SEQUELMED EHR
STAGE 2 MEANINGFUL USE

REFERENCE DOCUMENT
## Table of Contents

**Stage 2 Meaningful Use in a Nutshell** ............................................................... 3  
**Process Flow** ........................................................................................................ 4  

### Meaningful Use Core Measures

- CPOE ...................................................................................................................... 5  
- e-Prescribing (eRx) ................................................................................................. 8  
- Record Demographics ........................................................................................... 10  
- Record Vital Signs ................................................................................................ 12  
- Record Smoking Status ......................................................................................... 15  
- Clinical Decision Support .................................................................................... 17  
- Provide patients the ability to view online, download and transmit ................... 22  
- Clinical Summaries ............................................................................................... 25  
- Protect Electronic Health Information ................................................................... 28  
- Clinical Lab Test Results ...................................................................................... 29  
- Patient Lists .......................................................................................................... 32  
- Patient Reminders ............................................................................................... 33  
- Patient-specific Education Resources ................................................................... 36  
- Medication Reconciliation .................................................................................. 40  
- Summary of care ................................................................................................... 44  
- Immunization Registries Data Submission ............................................................ 48  
- Secure Electronic Messages .................................................................................. 50  

### Meaningful Use Menu Measures

- Syndromic Surveillance Data Submission .............................................................. 52  
- Electronic Notes .................................................................................................... 53  
- Imaging Results ..................................................................................................... 54  
- Family Health History .......................................................................................... 57  

### Clinical Quality Measures (CQM)s

- Apply in Batch ...................................................................................................... 62  
- Apply in Patient Chart ........................................................................................... 63  
- QRDA I Report ...................................................................................................... 65  
- QRDA III Report ................................................................................................... 65
Stage 2 Meaningful use in a nutshell

Requirements for Stage 2 of Meaningful Use

For Stage 2, there are 2-primary requirements:

- Meaningful Use Measures
- Clinical Quality Measures

1. For eligible professionals, there are a total of 23 meaningful use objectives. To qualify for an incentive payment, 20 of these 23 objectives must be met.

   - There are 17 required core measures.
   - The remaining 3 measures may be chosen from the list of 4 menu measures.

2. To demonstrate meaningful use successfully, eligible professionals will need to report 9 Clinical Quality Measures (CQMs) from total of 64. CQMs may be reported electronically, or via attestation at CMS website.

DEFINITIONS

Objective: Defines the specifics of a particular measure.

Measure: These are the minimum requirements to achieve each an objective.

Exclusion: These are criteria that exempt an eligible professional from meeting a specific measure.

Attestation Requirements: These are required criteria to submit during attestation for each measure. For example, this could either be Yes/No or Denominator and Numerator/Exclusion.

Denominator: Total number of patients/items which qualify to be included for a measure.

Numerator: Number of patients/items in denominator which qualify for a specific measure.

Un-compliant patients: This is the number of patients who do not meet the criteria of a numerator.

SequelMed Workflow: This is a brief step-by-step explanation of how each measure can be achieved in SequelMed EHR.
PROCESS FLOW

Register with CMS
https://ehrincentives.cms.gov/hitech/login.action

Use EHR according to CMS guidelines

Generate Report using
SequelMed Batch → MU Report and PQRI

Report MU Data to CMS generated by
SequelMed via Batch → MU Report and PQRI
Eligible Professional MU Core Measures

1. **CPOE**

(Meaningful Use Core Measure 1 of 17)

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

**Measure:** More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.

**Exclusion:** Any EP who writes fewer than 100 medication, radiology, or laboratory orders during the EHR reporting period.

**Attestation Requirements:** Numerator & Denominator OR Exclusion.

[View CMS Online Reference...]

**Workflow in SequelMed:**

**CPOE for Medication Order**

For “Medication Order Entry”, user can select a patient from patient inquiry window and can go to “Medication Management” window. From medication management, user can enter medication and prescribe.

