Meaningful Use Dashboard Calculation Guide

Learn how to use Practice Fusion’s Meaningful Use Dashboard to help you achieve Meaningful Use. For more information, visit the Meaningful Use Center.

General Functionality

How do I access the Dashboard?

- Go to Reports and click on “Meaningful Use dashboard.”

How do I set up the Dashboard?

- When first navigating to the Meaningful Use dashboard, you’ll select your attestation details.
- Select the correct provider and what attestation year of the dashboard you’d like to view.
- By clicking the gear icon, you can select whether you “plan to attest” or if you “don’t plan to attest.”
- You can select the year you first attested successfully for Meaningful Use, and whether you’re participating in the Medicare or Medicaid EHR Incentive Program. This selection will inform what Stage of the program you are in. In 2015, Stage 1 providers will be in a “Modified Stage 2.” In 2016, all providers will be in Stage 2.
- Select your reporting period. In 2015, all providers will complete a 90 day reporting period. In 2016, providers will complete a 90 day reporting period or a full year reporting period. If you have selected a 90 day reporting period previously, you can click “Load a previous reporting period” to view the data from those reporting periods.
- Click “update” when you have completed your selections in the Meaningful Use Dashboard settings.

How does the Dashboard update?

- The Meaningful Use Dashboard values update daily after 9PM ET/6PM PT for actions taken during the previous day.
- Only visits with dates of service during your reporting period are included in the Dashboard calculations.
- Patients are defined as “seen during the EHR reporting period” when they have an encounter that is categorized as an Office Visit, Home Visit, Nursing Home Visit, or Telemedicine Visit during the reporting period selected on your Dashboard. Encounter types are selected in the chart note.
- Only signed notes with the appropriate encounter types selected will count for measures based on unique patients or visits, so sign your notes promptly to see accurate progress for each measure.
- For each measure based on a signed note with an appropriate encounter type selected, only the provider who signs the note will get denominator credit.
- Criteria completed outside of the EHR (e.g. Security Risk Analysis from Protect Patient Health Information) are not calculated by the dashboard. To note this on your dashboard, check the Complete
box under the Current column to log that the measures are complete. You must also maintain supporting documentation of these actions for your records.

- If you believe a specific measure does not apply to your scope of practice, you may be eligible for an exclusion. To note an exclusion on your dashboard, switch the toggle from None to Claimed under the Report column and select the reason for exclusion. You must also maintain supporting documentation of the exclusion for your records.

How do I start completing criteria?

- Start charting patient visits using Practice Fusion.
- Meaningful Use applies to all patients you see, regardless of their insurance.

What do I do if I have not met all the criteria?

- Use the Gap Report by clicking the numerator and denominator under the Current column to see which patients are missing required information for specific measures. Gap reports are only available for measures that are patient-centric, meaning any measure where Practice Fusion can produce a list of patients not meeting the measure.
- If you feel your numbers aren’t accurate in the Dashboard, review this guide to ensure that you understand how all of the measures are calculated and ensure that you have signed all of your notes and selected appropriate encounter types for visits during the reporting period.

Other Tips

- Make sure you complete the criteria during your reporting period, not after.
- If you believe a specific measure does not apply to your scope of practice, you may be eligible for an exclusion. Learn more about qualifying for exclusions in our Knowledge Base.

Measure Calculations and Tips

To achieve Meaningful Use, you should first make sure you understand how to meet all of the measures using Practice Fusion’s EHR. Visit the Knowledge Base or click on the measure title directly in the Dashboard for full information on how the measures are calculated in Practice Fusion.

Each objective and measure below contains information on the CMS measure specification from which Practice Fusion derived the Meaningful Use Dashboard calculations. We also include Practice Fusion’s recommended workflow and tips for ensuring that your actions in Practice Fusion will help you achieve credit in the Dashboard. If applicable, the CMS-approved exclusion is listed.

