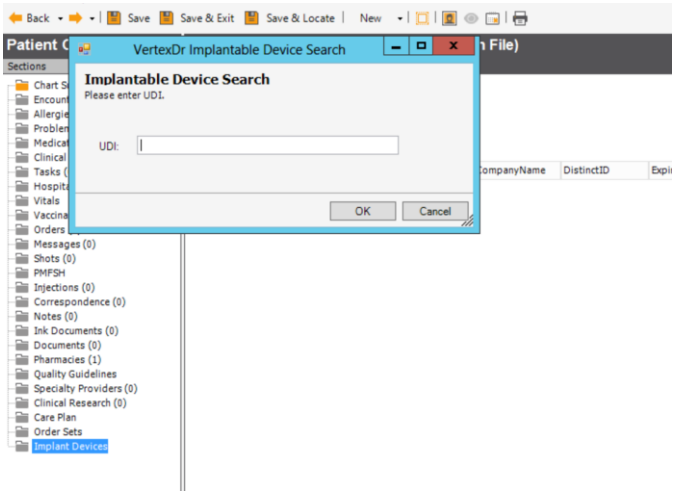
6. A preview is displayed. Problems can still be removed from this window if necessary. When ready, click the **Save** Button.

Note: Problems added to the Patient Chart from the Problem Reconciliation Tool will have a comment indicating such.



Implantable Device List

A new section of the patient's chart has been added to record implantable devices. Devices can be added to this list by clicking on the "New" button and typing in the implantable device unique identifier (UDI)



Documents Section

CCDA (Continuity of Care Documents) File Import

CCDA xml files can be imported into the Patient Chart. To do so, from the *Documents* Section, click the **New** Button and then click **CCDA Import**.

Any medications, drug allergies, and/or problems included in the imported CCDA file are added to the **Unreconciled Medications**, **Problems**, and **Allergies** Tab in the respective sections of the Patient Chart.

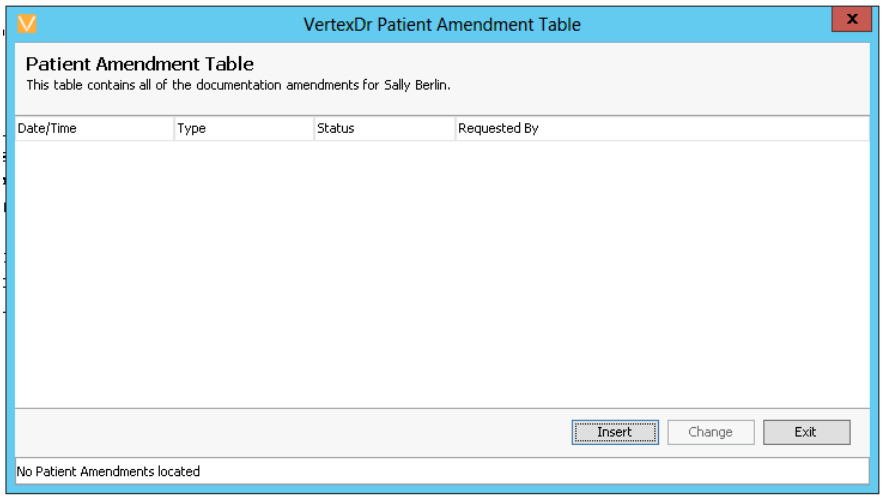
- If the selected has a Patient Portal account, the CCDA record can be exported to the Patient Portal.

Note: Whenever a record is exported a note is made in the *Correspondence* Section of the Patient Chart.

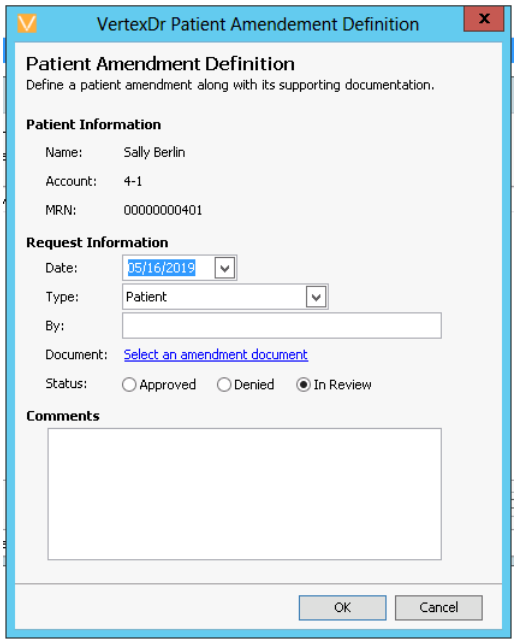
View Menu

Amendments can be added to the Patient Chart. To do so:

1. Click the **View** Menu and then select **Patient Amendments**. The *Patient Amendment* Table is displayed.



2. Click the **Insert** Button to create a new amendment or click the **Change** Button to edit and existing amendment. The *Patient Amendment Definition* Window is displayed.



The following fields can be defined:

- *Date* Field – This field defaults to today's date.
- **Type** Dropdown – Select **Patient**, **Provider**, or **Other** from the dropdown.
- *By* Field – The name of the individual requesting the amendment can by entered in the Free Text Box.
- **Status Radio** Buttons – Select **Approved**, **Denied**, or **In Review**.

Note: **In Review** is selected by default.

Comments Field – Specific information pertaining to the amendment can be entered in the Free Text Box.

- **Document** Link – Click the link to attach a document to the amendment.

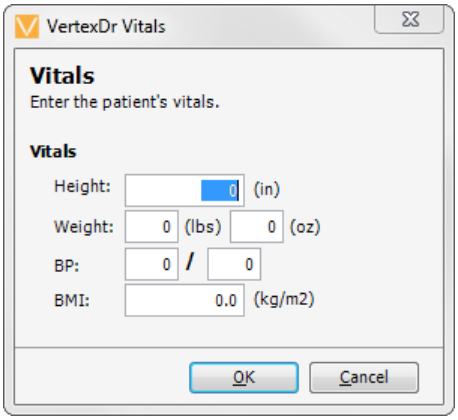
Note: If a document is already attached to the amendment, the attached document is displayed.

Charting

When charting, click the **View** Menu and then click **Vitals** to display the *Vitals* Window. Enter the *Height*, *Weight*, *BP* (systolic and diastolic). The *BMI* will automatically calculate.

Note: Only values greater than zero will be charted to the narrative.

Note: Access to the *Vitals* Window can be placed on the Medcin Toolbar.



Orders

The **Collected Specimen Date** and **Time** (in GMT format) are displayed on the Lab Report.

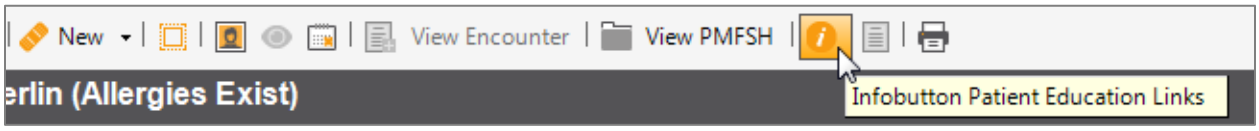
Patient Portal

From the Patient Chart, send a message directly to the patient's Portal account by clicking **Send Patient Message** from the **File** Menu. Compose the message and then click the **Send** Button.

Note: A different user within the practice can be selected from the **From** Dropdown if necessary.

