

Stage 2 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 have a selection: "I plan to attest for Meaningful Use" or "I'm not sure if I'll attest, but want to view my Meaningful Use progress."
- Set the correct provider, year, stage, program, and reporting period using the drop-down menus:

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 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 new 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.
- Changes to any of the drop-down menus are made in real time.
- Criteria completed outside of the EHR (e.g. information exchange, Security Risk Analysis) are not calculated by the dashboard. To note this on your dashboard, toggle the *Complete* button under the Current column to log that the measures are complete. Then, click "Apply" in the upper-right corner of the dashboard. 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 *Include* to *Exclude* under the *Report* column and select the reason for exclusion. Then, click "Apply" in the upper-right corner of the dashboard. 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 under the “Status” column to see which patients are missing required information for specific measures.
- 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 core and menu 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 you complete criteria that will achieve credit in the Dashboard. If applicable, the CMS-approved exclusion is listed.

Core Measures (you must report on all 17)

CORE 1: CPOE FOR MEDICATION ORDERS

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.

Exclusion: Any provider who writes fewer than 100 prescriptions during the EHR reporting period.

Practice Fusion Workflow: From the *Plan* tab of your SOAP note, click “Add Medication” and find your medication. Enter the details for the prescription, then click “Print Rx,” “Record Rx” or “Send e-Rx.”

New 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” or click the “v” to “Print Rx” or “Record Rx.”

CORE 1: CPOE FOR LAB ORDERS

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

Numerator: The number of lab tests in the denominator recorded using CPOE.

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

Practice Fusion workflow: Under the *Patient 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.

New 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.



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.

CORE 1C: CPOE FOR RADIOLOGY ORDERS

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.

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

Practice Fusion workflow: Under the Patient 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.

New 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.



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.

CORE 2: E-PRESCRIBING (PERMISSIBLE)

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.

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.

Practice Fusion Workflow: Click "Add Medication" from the *Plan* tab of a SOAP note or the "Add" button from the *Rx List*. Select a medication and select "Save and Prescribe." You will then be taken to another screen where you can enter the prescription details, select a pharmacy, and click "Send e-Rx."

New 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."

CORE 2: E-PRESCRIBING (PERMISSIBLE AND CONTROLLED SUBSTANCES)

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.

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.

New 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."

CORE 3: RECORD DEMOGRAPHICS

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

Numerator: Number of patients in the denominator who have the following demographics recorded in the *Basic* section: preferred language, sex, race, ethnicity, and date of birth.

Exclusion: None.

Practice Fusion workflow: Enter all patient demographics in the *Basic* section of the patient chart. You can choose multiple races if applicable to the patient.

New Practice Fusion Workflow: From the *Demographics* section of the patient's *Profile*, select an ethnicity, preferred language, and race.



Dashboard tip: Indicating that the patient declined to specify his or her race or ethnicity will count toward meeting the measure. The selection of "provider did not ask" will not satisfy the measure.

CORE 8A: VITAL SIGNS

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

Numerator: Number of patients in the denominator who have at least one entry of their height, weight and blood pressure (ages 3 and over) recorded as structured data in a note with a relevant encounter type selected.

Exclusion: Any provider who sees no patients 3 years or older is excluded from recording blood pressure. Any provider who believes that all 3 vital signs of height, weight, and blood pressure have no relevance to their practice is excluded from recording them.

Practice Fusion Workflow: Click “Start a chart note” from the patient chart, choose the relevant encounter type, and enter the required vital signs on the following screen. Blood pressure is not required for patients under the age of 3.

New Practice Fusion Workflow: From the *Summary* section of the patient’s chart, start a “New encounter”, select the appropriate encounter type, and enter the required vital signs. Blood pressure is not required for patients under the age of 3.



Dashboard tip: If you see the same patient multiple times during your EHR recording period, you do not need to record vital signs each time to meet the measure criteria.

CORE 8: VITAL SIGNS (HEIGHT/WEIGHT NOT IN SCOPE)

Denominator: Number of unique patients ages 3 and over seen during the reporting period.

Numerator: Number of patients in the denominator with at least one entry of blood pressure recorded as structured data in a note with a relevant encounter type selected.

Exclusion: Any provider who feels that recording height/weight is not part of their scope of practice should attest to the appropriate vital signs measure that excludes height/weight.

Practice Fusion Workflow: Click “Start a chart note” from the patient chart and enter the required vital signs on the following screen.