CMS has transitioned Stage 1 to Modified Stage 2 for the 2015 reporting period and beyond. The 13 core and 9 menu requirements have been adjusted to 10 objectives.

Practices that are reporting for Stage 1 in 2015 will now report on all the Stage 2 objectives with modified specifications and/or exclusions for measures that were not in Stage 1. This interim set of requirements is being called Modified Stage 2, and is clarified further below in the individual objectives.
OBJECTIVES:

OBJECTIVE 1: PROTECT ELECTRONIC HEALTH INFORMATION

Measure: Conduct or review a security risk analysis with respect to abiding by the HIPAA Security Rule, specifically the Security Management Process [45 CFR 164.308(a)(1)]. You also need to implement security updates as necessary and correct identified security deficiencies as part of your risk management process. You must conduct or review a security risk analysis and implement security updates as necessary at least once prior to the end of the EHR reporting period.

Practice Fusion workflow: Use the ONC Security Risk Analysis tool to conduct and document a comprehensive assessment to identify risks in your organization. Be sure to save these documents and any other documents related to actions completed as part of completing the security risk analysis (e.g. receipts for new security software) for your records.

Dashboard tip: After completing the requirements for this measure, you can manually indicate this in your Meaningful Use Dashboard by checking the box next to this measure.

OBJECTIVE 2: CLINICAL DECISION SUPPORT

Objective: This objective requires that you implement clinical decision support (CDS) notifications in the EHR to improve health outcomes. There are two measures for this objective:

- **Measure 1: Clinical Decision Support** - 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.

- **Measure 2: Drug Interaction Checks** - Implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Exclusion: For measure 2: Any provider who writes fewer than 100 medication orders during the EHR reporting period.

Modified Stage 2 Specification for Measure 1: Stage 1/Modified Stage 2 providers will be required to implement one clinical decision support rule for the entire reporting period.

Practice Fusion workflow: Practice Fusion enables all CDS rules by default, but you can configure CDS notifications and drug interactions under the **Settings** section of the EHR or by clicking the **CDS settings** and **Alert settings** on the Meaningful Use Dashboard. Ensure that you have at least five CDS interventions enabled and at least one alert for drug-drug and drug-allergy interactions enabled for the entire reporting period.

Dashboard tip: If you or your practice administrator disables four or more CDS rules or all drug interaction alerts, the Dashboard will indicate that you have not met this measure and you will not be able to complete this measure until the next reporting period. It is a
good practice to ensure that everyone on your staff, including EHR account administrators, understands these limitations and does not disable or alter CDS advisories or drug interaction alerts without understanding the ramifications to your Meaningful Use status.

OBJECTIVE 3: COMPUTERIZED PROVIDER ORDER ENTRY (CPOE)
This objective includes three measures. The threshold requirements of all three measures must be met in order to achieve this measure. CPOE is the entry of the order into the EHR and does not relate to how that order is filled or otherwise carried out. This objective requires that you use computerized physician order entry (CPOE) to record the following items during your EHR reporting period:

- Measure 1: More than 60% of medication orders
- Measure 2: More than 30% of lab orders
- Measure 3: More than 30% of radiology/imaging orders

Exclusion:
Any provider who writes fewer than 100 medication, radiology, and/or laboratory orders during the EHR reporting period is excluded from the corresponding measure.

Modified Stage 2 Alternate Measures and Exclusions: Stage 1/Modified Stage 2 providers in 2015 can meet the CPOE for Medication Orders measure in the following two ways: record at least one medication order using CPOE for more than 30% of patients seen during the reporting period; or use CPOE to record more than 30% of medication orders. Stage 1/Modified Stage 2 providers will not be required to report CPOE for Lab or Imaging Orders in 2015 because those measures did not exist in Stage 1.

MEASURE 1: CPOE FOR MEDICATION ORDERS
Exclusion: Any provider who writes fewer than 100 prescriptions during the EHR reporting period.