Patient Education Materials

From the Problem List or Medication section of the patient's chart, you may select the **Info Button** to generate educational materials for the patient.



Patient Query Facility

The **Data Source** Dropdown is arranged alphabetically.

The following enhancements have been made to the respective Data Sources:

Insurance

Patients can be located by insurance and/or insurance priority.

Note: When locating patients by insurance, the active case listed on the *Insurance* Section of Patient Definition is used by the Query Facility.

Medication Allergies

- When locating patients by medication allergy, the query can be filtered by drug or drug class.

- The **Recorded Date** can be used to locate patients with specific medication allergies.

Note: If a **Recorded Date** is not defined, the Query Facility will search all patients with allergies.

Medications

The **Date Issued** can be used to locate patients by prescribed medications.

Patient Communication Preferences

The **Patient Communication Preferences** Data Source allows for patients with specific communication methods listed in Patient Definition to be located.

Patient Definition

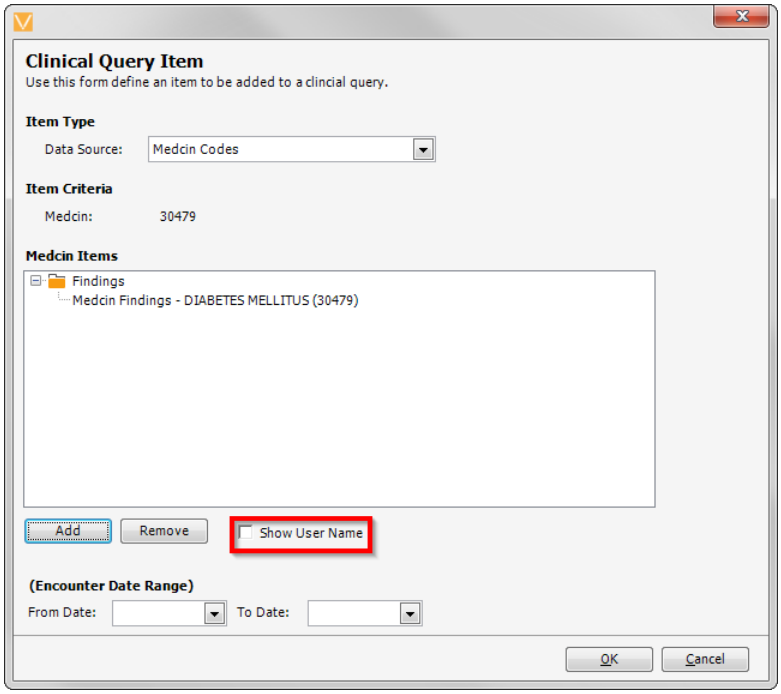
The following fields in Patient Definition can be used to locate patients via the Patient Query Facility: *City*, *State*, *Zip*, *Providing MD*, *Primary Care MD*, *Referring MD*, *Ethnicity*, and *Language*.

Problem List

When locating patients with a specific problem, the **Onset Date** can be used as a filter.

Medcin Codes/Medcin Codes with Value

Select the **Show User Name** Checkbox to also list the user who charted the selected finding(s).



Secure E-Mail

The VertexDr Practice Suite is certified to send secure e-mail communications via Direct. Secure e-mails are sent either when exporting CCDs or by simply generating a new e-mail message from the Patient Chart.

Note: The provider must have an official Direct E-Mail account.

Enabling Secure E-Mail

Secure E-Mail User Security>Third Party Addins Tab

Enter the provider's official Direct e-mail address in the Secure Email Field.

Enter the provider's official Direct e-mail address password in the Password Field.

Secure E-Mail Referring Provider Definition

Secure e-mail address can be added to Referring Provider Definition. To do so, in the *Referring Provider Definition* Window, enter the referring provider's secure e-mail address in the *Secure Email* Field on the **Provider** Tab.

Note: Secure e-mail addresses can only be used once. Secure e-mail addresses for providers in the practice should be added to the *User Security Definition* Window and not the *Referring Provider Definition* Window.

Generating Secure E-Mail Messages

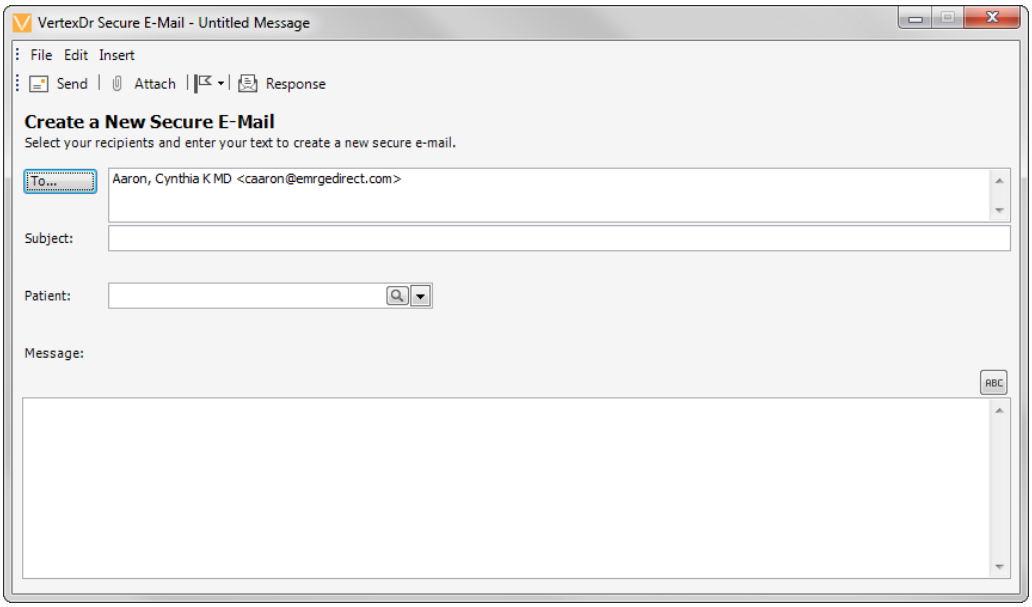
Secure e-mails can be generated in several ways:

1. When exporting CCDs,
2. When creating referrals via Transition Of Care.
3. From the Patient Chart by clicking the **New** Menu and then clicking **Secure Email**.

Secure E-Mail Window

The *Secure E-Mail* Window looks and functions like a message. Compose the e-mail as you would a message or any other e-mail messages.

To enter a recipient, either type another provider's secure e-mail address in the *To* Field or click the **To** Button to search for a referring provider with an associated secure e-mail address.



