

Stage 1 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 13)

CORE 1A: CPOE FOR MEDICATION ORDERS

Denominator: The number of unique patients seen during the EHR reporting period with at least one medication in their medication (*Rx*) list.

Numerator: The number of patients in the denominator with at least one prescription entered.

Exclusion: Providers who write 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 MEDICATION ORDERS (ALTERNATE MEASURE)

Denominator: The number of medications recorded or prescribed (including refills) during the EHR reporting period.

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

Exclusion: Providers who write 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 2: DRUG INTERACTION CHECKS

Measure: Implement drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Practice Fusion Workflow: Practice Fusion has all levels of drug-drug and drug-allergy alert notifications turned on by default. You can adjust your alert settings in the *Permissions* tab of the settings section, but you must leave severe alerts on or you will not get credit for this measure.

New Practice Fusion Workflow: Practice Fusion has all levels of drug-drug and drug-allergy alert notifications turned on by default. You can adjust your alert settings in the "Medication alerts" of the *Settings* section, but you must leave severe alerts on or you will not get credit for this measure.

CORE 3: MAINTAIN PROBLEM LIST

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

Numerator: Number of patients in the denominator who have at least one diagnosis recorded in the *Dx History* or have the "No Active Diagnosis" box checked.

Practice Fusion Workflow: From the *Assessment* tab of a SOAP note, click "Add Diagnosis" and search for a diagnosis. Click "Save" or "Save and Prescribe." You must enter a diagnosis start date to receive credit in the Dashboard.

New Practice Fusion Workflow: From the patient's *Summary* section, click the icon to the right of *Diagnoses* and search for a diagnosis by typing into the search bar. Alternately, start a *New encounter* and click "Record" by *Diagnoses* to search for a medication. After selecting the diagnosis and including a start date, click "Done." If a patient does not have an active diagnosis, select the "Patient has no active diagnoses" checkbox in the patient's *Summary* section or chart note.

CORE 4: 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 4: 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 5: ACTIVE MEDICATION LIST

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

Numerator: Number of patients in the denominator with at least one active medication entered in the medication (*Rx*) list or the "No Active Medications" box checked.

Practice Fusion Workflow: If you are prescribing, click "Add Medication" from the *Plan* tab of your SOAP note and search for a medication. If you are updating the patient's medication history, go their *Rx List* and click "Add." Find the medication and click "Save." You must enter a medication start date to receive credit in the Dashboard.

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 a start date, click "Done." If a patient does not have an active medication, select the "Patient has no active medications" checkbox in the patient's *Summary* section or chart note.

CORE 6: MEDICATION ALLERGY LIST

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

Numerator: Number of patients in the denominator with at least one drug allergy entered in the *Allergies* list or the “No Known Drug Allergies” box checked.

Practice Fusion Workflow: In the *Subjective* tab of a SOAP note, click on “Add Allergy” and search for a drug allergy. If a patient does not have a drug allergy, select the “No Known Drug Allergies” checkbox in the patient’s Allergy List.

New Practice Fusion Workflow: From the patient’s *Summary* section, click the icon to the right of *Allergies* and search for a drug medication by typing into the search bar. Alternately, start a “New encounter” and click “Record” by *Allergies* to search for a drug allergy. After selecting the drug allergy and including a severity, click “Done.” If a patient does not have a drug allergy, select the “Patient has no known drug allergies” checkbox in the patient’s *Summary* section or chart note.



Dashboard tip: Food and environmental allergies entered in the patient’s Allergy List do not satisfy the requirements of this measure.

CORE 7: 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.

Practice Fusion Workflow: Enter all patient demographics in the Basic section of their 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 8: 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 9: 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 smoking status recorded in the EHR.

Exclusion: Providers who see no patients 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 10: CLINICAL DECISION SUPPORT

Measure: Implement at least one clinical decision support (CDS) rule and have this functionality enabled for the entire 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 one CDS intervention enabled for the entire duration of your EHR reporting period.



Dashboard tip: If you or your practice administrator disable all CDS rules and subsequently start a chart note, the Dashboard will indicate that you have not met this measure and you will not be able to reactivate 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 without understanding the ramifications to your Meaningful Use status.

CORE 11: PATIENT ELECTRONIC ACCESS

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

Numerator: The number of patients in the denominator who are given online access to their health information within 4 business days of the most recent 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 12: 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 three business days.

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 3 business days 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 3 business days 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 *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 13: PROTECT ELECTRONIC HEALTH INFORMATION

Measure: Conduct or review a security risk analysis in accordance with the requirements under the HIPAA Security Rule [[45 CFR 164.308\(a\)\(1\)](#)] and implement security updates as necessary and correct identified security deficiencies as part of its 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, manually indicate this in your Meaningful Use Dashboard by checking the box next to this measure.