New Practice Fusion Workflow: From the *Summary* section of the patient’s chart, start a “New encounter”, select the appropriate encounter type, and enter the required vital signs.



Dashboard tip: If you see the same patient multiple times during your EHR recording period, you do not need to record vital signs each time to meet the measure criteria.

CORE 8: VITAL SIGNS (BLOOD PRESSURE NOT IN SCOPE)

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

Numerator: Number of patients in the denominator who have at least one entry of height and weight recorded as structured data in a note with an appropriate encounter type selected.

Exclusion: Any provider who feels that recording blood pressure is not part of their scope of practice should attest to the appropriate vital signs measure that excludes blood pressure.

Practice Fusion Workflow: Click “Start a chart note” from the patient chart and enter the required vital signs on the following screen.

New Practice Fusion Workflow: From the *Summary* section of the patient's chart, start a "New encounter", select the appropriate encounter type, and enter the required vital signs.



Dashboard tip: If you see the same patient multiple times during your EHR recording period, you do not need to record vital signs each time to meet the measure criteria.

CORE 5: SMOKING STATUS

Denominator: Number of unique patients 13 years or older on the day of service who are seen during the reporting period.

Numerator: Number of patients in the denominator who have a smoking status recorded in the *Lifestyle* section.

Exclusion: Providers who see no patients who are 13 years or older.

Practice Fusion workflow: From the *Lifestyle* section of a patient chart, click "New" and select the patient's current smoking status with an effective date. You can enter multiple statuses to reflect a change in smoking habits over time.

New Practice Fusion Workflow: From the patient's *Summary* section, click the icon to the right of *Smoking status* and select a current status, then "Done". Alternately, start a "New encounter" and click "Record" by *Smoking status* to select a current status.



Dashboard tip: A smoking status of 'Unknown if ever smoked' will still give you Dashboard credit as long as it is recorded.

CORE 6: CLINICAL DECISION SUPPORT

Measure: This measure requires that you implement clinical decision support (CDS) notifications in the EHR to improve health outcomes. There are two components to this measure:

- **Measure 1:** Implement five CDS interventions for the entire EHR reporting period.
- **Measure 2:** 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.

Practice Fusion workflow: Practice Fusion enables eight CDS rules by default, but you can configure CDS notifications under the *Settings* section of the EHR. 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 disable four or more CDS rules or all drug interaction alerts and subsequently start a chart note, 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.

CORE 7: TIMELY ELECTRONIC ACCESS FOR PATIENTS

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.

Exclusion: Any provider who doesn't order or create any of the information listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office, contact information."

Practice Fusion Workflow: Ensure all patients' email addresses are recorded in the EHR and enroll patients in the Patient Portal under the *Patient Actions* drop-down menu in their chart at their first visit.

New Practice Fusion Workflow: From the *Actions* drop-down of the patient's chart, click "enroll in PHR", "Add record access," and "Enable access."



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.

CORE 7: PATIENT VIEW, DOWNLOAD, OR TRANSMIT OF HEALTH INFORMATION

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

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

Exclusion: Any provider who neither orders nor creates any of the information listed for inclusion as part of the measure, except for "Patient name" and "Provider's name and office contact information. 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 EHR reporting period may exclude only the second measure.

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



Dashboard tip: You must meet the requirements for both Core 7 sub-measures in order to receive credit for Core 7 as a Stage 2 provider.

CORE 8: CLINICAL SUMMARIES

Denominator: Number of office visits during the EHR reporting period.

Numerator: Number of office visits in the denominator for which the patient is provided a clinical summary within one business day.

Exclusion: Any provider who has no office visits during the EHR reporting period.

Practice Fusion workflow: Give patients access to the Patient Portal under the Patient Actions drop-down menu in their chart or give the patient a printed copy of the clinical summary after each visit. Anyone in your office can create and print clinical summaries by selecting "Create Clinical Documents" from the Patient Actions dropdown menu of the patient chart. Leave all fields checked and then select "Generate." Once the clinical summary has been created, preview the document to ensure it contains the information you have selected and then select "Print." Alternatively, if you ensure the patient's email and phone number are recorded in the Basic section of the patient's chart and sign your note within 1 business day of the note's date of service, that patient will automatically receive an invitation to the Patient Portal.

New Practice Fusion Workflow: From the *Actions* drop-down of the patient's chart, click "enroll in PHR", "Add record access," and "Enable access." 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. Alternately, you can "Create clinical document" from the *Actions* drop-down, include all elements, create, and print the clinical summary with 1 business day of the date of service of the visit.