Transition of Care

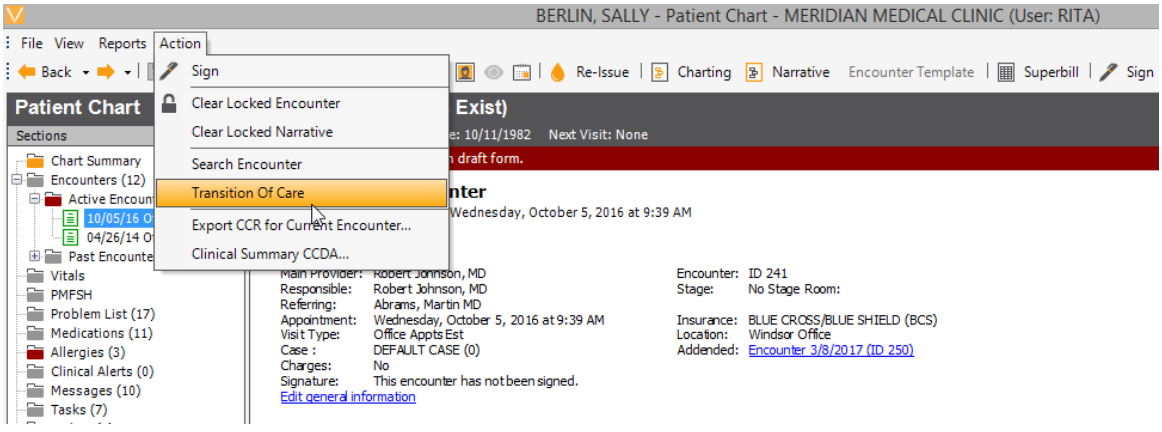
Access the Referral Tracking Form

There are several ways to access the Referral Tracking Form in our system.

Access the *Referral Tracking* Form the following way to link this action to track for credit for MIPS.

From the Patient Encounter,

- Click the **Action** Menu. Select *Transition of Care* from the dropdown menu.



The information entered in the Referral Tracking Form is used solely by the practice for the record keeping purposes.

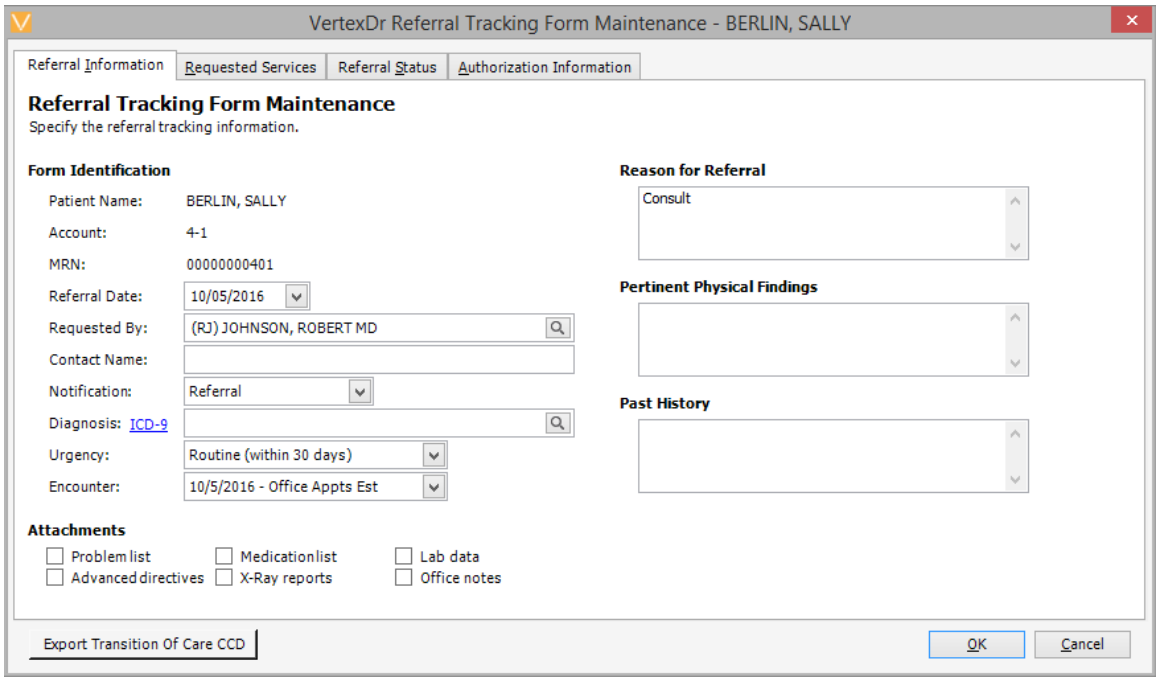
Referral Information Tab

The *Referral Tracking Form Maintenance* Window opens. The system auto-populates the fields in the *Form Identification* Section.

- Select any applicable checkboxes in the *Attachments* Section.

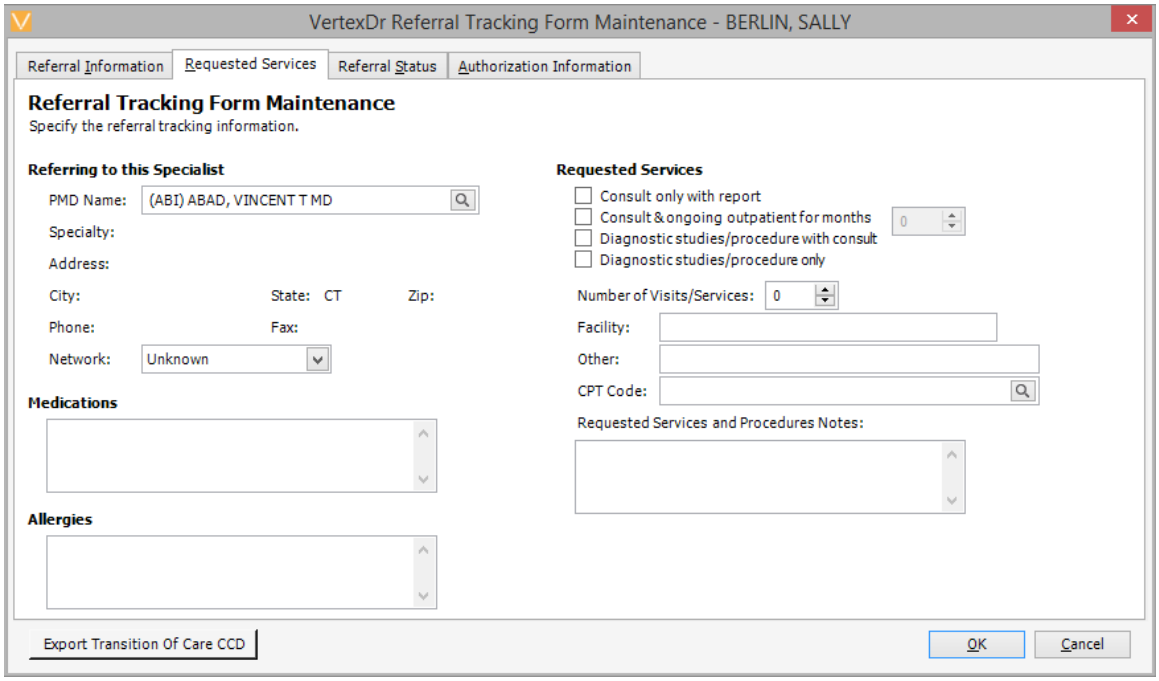
- Information must be entered in the ***Reason for Referral*** Field. This is so the **Export Transition of Care** Button becomes enabled.

- Complete any other pertinent information in this form. The ***Pertinent Physical Findings*** and ***Past History*** Fields are optional.



Requested Services Tab

- Click the ***PMD Name Dropdown*** Field. Search and select the provider or facility the patient is being transitioned or referred to.