Screenshot 1-a: Medication Order Entry from Medication Management.
CPOE for Laboratory Order

For “Laboratory Order Entry”, user can select a patient from patient inquiry window and can go to “Lab Management” window. From lab management, user can enter laboratory order.

Screenshot 1-b: Laboratory Order Entry from Lab Management.

CPOE for Radiology Order

For “Radiology Order Entry”, user can select a patient from patient inquiry window and can go to “Lab Management” window. From lab management, user can enter radiology order.

Screenshot 1-c: Radiology Order Entry from Lab Management.
Meaningful Use Reports Review:

CPOE for Medication Order:

**Denominator:** Number of medications prescribed/ordered by the EP during the reporting period. (Past medications are not included)

**Numerator:** Number of medications prescribed/ordered by the EP during the reporting period using CPOE.

CPOE for Laboratory Order:

**Denominator:** Number of laboratory order created by the EP during the reporting period.

**Numerator:** Number of laboratory orders created by the EP during the reporting period using CPOE.

CPOE for Radiology Order:

**Denominator:** Number of radiology orders created by the EP during the reporting period.

**Numerator:** Number of radiology orders created by the EP during the reporting period using CPOE.
2. e-Prescribing (eRx)

(Meaningful Use Core Measure 2 of 17)

**Objective:** Generate and transmit permissible prescriptions electronically (eRx).

**Measure:** More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

**Exclusion:** Any EP who:
- Writes fewer than 100 permissible prescriptions during the EHR reporting period.
- Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

**Attestation Requirements:** Numerator & Denominator OR Exclusion

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**Workflow in SequelMed:**

User can select a patient from patient inquiry window and can go to “Medication Management” window. In the medication management window, user can click on “Patient Eligibility” to query the drugs for drug formulary. In order to get formulary information for a patient, user will need to get patient’s Rx eligibility.

In order to get Rx eligibility, click “Get Patient Eligibility” icon. Once the eligibility response comes back and patient is found eligible for Rx, formulary data is automatically populated which the user can review.

**Please Note:** This process of getting drug formulary is an automated process for patients whose appointments are scheduled within next 24 hrs. An automated process executes every night to get this formulary information. In order to manually get formulary information, user can click on “Get patient eligibility” icon to query for drug formularies.

**Screenshot 2-a: Patient eligibility**
Now, from “Medication Management” user can select the pharmacy from pharmacy dropdown, fill up the required fields for a prescription and then click on the eRx (ePrescription) icon. The drug will be sent electronically to the selected pharmacy.

Screenshot 2-b: Electronic Prescribing

**Meaningful Use Reports Review:**

**Denominator:** Number of medications prescribed/ordered (other than controlled substances) by the EP during the reporting period. Past medications are not included.

**Numerator:** The number of prescriptions in the denominator queried for a drug formulary and transmitted electronically.

**Un-compliant Patients:** Numbers of medications in the denominator which are not queried for drug formulary and are not sent electronically (eRx).
3. **Record Demographics**

(Meaningful Use Core Measure 3 of 17)

**Objective:** Record all of the following demographics:
(A) Preferred language  
(B) Sex  
(C) Race  
(D) Ethnicity  
(E) Date of birth

**Measure:** More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.

**Exclusion:** No exclusion

**Attestation Requirements:** Numerator & Denominator

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**Workflow in SequelMed:**

For recording patient demographics measure, make sure to enter the required information, including "Sex," "Date of Birth," "Race," "Ethnicity," and "Preferred Language," on patient registration window and save it. The dropdown choices contain all possible values that are required for data to be ONC compliant.

[Screen Shot 3-a: Recording Patient Demographics](#)
Meaningful Use Reports Review:

**Denominator:** Any patient who has a visit (office visit or EC visit) in the reporting period.

**Numerator:** Number of patients in denominator whose preferred language, ethnic group, race, DOB and sex are recorded in Patient Detail window.