Dashboard tip: Once a patient is enrolled in the Patient Portal, you will automatically achieve credit for this measure at the conclusion of each office visit since the Patient Portal is updated with any new information that results from each encounter. If a patient declines to receive a printed clinical summary, you can indicate this by selecting the "Patient Declined Clinical Summary" checkbox in the *Quality of Care* section of the *Finalization* section of the SOAP note or new chart note. You will receive numerator credit for patients who decline the summary as long as you indicate this in their chart note prior to signing it.

CORE 9: 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.

CORE 10: CLINICAL LAB TEST RESULTS

Denominator: Total number of lab tests ordered during the reporting period whose results are expressed in a positive or negative affirmation or as a number.

Numerator: Number of lab tests from the denominator whose results are attribute to the appropriate patient, signed and incorporated into the EHR as structured data.

Exclusion: Any provider who orders no lab tests where results are either in a positive/negative affirmation or numeric format during the reporting period.

Practice Fusion workflow: Connect to a Practice Fusion lab that sends structured electronic lab results. All lab results that are structured will appear in the *Labs/Imaging* section of the patient chart. Within the lab result screen, attribute the result to the correct patient if necessary and ensure that the provider seeking credit for this measure signs the result. You can also manually “Enter lab results” from the *Patient Actions* drop-down. Select a lab and provider, begin typing to choose a test, enter observations and results, and sign the results.

New Practice Fusion Workflow: Connect to a Practice Fusion lab that sends structured electronic lab results. All lab results that are structured will appears in the *Tasks* section of the new EHR. Click on a lab result, click on the checkbox, and then “Sign selected result(s)” to sign the result. You can also manually “Enter lab results” from the *Actions* drop-down. Select a lab and provider, begin typing to choose a test, enter observations and results, and sign the results.



Dashboard tip: You can request a lab integration by clicking on “Connect Labs” in the *Labs/Imaging* or *Tasks* section.

CORE 11: PATIENT LISTS

Measure: This measure requires that you generate at least one patient list report for patients with a specific condition.

Practice Fusion workflow: Create a patient list by using the “New Patient Lists Interface” feature under the *Reports* section. You must include at least one diagnosis under the Problems category of your list query in order to meet the requirements of this measure.

New Practice Fusion Workflow: Create a patient list by using the “Patient Lists” feature under the *Reports* section. You must include at least one diagnoses under the Problems category of your list query in order to meet the requirements of this measure.



Dashboard tip: The provider qualifying for Meaningful Use must run this report under their own login in order to receive credit in the Dashboard.

CORE 12: SEND PATIENT REMINDERS

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

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

Exclusion: Any provider who has had no office visits in the 24 months before the EHR reporting period.

Practice Fusion workflow: Identify patients who have been seen twice in the 24 months preceding the reporting period using the Gap Report under the *Status* column in the Meaningful Use Dashboard and send a reminder for preventative or follow-up care. Reminders should be sent to patients using their preferred communication method and should meet the requirements of the HIPAA Privacy Rule and any other applicable federal, state or local regulations. Once the patient has been sent a reminder, click the "Patient reminder sent from button" in the *Appointments* tab of the patient's chart and select your name to receive credit for this measure. Make sure to track the reminders sent for your records.

New Practice Fusion Workflow: Identify patients who have been seen twice in the 24 months preceding the reporting period the Gap Report under the *Status* column in the Meaningful Use Dashboard and send a reminder for preventative or follow-up care. Reminders should be sent to patients using their preferred communication method and should meet the requirements of the HIPAA Privacy Rule and any other applicable federal, state or local regulations. Once the patient has been sent a reminder, click the "Record Patient Reminder" from the *Actions* drop-down of the patient's chart. On the next window, select the provider from whom the reminders was sent. Make sure to track the reminders sent for your records.



Dashboard tip: Anyone in your practice can record the patient reminder as long as you are selected as the provider from whom the reminder was sent.

CORE 13: PATIENT-SPECIFIC EDUCATION RESOURCES

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.

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

Practice Fusion workflow: Click on the *Patient Education* or *Medline Plus* button in any diagnosis, lab, or medication window and provide the resources to the patient. If you determine that the resources are not adequate and instead provide additional resources that did not originate in the EHR, select the "Patient Decision Aids / Education Materials Given" checkbox in the *Finalization* section of the SOAP note or new chart note.



Dashboard tip: Providers can share education materials with patients in any manner (i.e. printed or delivered verbally).

CORE 14: PERFORM MEDICATION RECONCILIATION

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.