Referral Status Tab

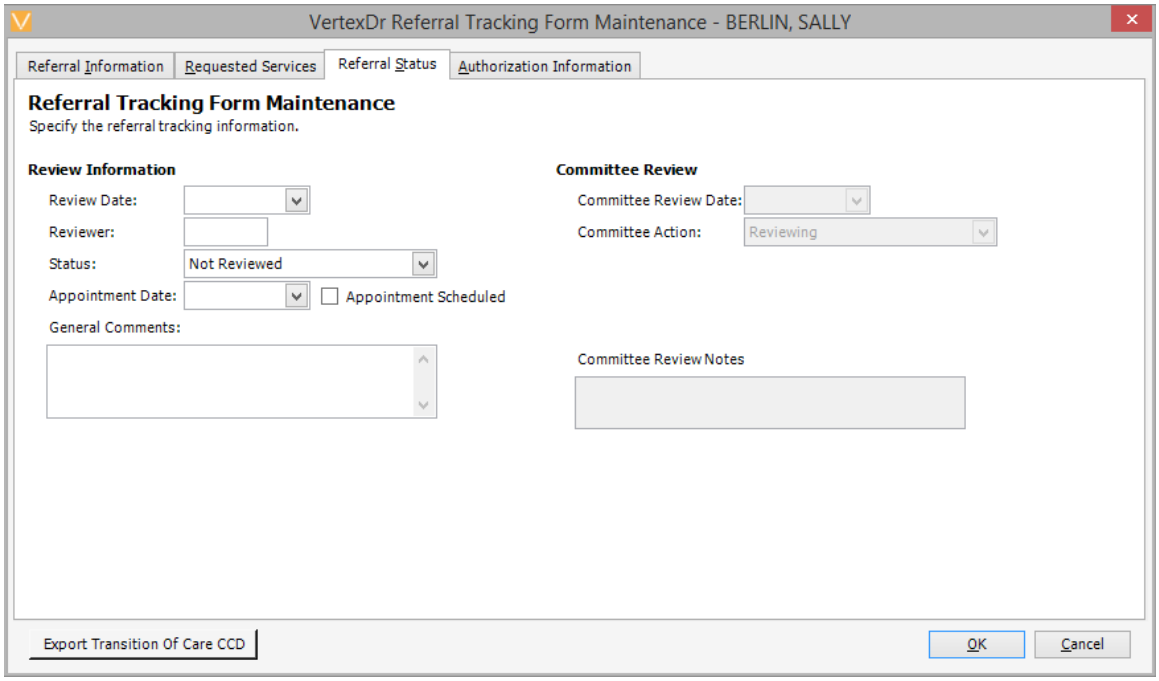
The *Review Information* and *Committee Review Information* Sections are optional.

It may be helpful to note the appointment date with the referral provider/facility.

- Click the ***Appointment Date Dropdown*** Field to record the appointment date.

If the date of the appointment is unknown, it may be helpful to know the appointment was scheduled.

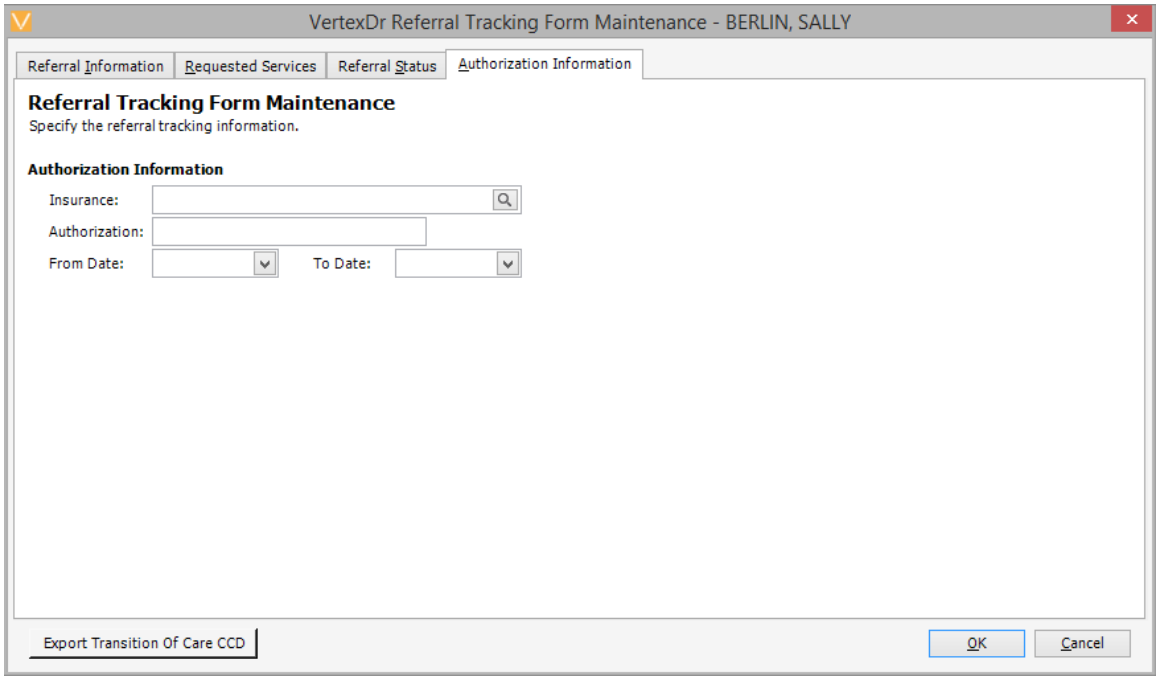
- Click the **Appointment Scheduled** Checkbox.



Authorization Information Tab

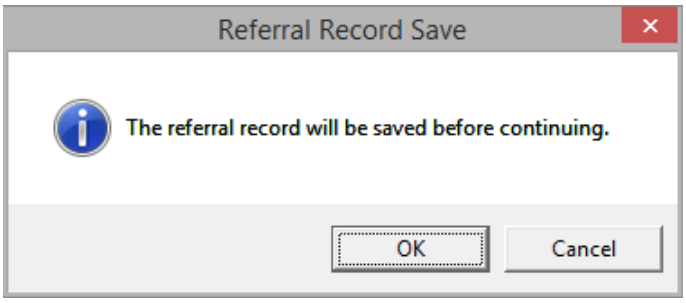
The *Authorization* Section is optional.

- Click the **Export Transition of Care CCD** Button from any of the tabs.



The *Referral Record Save* Message Box appears.

- Click the **OK** Button to save the referral information.

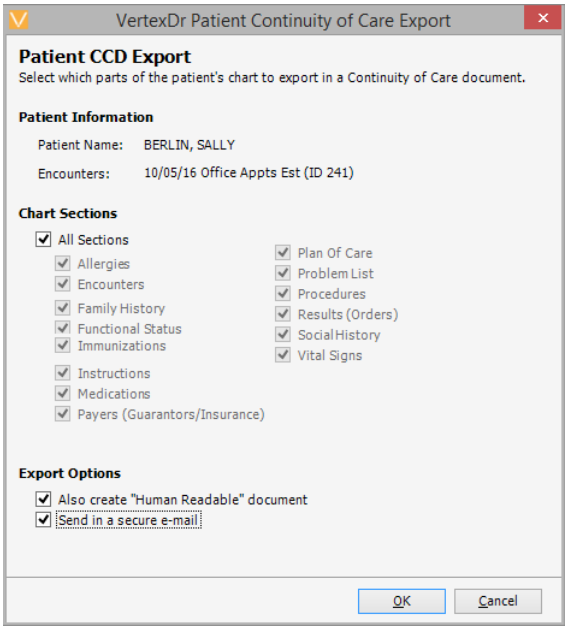


Export the Transition of Care CCD

The *Patient CCD Export* Window opens.