Denominator: The number of prescriptions recorded, printed or e-prescribed (including refills) during the EHR reporting period.

Numerator: The number of prescriptions in the denominator that are recorded using CPOE.

Practice Fusion Workflow: To add a medication to a patient’s encounter and send an e-prescription, scroll to the Plan section of the encounter and click Record. From the Medications tab, search for and select a medication. Please click on the newly added medication to proceed with ordering. Add directions and a start date along with any notes to the pharmacy in the details window, then click Order. Review your prescription summary and select a pharmacy to fill the order if applicable. Click Send eRx, Print Rx, or Record Rx.

OBJECTIVE 3B: CPOE FOR LAB ORDERS
Exclusion: Any provider who writes fewer than 100 lab orders during the EHR reporting period.

Denominator: The number of lab tests ordered during the EHR reporting period.

Numerator: The number of lab tests in the denominator recorded using CPOE.
**Practice Fusion workflow:** Under the *Actions* menu of a patient’s chart, select “Add lab order” to gain access to the ordering workflow. From within the ordering screen, select the lab you want to send orders to and then enter in the required information. When entering a lab test, you must add a ‘Test Code’ if you are ordering a custom test. If you are connected with a lab, click *Send* to submit the order electronically to the lab. If you are not connected with a lab, click *Print*.

**Dashboard tip:** If you have your office staff record orders on your behalf, they must select your name under the *Ordering Physician* drop-down in order for you to receive credit in the Meaningful Use Dashboard.

**OBJECTIVE 3C: CPOE FOR RADIOLOGY ORDERS**

**Exclusion:** Any provider who writes fewer than 100 radiology orders during the EHR reporting period.

**Denominator:** The number of radiology tests ordered during the EHR reporting period.

**Numerator:** The number of orders in the denominator that are recorded using CPOE.

**Practice Fusion workflow:** Under the *Actions* menu of a patient’s chart, select *Add image order* to gain access to the ordering workflow. From within the ordering screen, select the imaging center you want to send orders to and then enter in the required information. If you are not connected with an imaging center, you have the option to select *Other*. When entering an imaging test, you must add a ‘Test Code’ if you are ordering a custom test. If you are connected with an imaging center, click *Send* to submit the order electronically to the imaging center. If you are not connected with an imaging center, click *Print*.

**Dashboard tip:** If you have your office staff record orders on your behalf, they must select your name under the “Ordering Physician” menu in the ordering screen in order for you to receive credit in the Meaningful Use Dashboard.

**OBJECTIVE 4: ELECTRONIC PRESCRIBING**

**Measure:** To achieve the e-prescribing objective, more than 50% of all prescriptions should be checked for drug formulary and sent electronically. E-refills are considered electronic prescriptions and count towards meeting this requirement.

Depending on whether or not you are able to send electronic prescriptions for controlled substances, you will attest to one of the following measures:

- e-Prescribing: Permissible
- e-Prescribing: Permissible and Controlled Substances

**Modified Stage 2 Specifications:** Stage 1/Modified Stage 2 providers must send more than 40% of all permissible prescriptions electronically.
MEASURE 4A: E-PRESCRIBING: PERMISSIBLE

**Exclusion:** Providers who write fewer than 100 prescriptions during the EHR reporting period or if no pharmacies accept e-prescriptions within 10 miles of the practice location at the start of the reporting period.

**Denominator:** Number of prescriptions written for drugs other than controlled substances during the EHR reporting period.

**Numerator:** Number of prescriptions from the denominator that are generated and transmitted electronically.

**Practice Fusion Workflow:** From the patient’s Summary section, click the icon to the right of Medications and search for a medication by typing into the search bar. Alternately, start a “New encounter” and click “Record” by Medications to search for a medication. After selecting the medication and including prescribing information, click “Order Rx.” Review the prescription information, click next, and then “Send eRx.”