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

Practice Fusion workflow: In the *Finalization* section of the SOAP note or new chart note, 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" checkbox.

New Practice Fusion Workflow: In the note, 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" checkbox.

CORE 15: TRANSITION OF CARE SUMMARY OF RECORD

There are three sub-measures you are required to meet for Core 15, all of which must be completed to meet the full requirements for this measure.

Measure 1: Transition of Care Summary of Record

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 was provided either directly to the patient (through a printed record), through the patient's PHR, or electronically to the provider to which you are referring the patient during the reporting period.

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.

Measure 2: Transition of Care Electronic Summary of Care Record

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 was electronically transmitted using Practice Fusion during the reporting period.

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.

Measure 3: Electronic Exchange of Summary of Care Record

Measure: Send at least one successful referral using Direct messaging that contains an attachment of a clinical document (clinical summary or referral summary) to a provider using a different ONC 2014 edition certified EHR or a [CMS designated test EHR](#). You must create at least one clinical document prior to sending the referral in order to attach it during the referral workflow

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.

Practice Fusion workflow:

The table below will help you understand the different Practice Fusion workflows that will help you meet the requirements of Core 15 measures.

Practice Fusion Summary of Care workflow	Achieves numerator credit for
<p>Invite the patient to the Patient Portal: Because the Patient Portal automatically updates after each patient visit, you can get credit for Measure 1 for all patients who are enrolled in the Patient Portal during the reporting period where they are also transitioned to another provider.</p>	<p>MEASURE 1</p>
<p>Printing a Summary of Care record: If you wish to print a summary of care record to give to your patient, create and print a clinical document from the <i>Patient Actions</i> or <i>Actions</i> dropdown of the patient chart. Anyone in your practice can create and print the clinical document and any type of clinical document will give you credit for this measure.</p>	<p>MEASURE 1</p>
<p>Send a digital (electronic) referral from within Practice Fusion using email: Send a digital referral to a verified Practice Fusion provider (either someone you previously exchanged messages with or someone who has completed identity verification within Practice Fusion) and make sure that the referral contains an attached clinical summary. Anyone in your practice can send the referral. Your trusted connection must open the referral (by clicking on the link in his/her email and logging into his/her Practice Fusion account) before you will get numerator credit for sub-measure #2.</p>	<p>MEASURE 1 MEASURE 2</p>
<p>Send a referral outside the Practice Fusion network using Direct messaging: Sending referrals to a colleague with a Direct address that contain a clinical document attachment (referral summary or clinical summary) achieves credit for all three sub-measures. To utilize Direct messaging for referrals, you must be provisioned a Direct address and include a valid Direct address in the information stored for your contacts to utilize this feature. Learn more about how to be provisioned a Direct account.</p>	<p>MEASURE 1 MEASURE 2 MEASURE 3</p>

CORE 16: IMMUNIZATION REGISTRY DATA SUBMISSION

Measure: This measure requires that you successfully submit electronic immunization data from the EHR to an immunization registry or immunization information system on an ongoing basis for the entire EHR reporting period.

Exclusion: Any provider that meets one or more of the following criteria may be excluded from this objective:

- The provider doesn't administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry during the reporting period;
- The provider operates in a jurisdiction for which no immunization registry is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period;
- The provider operates in a jurisdiction where no immunization registry provides information timely on capability to receive immunization data; and
- The provider operates in a jurisdiction for which no immunization registry that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional providers.

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 Settings* section and [set up your account for electronic transmission](#). Once you are connected and you activate your integration in the *Immunization 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."



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.

CORE 17: SECURE ELECTRONIC MESSAGING

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

Numerator: The number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the provider that is received using the electronic messaging function of Practice Fusion during the reporting period.

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.

Practice Fusion workflow: You must first enable secure messaging by clicking on *Settings* and selecting *Patient engagement settings*. 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. They then must utilize the Patient Fusion messaging feature to

send a message to your practice. One way to encourage patients to utilize this function is to ask them to send you a message after they complete the Patient Portal enrollment process so that you know they have successfully enrolled.

New Practice Fusion workflow: You must first enable secure messaging by clicking *Settings* and selecting *Patient engagement settings*. Click on the *Patient Messages* tab to enable secure patient messaging for your entire practice. 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. They then must utilize the Patient Fusion messaging feature to send a message to your practice. One way to encourage patients to utilize this function is to ask them to send you a message after they complete the Patient Portal enrollment process so that you know that have successfully enrolled.