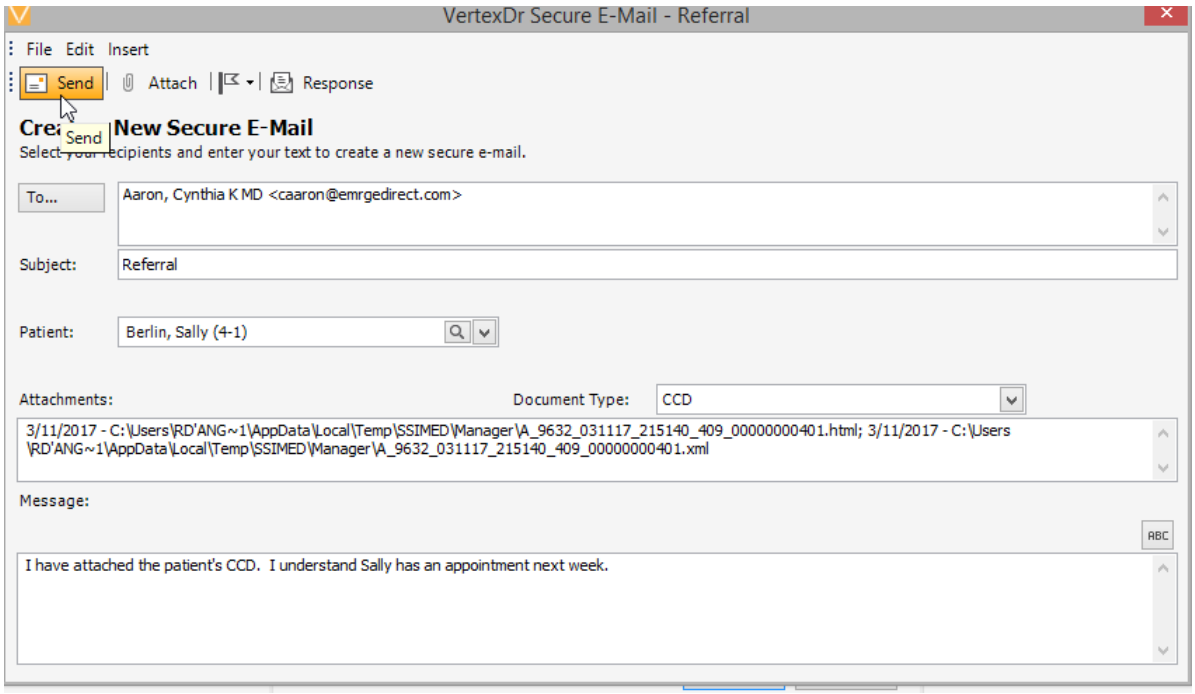
- The **All Sections** Checkbox is defaulted. Click it to uncheck it.
- Click a **Chart Section** Checkbox to unslelect it.
- Click the **Also Create "Human Readable" Document** Checkbox.
- Click the **Send in Secure-Email** Checkbox.
- Click the **OK** Button to export the CCD.

Note: The Continuity of Care Document (CCD) gives a summary of the chart sections. Encounter notes are not included.



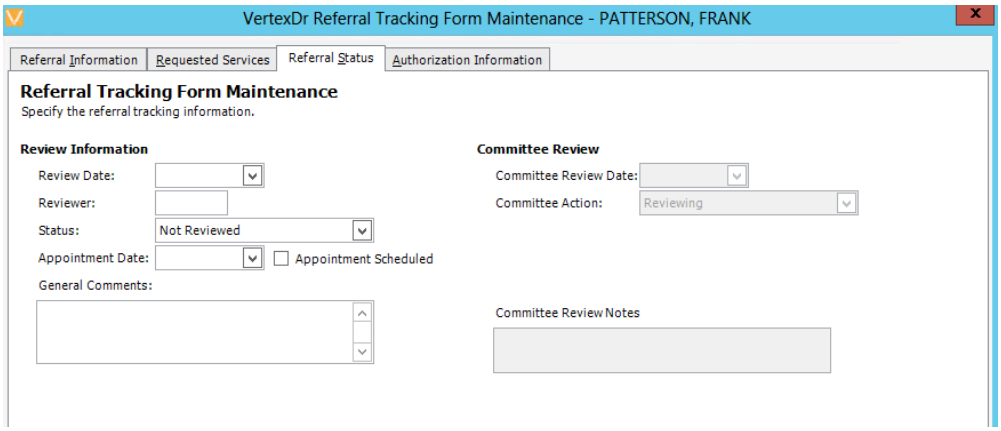
The *Secure Email Referral* Window opens.

- Click the ***To*** Field to search and select the recipient.
- Enter a subject in the ***Subject*** Field.
- Select CCD from the ***Document Type Dropdown*** Field.
- Click the ***Document Type Dropdown*** Field. Select *CCD* from the dropdown menu.
- An ***Attachment*** Field appears with the selected CCD information.
- Click the **Send** Button to send the CCD record via direct email.



Recording Receipt

Confirming receipt of a transition is done by again selecting the transition of care that was created for the denominator, navigating to "Referral Status" and filling out the review date and Status under "Review Information":



Definition

Office

Profiles

The Immunization Facility ID Field is populated when the practice is set-up with immunization registry.

The CMS Certification Number Field is reserved for the VertexDr's CMS certification number.

Service Location

An HL7 code can be entered in the *HL7 Code* Field. If defined, the code in this field will be used when exporting CCDs (Continuity of Care Documents).

Quality Guidelines>Quality Guideline Concepts

The Citation Field can be used to enter then the Quality Guideline source (i.e. website, book, etc.) If this field is populated, the source will be visible when the Quality Guideline Window displays in the Patient Chart.

Note: The *Citation* Field will only display in the Patient Chart for Quality Guidelines that are populated after the practice is updated Version 8.2, Service Pack 1.

The following fields are available in the *Quality Guideline Concept Definition* Window:

Funding Source Field - Insert the funding source for the Quality Guideline Concept.

Diagnostic Field - Enter a website for the diagnostic information pertaining to the Quality Guideline Concept. When the guideline is viewed in the Patient Chart, this field will display as a link. Click the link to open the website in the default browser.

Therapeutic Field - Enter a website for the therapeutic information pertaining to the Quality Guideline Concept. When viewing the guideline in the Patient Chart, this field will display as a link. Click the link to open the website in the default browser.

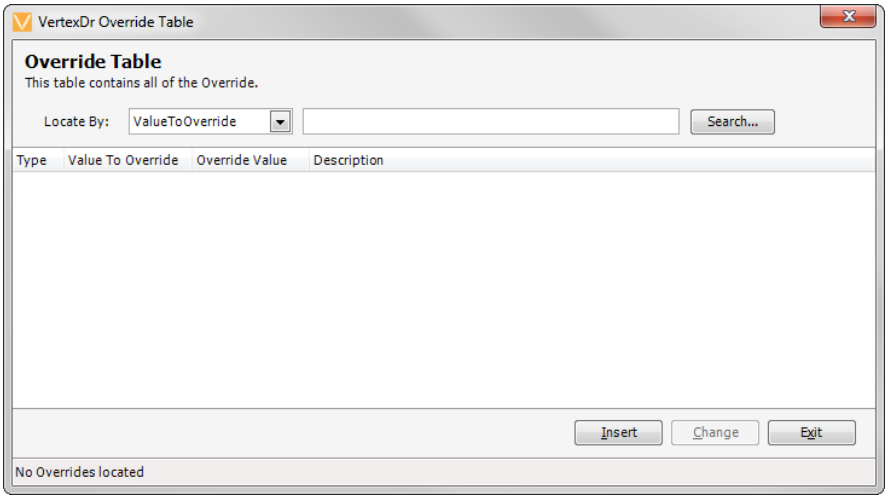
Meaningful Use Overrides>Overrides

The Override Table allows for multiple unit values to be defined.