MEASURE 4B: E-PRESCRIBING (PERMISSIBLE AND CONTROLLED SUBSTANCES)

**Exclusion:** Providers who write fewer than 100 prescriptions during the EHR reporting period or if no pharmacies accept e-prescriptions within 10 miles of the practice location at the start of the reporting period.

**Denominator:** Number of prescriptions, including controlled substances, written during the EHR reporting period.

**Numerator:** Number of prescriptions from the denominator that are generated and transmitted electronically.

**Practice Fusion Workflow:** From the patient’s Summary section, click the icon to the right of Medications and search for a medication by typing into the search bar. Alternately, start a “New encounter” and click “Record” by Medications to search for a medication. After selecting the medication and including prescribing information, click “Order Rx.” Review the prescription information, click next, and then “Send eRx.”

OBJECTIVE 5: HEALTH INFORMATION EXCHANGE

**Measure:** When you transition or refer your patient to another setting of care or provider of care, you must create a summary of care record and electronically transmit it to a receiving provider for more than 10% of transitions of care and referrals.
**Exclusion:** Any provider who transfers a patient to another setting or refers a patient to another provider less than 100 times during the reporting period.

**Alternate Exclusion for Modified Stage 2:** Stage 1/Modified Stage 2 providers can claim an exclusion to this objective in 2015 because there is no equivalent measure in Stage 1.

**Denominator:** Number of transitions of care and referrals made during the reporting period.

**Numerator:** Number of transitions of care and referrals where a summary of care record, including a clinical document, was successfully electronically transmitted using Practice Fusion during the reporting period.

**Practice Fusion workflow:**

From the Actions drop-down menu in a patient’s chart, select *Create clinical document*. You may generate either a clinical or referral summary, but we recommend a referral summary for completeness.

Once you have generated your clinical document, select *Add referral* from the Actions drop-down menu.

In order to receive credit for this measure, you must send referral electronically to another Practice Fusion provider or provider outside the Practice Fusion network using Direct messaging. You must attach the clinical document to the electronic referral.

**Dashboard tip:** Referrals do not need to be sent within 24 hours of a patient’s chart note to meet this measure. Fax referrals and indicating the referral was sent in the Screenings/Interventions/Assessments section of the chart note do not count towards this measure. Attaching a chart note to the referral does not meet the requirements of this measure. A clinical document (clinical summary or referral summary) must be attached to the referral for credit.

**OBJECTIVE 6: PATIENT SPECIFIC EDUCATION**

**Measure:** Use clinically relevant information to identify patient-specific education resources and provide those resources to the patient.

**Exclusion:** Any provider who has no office visits during the reporting period is excluded from this measure.

**Alternate Exclusion for Modified Stage 2:** Stage 1/Modified Stage 2 providers can claim an exclusion to this objective in 2015 because there is no equivalent measure in Stage 1.
**DENOMINATOR:** Number of unique patients you see during the EHR reporting period.

**NUMERATOR:** Number of patients in the denominator who are provided patient-specific education resources using Practice Fusion.

**Practice Fusion workflow:** Click on "Medline Plus" or "Patient Education Materials" in any diagnosis, lab, or medication window and provide the resources to the patient.

**OBJECTIVE 7: PERFORM MEDICATION RECONCILIATION**

**Measure:** When receiving a patient from another setting or provider of care, perform medication reconciliation.

**Exclusion:** Any provider who was not the recipient of any transitions of care during the EHR reporting period.

**Alternate Exclusion for Modified Stage 2:** Stage 1/Modified Stage 2 providers can claim an exclusion to this objective in 2015 if they did not intend to attest to the menu measure.

**Denominator:** Number of transitions of care during the EHR reporting period for which you were the receiving party of the transition.