Dashboard tip: This measure is based on all unique patients seen during the reporting period, not just patients who have been enrolled in the PHR.

Menu Measures (you must report on 3 of 6)

MENU 1: SYNDROMIC SURVEILLANCE DATA SUBMISSION

Measure: This measure requires that you successfully submit syndromic surveillance data to a public health agency throughout the reporting period on an ongoing basis.

Exclusion: Any provider who:

1. Isn't in a category of providers that collect ambulatory syndromic surveillance information on their patients during the reporting period;
2. 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 reporting period;
3. Operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or
4. Operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their reporting period can enroll additional providers.

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. 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. Under the *Charting Shortcuts* menu of a test patient's SOAP note, select "Syndromic Surveillance" and submit the exported file to your local public health department following their specified reporting method. Continue to follow additional instructions for ongoing submission.

New 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. 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. Under the *Actions* drop-down of a test patient's chart, select "Syndromic Surveillance" and submit the exported file to your local public health department following their specified reporting method. Continue to follow additional instructions for ongoing submission.



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 your public health department.

MENU 2: ELECTRONIC NOTES

Denominator: Number of unique patients with at least one office visit during the reporting period.

Numerator: The number of patients in the denominator who have at least one electronic progress note from a provider recorded as text searchable data.

Practice Fusion workflow: From the patient chart, select "Start a chart note" and choose "SOAP note." After entering information in the note for the visit, navigate to the *Finalization* section or new chart note, select an "office visit" encounter type, and sign the note.

New Practice Fusion workflow: From the patient chart, select "New encounter." After selecting an encounter type of "office visit," enter information in the note for the visit, and sign the note.

MENU 3: IMAGING RESULTS

Denominator: Number of tests whose result is one or more images ordered during the reporting period.

Numerator: The number of results in the denominator that are accessible through Practice Fusion.

Exclusion: Any provider who orders less than 100 tests whose result is an image during the reporting period or has no access to electronic imaging results at the start of the reporting period.

Practice Fusion workflow: First, connect with your imaging center to set up your EHR for results. Enter imaging orders by selecting "Add image order" from the *Patient Actions* drop-down menu. After you receive results, attribute them to the applicable patient and provider and sign the results. Images and imaging results that are scanned into Practice Fusion using the *Documents* section meet the numerator requirement for this measure, but you will need to manually calculate and keep track of those results if you choose to incorporate scanned imaging results into the EHR.

New Practice Fusion workflow: First, connect with your imaging center to set up your EHR for results from *Tasks*. Enter imaging orders by selecting "Add image order" from the *Actions* drop-down menu. After you receive results, attribute them to the applicable patient and provider and sign the results. Images and

imaging results that are scanned into Practice Fusion using the Documents section meet the numerator requirement for this measure, but you will need to manually calculate and keep track of those results if you choose to incorporate scanned imaging results into the EHR.



Dashboard tip: Make sure that you are attributing imaging results to the correct patients and to the provider that ordered the initial test in order to see accurate calculations in the Meaningful Use Dashboard. The provider seeking credit for this measure must sign the imaging results.

MENU 4: FAMILY HEALTH HISTORY

Denominator: Number of unique patients you see during the reporting period.

Numerator: The number of patients in the denominator with a structured data entry for one or more first-degree relatives.

Exclusion: Any provider who has no office visits during the reporting period.

Practice Fusion workflow: From the *Family Health History* section of the patient chart, add a new relative and diagnosis, or indicate that the family health history is unknown. Only records that contain first-degree relatives will count towards meaningful use credit.

New Practice Fusion workflow: From the patient's *Summary* section, click "Go to..." and select *Family History*. Add a new relative and diagnosis, or indicate that the family health history is unknown. Only records that contain first-degree relatives will count towards meaningful use credit.

MENU 5: REPORT CANCER CASES (NOT SUPPORTED)

Measure: This measure requires that you successful ongoing submission of cancer case information to a public health central cancer registry for the entire reporting period. See the [CMS specifications](#) for more information.

NOTE: Practice Fusion does not support this measure. Achieving this measure is not required to meet Meaningful Use.

MENU 6: REPORT SPECIFIC CASES (NOT SUPPORTED)

Measure: This measure requires that you successfully submit specific case information from the EHR to a specialized registry (other than a cancer registry) on an ongoing basis for the entire reporting period. See the [CMS specifications](#) for more information.

NOTE: Practice Fusion does not support this measure. Achieving this measure is not required to meet Meaningful Use.