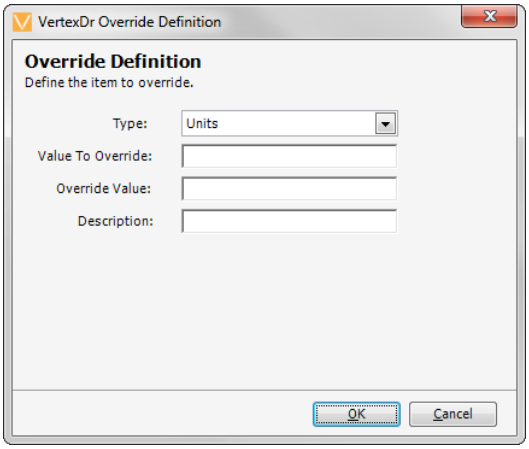
Note: The unit values are used when exported electronic lab values on CCDs.

To add unit values:

1. Click the **Definition** Menu, then click the **Office** Menu, then click **Meaningful Use Overrides**, and then click **Overrides**. The *Overrides* Table displays.



2. Click the **Insert** Button to add a new unit value or click the **Change** Button to edit an existing unit value. The *Override Definition* Window displays.



The following fields can be defined:

- **Type** Dropdown – Currently **Units** is the only option available.

Note: This field may be developed further in future releases.

Value to Override Text Box – Enter the original lab value which will be overridden, such as milliliters.

Override Value Field – Enter the lab value that will be used as the override, such as mls.

Description Textbox – This field can be used to enter a description of the override.

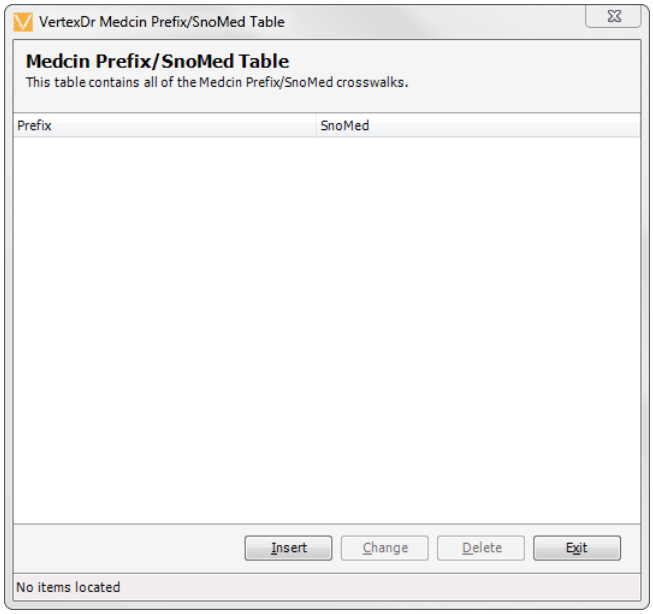
Meaningful Use Overrides>SnoMed

Medcin may attach the same SnoMed code to a finding, regardless of the prefix. The Medcin Prefix/SnoMed Crosswalk Table allows for unique SnoMed

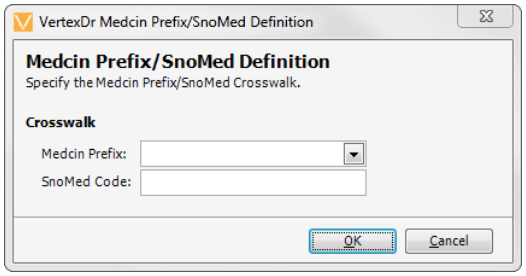
codes, like "Maternal history of" or "Paternal history of," respectively, to be added to Medcin prefixes.

To add a SnoMed code to a Medcin prefix:

1. Click the **Definition** Menu, then click the **Office** Menu, then click **Meaningful Use Overrides**, then click **SnoMed**, and then click **Medcin Prefix/SnoMed Crosswalk**. The *Medcin Prefix/SnoMed* Table displays.



2. Click the **Insert** Button to add a new Medcin Prefix/SnoMed code pairing or click the **Change** Button to edit an existing Medcin Prefix/SnoMed code pairing. The *Medcin Prefix/SnoMed Definition* Window displays.



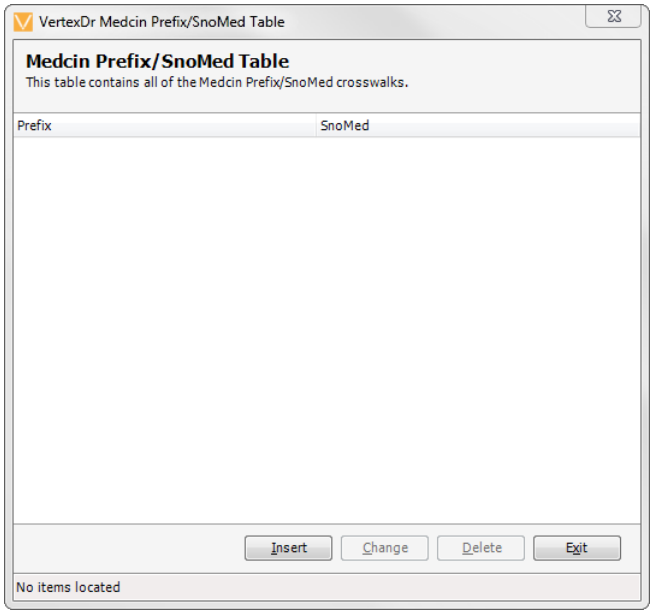
3. Select the **Medcin Prefix** from the dropdown and then enter the appropriate SnoMed code in the *SnoMed Code* Field.

Note: SnoMed codes are transmitted with CCDAs (Continuity of Care Documents). They are not visible in the Charting Area or in the Patient Chart.

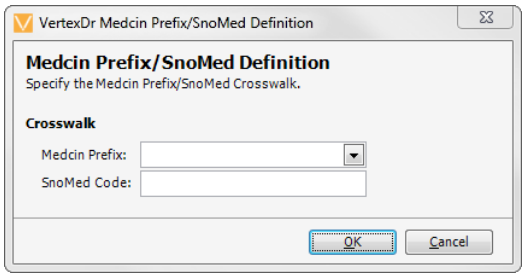
Medcin may attach the same SnoMed code to a finding, regardless of the status. The Medcin Stauts/SnoMed Crosswalk Table allows for unique SnoMed codes, like "not done for medical reason" or "refused," respectively, to be added to Medcin statuses.

To add a SnoMed code to a Medcin status:

1. Click the **Definition** Menu, then click the **Office** Menu, then click **Meaningful Use Overrides**, then click **SnoMed**, and then click **Medcin Status/SnoMed Crosswalk**. The *Medcin Status/SnoMed* Table displays.