Menu Measures (you must report on 5 of 9)

MENU 1: DRUG FORMULARY CHECKS

Measure: Implement drug formulary checks and ensure that this functionality is enabled for your entire EHR reporting period.

Exclusion: Providers who write fewer than 100 prescriptions during the EHR reporting period.

Practice Fusion Workflow: Complete the steps required for the [e-prescribing verification process](#) within 24 hours of the start of your EHR reporting period to enable drug formulary and meet this measure.



Dashboard tip: In order to achieve this measure, your reporting period start date must be on or after the date you were enabled to e-prescribe.

MENU 2: 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: Providers who order no lab tests with results that are either in positive/negative or numeric format during the EHR 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 In the *Lab Orders* 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 appear 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.

MENU 3: PATIENT LISTS

Measure: Generate at least one report listing patients with a specific condition.

Practice Fusion Workflow: Create a patient list by using the "New Patient Lists Report" 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.

Practice Fusion Workflow: Create a patient list by using the "Patient Lists" 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.



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

MENU 4: SEND PATIENT REMINDERS

Denominator: Number of unique patients over 65 and under 5 at any point during the EHR reporting period with records maintained in Practice Fusion.

Numerator: Number of patients in the specified age range that are sent a reminder for preventative or follow-up care using their preferred communication method.

Exclusion: Providers who have no patients 65 years old or older or 5 years old or younger with records maintained in the EHR.

Practice Fusion Workflow: Identify patients in the age range 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 in the age range 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 "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.

MENU 5: 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.

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.

New 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).

MENU 6: 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: Providers who do not receive 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. You can also use this time to select the "Documentation of current medications" checkbox, which will give you credit for a Clinical Quality Measure.

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. You can also use this time to select the "Documentation of current medications" checkbox, which will give you credit for a Clinical Quality Measure.

MENU 7: TRANSITION OF CARE SUMMARY

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

Numerator: Number of transitions of care and referrals where a summary of care record was provided that includes, at minimum data for the patient's diagnoses, drug allergies, and medications.

Exclusion: Providers who neither transfer a patient to another setting nor refer a patient to another provider during the reporting period.

Practice Fusion Workflow: Send a referral that includes a chart note, clinical summary, or clinical document within 24 hours of the encounter date of service. Anyone on your staff can send the referral within this time frame and you will receive credit in the Dashboard

New Practice Fusion Workflow: Send a referral that includes a chart note, clinical summary, or clinical document from the *Actions* drop-down within 24 hours of the encounter date of service. Anyone on your staff can send the referral within this time frame and you will receive credit in the Dashboard



Dashboard tip: If the receiving provider is unknown, you can receive Dashboard credit by indicating the patient is being referred via a referral code in the *Screenings/Interventions/Assessments* section of the *Finalization* section of the SOAP note or new chart note by selecting the "Transition of Care - outgoing" checkbox under *Quality of Care* and creating and printing a referral summary clinical document for the patient. You can also receive credit by inviting the patient to the Patient Portal so they can access the referral summary information online.

Public Health Meaningful Use Menu Measures

The following two measures are public health measures. You must attest to at least one public health measure. If you are excluded from one, you must attest to the alternate measure. If you are excluded from both, you will claim an exclusion to only one of these measures during attestation. In that case, be prepared to prove that you were eligible for exclusions from both measures.

MENU 8: IMMUNIZATION REGISTRY DATA SUBMISSION

Measure: Perform at least one test submission of immunization data to your state immunization registry and continue follow up submission if the test is successful.

Exclusion: Providers who administer no immunizations during the EHR reporting period or where your state immunization registry doesn't have the ability to receive the information electronically.

Practice Fusion Workflow: [Contact your local immunization registry](#) and confirm their ability receive data in HL7 2.5.1 format. If your registry can receive the data electronically, register your intent to submit

immunization data. If your registry does not have the capability to receive the 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 submission for your records, such as a copy of the email that you sent and/or an email from the receiving party.

MENU 9: SYNDROMIC SURVEILLANCE DATA SUBMISSION

Measure: Perform at least one test submission of syndromic surveillance data to a public health agency and continue follow-up submission if the test is successful.

Exclusion: Providers who do not collect any reportable syndromic surveillance information on their patients during the EHR reporting period or where your local public health agency does not have the capacity to receive the information electronically.

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. If they can accept the file but you are not successful in transmitting the electronic data, you will still receive credit for this measure.

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. If they can

accept the file but you are not successful in transmitting the electronic data, you will still receive credit for this 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 that you sent and/or an email from the receiving party.