**Numerator:** Number of transitions of care in the denominator where medication reconciliation was performed.

**Practice Fusion workflow:** Within the encounter, mark "Transition of Care-incoming" under Quality of Care to indicate that this was a new patient or a patient that was transitioned into your care from another provider or another setting. Confirm that your patient’s medication list is up to date and select the Medication Reconciliation check-box.

**Dashboard tip:** While in this section of the chart note, select the Documentation of current medications check-box, which will give you credit for one of the Meaningful Use Clinical Quality measures.

**OBJECTIVE 8: TIMELY ELECTRONIC ACCESS FOR PATIENTS**

**Objective:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the provider. There are 2 measures for this objective:
• **Measure 1: Patient Electronic Access** - Provide more than 50% of all unique patients seen during the reporting period timely access to view online, download, and transmit to a third party their health information.

• **Measure 2: View, Download, Transmit** - At least 1 patient seen by the provider during the reporting period views, downloads or transmits his or her health information to a third party during the reporting period.

**Exclusion:** Any provider who doesn’t order or create any of the information listed for inclusion. For Measure 2: Conducts 50% or more of his or her patient encounters in a county that does not have 50% 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 reporting period.

**Alternate Exclusion for Modified Stage 2:** For measure 2, Stage 1/Modified Stage 2 providers can claim an exclusion to this measure in 2015 because there is no equivalent measure in Stage 1.

**MEASURE 1: PATIENT ELECTRONIC ACCESS**

**Denominator:** Number of unique patients seen during the reporting period.

**Numerator:** The number of patients in the denominator who have online access to their health information within four business days of the date of service.

**Practice Fusion Workflow:** Use the auto-invite feature to provide patients timely access to their Patient Portal. In order to effectively use the auto-invite feature for this measure, you must sign your chart notes within 4 business days of the chart note’s date of service.

You can also manually enroll your patients in the Patient Portal by clicking the Actions drop-down menu in the upper-right corner and select *Invite to patient portal*. Click “Add record access,” and enter the contact information of the patient or authorized representative. You can select the contact’s relationship to the patient from the drop down menu. Once completing the contact details section, click to “Enable access” for your patient.

**Dashboard tip:** Anyone in your practice who has authority to give patients access to the Patient Portal can do so and you will still achieve credit for this measure. An account administrator can change the patient engagement settings under the *Settings* section of the EHR. Patients between the ages of 18-85 will be automatically invited to the portal if the patient has a recorded email, phone number, and signed chart note.

**MEASURE 2: VIEW, DOWNLOAD, TRANSMIT**

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

**Practice Fusion workflow:** After you invite patients to the Patient Portal, encourage your patients to complete the enrollment as soon as they get home from the appointment using the PIN code that you give them during the visit or their phone number. Your patients must log into the Patient Portal at least once during the reporting period in order for you to get credit for this measure.

**OBJECTIVE 9: SECURE ELECTRONIC MESSAGING**

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

**Exclusion:** Any provider who has no office visits during the reporting period, or any provider 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 reporting period.

**Alternate Exclusion for Modified Stage 2:** Stage 1/Modified Stage 2 providers can claim an exclusion to this objective in 2015 because there is no equivalent measure in Stage 1.

**Practice Fusion workflow:** An administrator must enable secure messaging by clicking the *Messaging* Settings link next to the measure in the Meaningful Use Dashboard or clicking the *Settings* in the upper right-hand corner of your Practice Fusion account and selecting *Patient Communications*. Within the *Patient Communication Settings*, select the *Patient Messages* tab. To opt into patient messaging, check the "Enable secure messaging" box. Enabling or disabling patient messaging will update this setting for the entire practice. This setting must be enabled and stay enabled during the reporting period to receive credit for this objective on the Meaningful Use dashboard. Once messaging is enabled, every member of your practice can use the new feature.

After you enroll a patient in the PHR, the patient can complete enrollment using the unique PIN that you give to them and then utilize the Patient Fusion messaging feature to send a message to your practice.