2. Click the **Insert** Button to add a new Medcin Status/SnoMed code pairing or click the **Change** Button to edit an existing Medcin Status/SnoMed code pairing. The *Medcin Status/SnoMed Definition* Window displays.



3. Select the **Medcin Status** from the dropdown and then enter the appropriate SnoMed code in the *SnoMed Code* Field.

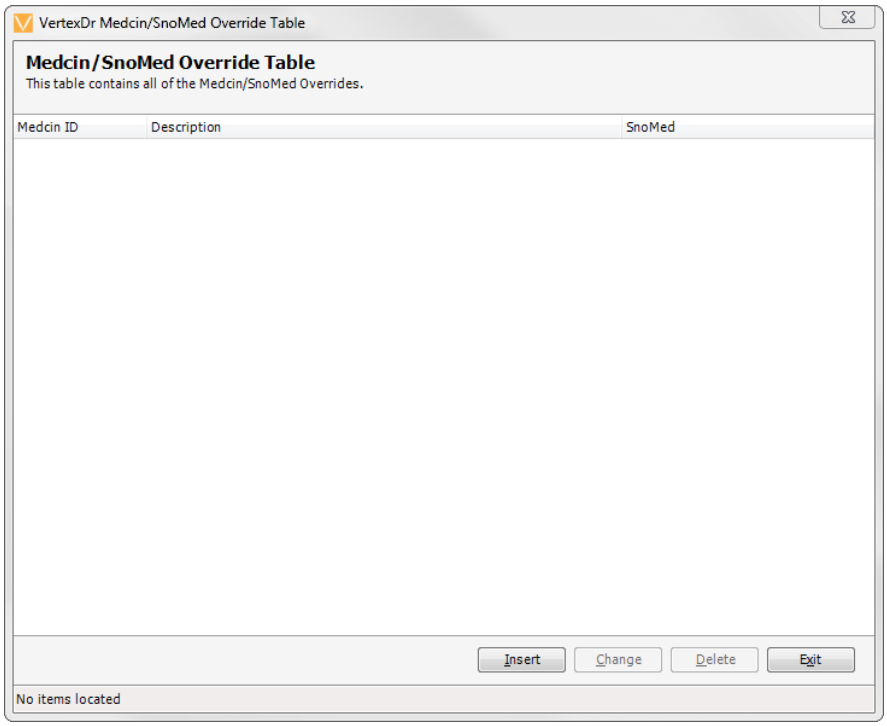
Note: SnoMed codes are transmitted with CCDAs (Continuity of Care Documents). They are not visible in the Charting Area or in the Patient Chart.

Medcin contains a limited array of SnoMed codes. The Medcin/SnoMed Override Table allows for unique SnoMed codes to be attached to any Medcin finding.

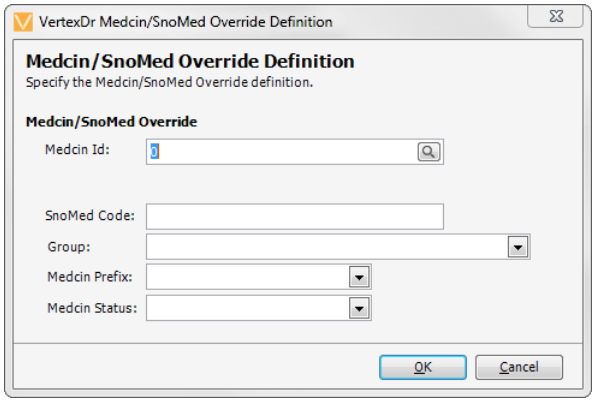
Note: SnoMed codes are transmitted with CCDAs (Continuity of Care Documents). They are not visible in the Charting Area or in the Patient Chart.

To pair a Medcin finding and SnoMed codes:

1. Click the **Definition** Menu, then click the **Office** Menu, then click **Meaningful Use Overrides**, then click **SnoMed**, and then click **Medcin/SnoMed Override**. The *Medcin/SnoMed* Table displays.



2. Click the **Insert** Button to add a new Medcin finding/SnoMed code pairing or click the **Change** Button to edit an existing Medcin finding/SnoMed code pairing. The *Medcin/SnoMed Override Definition* Window displays.



The following fields can be defined:

Medcin ID Field – Specify the Medcin finding by selecting or entering the Medcin ID.

Note: The *Medcin ID* Field is required.

- **SnoMed Code** Text Box – Enter the corresponding SnoMed code in the text box.

Note: The **SnoMed Code** Text Box is a required field.

- **Group** Dropdown – If the SnoMed code override should only take place when the selected finding is assigned to a specific Narrative Group, select a **Narrative Group** from the dropdown.

Note: If a Narrative Group is not selected, the override will take place regardless of which Narrative Group the finding is associated with.

- **Medcin Prefix** Dropdown – If the SnoMed code override should only take place when the selected finding contains a specific prefix, select the prefix from the dropdown.
- **Medcin Status** Dropdown – If the SnoMed code override should only take place when the selected finding is associated with a specific status, select the status from the dropdown.

  Medcin contains a limited array of SnoMed codes. The Medcin/SnoMed Override Table allows for unique SnoMed codes to be attached to any Medcin finding.

Note: SnoMed codes are transmitted with CCDAs (Continuity of Care Documents). They are not visible in the Charting Area or in the Patient Chart.

To pair a Medcin finding and SnoMed codes:

1. Click the **Definition** Menu, then click the **Office** Menu, then click **Meaningful Use Overrides**, then click **SnoMed**, and then click **Medcin/SnoMed Override**. The *Medcin/SnoMed* Table displays.
2. Click the **Insert** Button to add a new Medcin finding/SnoMed code pairing or click the **Change** Button to edit an existing Medcin finding/SnoMed code pairing. The *Medcin/SnoMed Override Definition* Window displays.

The following fields can be defined:

Medcin ID Field – Specify the Medcin finding by selecting or entering the Medcin ID.

Note: The *Medcin ID* Field is required.

- **SnoMed Code** Text Box – Enter the corresponding SnoMed code in the text box.

Note: The **SnoMed Code** Text Box is a required field.

- **Group** Dropdown – If the SnoMed code override should only take place when the selected finding is assigned to a specific Narrative Group, select a **Narrative Group** from the dropdown.

Note: If a Narrative Group is not selected, the override will take place regardless of which Narrative Group the finding is associated with.

- **Medcin Prefix** Dropdown – If the SnoMed code override should only take place when the selected finding contains a specific prefix, select the prefix from the dropdown.

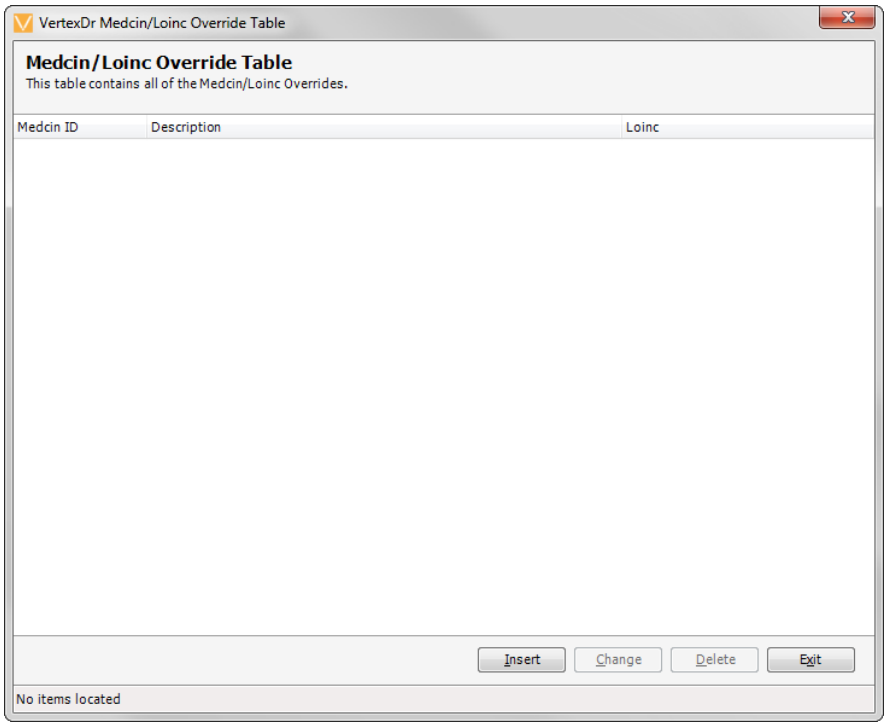
- **Medcin Status** Dropdown – If the SnoMed code override should only take place when the selected finding is associated with a specific status, select the status from the dropdown.

  The Medcin/Loinc Override Table allows for unique Loinc (electronic lab) codes to be attached to any Medcin finding.

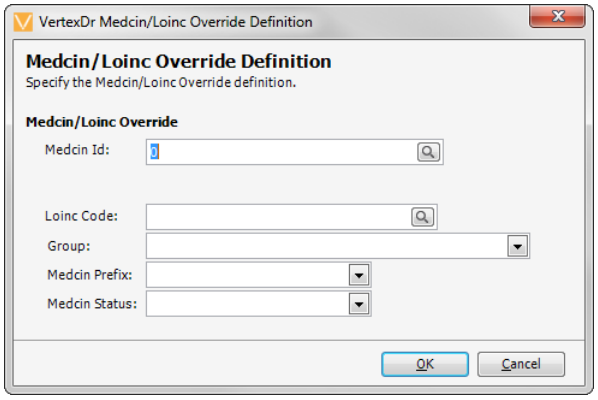
Note: Loinc codes are transmitted with CCDAs (Continuity of Care Documents). They are not visible in the Charting Area or in the Patient Chart.

To pair a Medcin finding and Loinc codes:

1. Click the **Definition** Menu, then click the **Office** Menu, then click **Meaningful Use Overrides**, and then click Medcin/Loinc Override. The *Medcin/Loinc* Table displays.



2. Click the **Insert** Button to add a new Medcin finding/Loinc code pairing or click the **Change** Button to edit an existing Medcin finding/Loinc code pairing. The *Medcin/Loinc Override Definition* Window displays.



The following fields can be defined:

Medcin ID Field – Specify the Medcin finding by selecting or entering the Medcin ID.

Note: The *Medcin ID* Field is required.

- **Loinc Code** Field – Select the corresponding Loinc code.

Note: The **Loinc Code** field is required.

- **Group** Dropdown – If the Loinc code override should only take place when the selected finding is assigned to a specific Narrative Group, select a **Narrative Group** from the dropdown.

Note: If a Narrative Group is not selected, the override will take place regardless of which Narrative Group the finding is associated with.

- **Medcin Prefix** Dropdown – If the Loinc code override should only take place when the selected finding contains a specific prefix, select the prefix from the dropdown.
- **Medcin Status** Dropdown – If the Loinc code override should only take place when the selected finding is associated with a specific status, select the status from the dropdown.

Prescriptions

Allergens

The Allergen Table allows for Substance Codes to be linked to allergen descriptions.

Note: The *Substance Code* field is a required field. Substance codes cannot be altered.

Parameters

System Wide Defaults

VertexDr 2

With the **Use Clinical Intervention Window** Checkbox enabled, the Suite will verify Quality Guidelines as the patient's record is updated with medications, lab orders, test results, problems, and other charted items.

Note: The Quality Guideline Parameter **Display Guidelines when Entering the Chart** must also be enabled.

System

With the **Do not generate images in with error logs** Checkbox enabled, image files will not be produced when error logs are created.

Third Party Settings

The Infobutton Settings Field contains the web service information for the patient education search engine.

Note: This field works in conjunction with the **Infobutton** User Security. See the *User Security* Section of this guide for more information.

Prescriptions

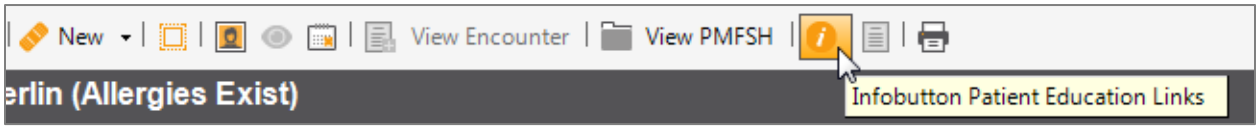
- With the **Perform Interaction Checks when Entering Medication Allergies** Checkbox enabled the system will perform an interaction check when a new allergy is recorded in the Patient Chart.

Security

Users

VertexDr Misc

With the **Allow User Access to Infobutton** Checkbox enabled, the selected user is able to click the **Info** Button on the toolbar from the *Problem List* Record, *Medication* Record, or a specific *Lab Test* Record.



Auditing

Provider Audits

Changes made to provider suppression settings in Provider Definition are tracked.

Quality Guideline Concepts

The *Quality Guideline Concept* audit tracks all changes made to Quality Guideline Concepts, including when guidelines are created.

File Menu

Export CCD for Patients

The CCD can be exported as an XML file type. Once generated, the file name is MRN.xml.

When a CCD is generated for a patient(s), a record of the export is noted in the Correspondence Section of the Patient Chart.

The following options are available on the respective tabs in the *Patient(s) CCD Exporter* Window:

Report Options Tab

- Click the **Output Directory** Ellipse Button to select where the exported filed will be saved.

Note: This field is required.

If export patients with a specific referral reason indicated on the Referral Tracking Form, enter the reason in the Referral Reason Field.

To export patients seen between specific encounter dates, enter the appropriate dates in the From Date and To Date Fields.

- Click the **Create "Human Readable" document** Checkbox to generate an html file for each corresponding CCD file.

Clients Tab

Select the **Locate by Client ID** Magnifying Glass Icon to export patients for a specific profile, if the practice has multiples.

Note: By default, defined patients for all profiles will be exported unless a specific profile is selected.

Providers Tab

Select one or more providers from the **Providers** Tab to export patients for only those providers.

Note: This field reads from the provider listed on the *Personal* Section of Patient Definition.

Note: By default, patients for all providers are exported unless a specific selection is made.

Locations Tab

Export patients associated with a specific office location by select the location(s) from the **Locations** Tab.

Note: This field reads from the location listed on the *Personal* Section of Patient Definition.

Note: By default, patients for all locations are exported unless a specific selection is made.

Help

About

The local machine data and time are displayed in the *VertexDr* Window.

Note: Local machines should be synced with an NIST server for Meaningful Use, Stage II.

References:

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Advancing-Care-information-Fact-Sheet.pdf

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage3Medicaid_Require.html

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2019ProgramRequirementsMedicare.html

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

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