**OBJECTIVE 10: PUBLIC HEALTH REPORTING**

**Objective:** this objective requires you be in active engagement with a public health agency to submit electronic public health data from Practice Fusion. The objective has three measures:

- **Measure 1: Immunization Registry Reporting** - The provider is in active engagement with a immunization registry to submit immunization data.

- **Measure 2: Syndromic Surveillance Reporting** - The provider is in active engagement with a public health agency to submit syndromic surveillance data.
• **Measure 3: Specialized Registry Reporting** - The provider is in active engagement to submit data to a specialized registry.

Stage 1/Modified Stage 2 providers will need to meet 1 of the 3 measures, and Stage 2 providers will need to meet 2 of the 3 measures.

**MEASURE 1: IMMUNIZATION REGISTRY REPORTING**

**Exclusion:** Any eligible provider meeting one or more of the following criteria may be excluded from the immunization registry reporting sub-measure if the eligible provider:

• Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period.
• Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period
• Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.

**Practice Fusion workflow:** Visit to your local immunization registry’s website and register your intent to submit immunization data within the first 60 days of your reporting period. If your registry does not have the capability to receive HL7 2.5.1 data electronically, you can qualify for an exclusion. In Practice Fusion, go to the Immunization registry section of your practice Settings and set up your account for electronic transmission.

**Learn how to set up electronic transmission to your registry >>**
This process will vary depending on the registry. Refer to the definition of "active engagement" below to determine if you have met the requirements for this measure based on the status of your integration. Your registry will be the contact for any confirmation about completion of this measure, so make sure to save documentation of all communication with your registry for your records. Once you are connected and you activate your integration in the Immunization registry section of your practice Settings, you can start submitting immunization files directly to your state registry on an individual patient basis. In order to do so, visit the Immunizations section of the patient’s chart, click on "Actions," and then select “Transmit to immunization registry.”

**MEASURE 2: SYNDROMIC SURVEILLANCE REPORTING**

**Exclusion:** Any eligible provider meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the provider:

• Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
• Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period;
• Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.
Alternate Exclusion for 2015:
Providers can claim an alternate exclusion for a measure if they did not intend to attest to the equivalent prior menu objective.

Practice Fusion workflow
Find your local public health department and email them to see if they can accept syndromic surveillance data in HL7 2.5.1 format. If they are unable to accept the data in this format, you may qualify for an exclusion.

If your public health department can accept syndromic surveillance data in HL7 2.5.1 format, confirm what their list of reportable diseases are and whether they accept ambulatory syndromic surveillance data. If you don’t collect any reportable syndromic surveillance information according to your public health department, you may qualify for an exclusion.

If you do collect reportable syndromic surveillance data and your public health department can accept the file in HL7 2.5.1 format, you must proceed to send them the file if you don’t qualify for any other exclusions to the measure.

In the EHR, under the Actions drop-down menu of a patient's chart note, select "Syndromic Surveillance." Export the file, save it to your computer, and submit the exported file to your local public health department following their specified reporting method. Continue to follow additional instructions for ongoing submission.

Make sure to keep documentation of your communication with your public health department.

MEASURE 3: SPECIALIZED REGISTRY REPORTING
Exclusion: Any eligible professional (EP) that meets at least 1 of the following criteria may be excluded from this objective:

• Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period.
• Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
• Operates in a jurisdiction where no specialized registry for which the EP, eligible hospital, or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

Alternate Exclusion for 2015:
Providers can claim an alternate exclusion for a measure if they did not intend to attest to the equivalent prior menu objective.

Workflow:
Practice Fusion does not support this measure, as becoming certified to this measure was not required as part of 2014 edition certification. Providers may use electronic submission methods beyond the functions of CEHRT to meet the requirements for the Specialized Registry Reporting measure.

Dashboard tip: You must manually indicate that you have completed this requirement in the Meaningful Use Dashboard. Be sure to maintain documentation of the exchange for your records, such as a copy of the email from the receiving party.