**Un-compliant Patients:** Number of patients in denominator whose demographics are not recorded in Patient Detail window.
4. **Record Vital Signs**

(Meaningful Use Core Measure 4 of 17)

**Objective:** Record and chart changes in the following vital signs:
(A) Height
(B) Weight
(C) Blood pressure
(D) Calculate and display body mass index (BMI)
(E) Plot and display growth charts for children 0-20 years, including BMI

**Measure:** For more than 80 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over) and height and weight (for all ages) recorded as structured data.

**Exclusion:** Any EP who:
- Sees no patients 3 years or older is excluded from recording blood pressure.
- Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.
- Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.
- Believes that blood pressure is relevant to their scope of practice, but height and weight are not is excluded from recording height and weight.

**Attestation Requirements:** Numerator & Denominator OR Exclusion

[View CMS Online Reference...](#)

**Workflow in SequelMed:**

Vital Signs ("Height," "Weight," and "Blood Pressure") are recorded in "Vital Signs" section of the Clinical Visit’s (office visit) progress note.

**Screenshot 4-a: Vital Signs recording in Clinical Visit**

![Screenshot](image)

NOTE: Upon entering "Height" and "Weight", the system will automatically calculate the patient’s BMI. Vital Signs recorded in the clinical visit are automatically updated in “Patient Extra Information” at the time of visit sign-off.
Screenshot 4-b: “Height”, “Weight”, “Blood Pressure” values from Patient Extra Info window.

Meaningful Use Reports Review:

- **Vital Signs:**

  **Denominator:** Any patient who has a visit (Office visit or EC visit) in the reporting period.

  **Numerator:** Number of patients in denominator whose vitals which are Height, Weight, BP systolic, BP diastolic, and BMI are recorded in patient extra information window.

  **Un-compliant Patients:** Number of patients in denominator whose vitals which are Height, Weight, BP systolic, BP diastolic, and BMI are not recorded in patient extra information window.

- **Vital Signs, BP Out of Scope:**

  **Denominator:** Any patient who has a visit (Office visit or EC visit) in the reporting period.

  **Numerator:** Number of patients in denominator whose vitals which are Height, Weight and BMI are recorded in patient extra information window.

  **Un-compliant Patients:** Number of patients in denominator whose vitals which are Height, Weight and BMI are not recorded in patient extra information window.
• **Vital Signs, Height/Weight Out of Scope:**

**Denominator:** Any patient who has a visit (Office visit or EC visit) in the reporting period and age is greater than 3 yrs.

**Numerator:** Number of patients in denominator whose vitals which are BP systolic and BP diastolic are recorded in patient extra information window. (Patient age should be greater than 3 years)

**Un-compliant Patients:** Number of patients in denominator whose vitals which are BP systolic and BP diastolic are not recorded in patient extra information window.
5. Record Smoking Status

(Meaningful Use Core Measure 5 of 17)

Objective: Record smoking status for patients 13 years old or older.

Measure: More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Exclusion: Any EP who sees no patients 13 years or older.

Attestation Requirements: Numerator & Denominator OR Exclusion

View CMS Online Reference...

Workflow in SequelMed:

In SequelMed EHR, user can either record “Smoking Status” of a patient in “Patient Extra Information” or within “Social History” section of the Clinical Visit’s (office visit) progress note.

If recorded within “Social History” section, it will auto populate in the patient’s extra information after the clinical visit is signed off.

Dropdown choices contain all possible values for “Smoking Status” of a patient that is required to be ONC compliant.

Screenshot 5-a: Recording Smoking Status from “History” section in Clinical visit.
Screenshot 5-b: Smoking status from Patient Extra Info.

**Meaningful Use Report Review:**

**Denominator:** Any patient who has a visit (Office visit or EC visit) in the reporting period and their age is greater than 13 years.

**Numerator:** Number of patients in denominator whose smoking status is recorded in "Patient Extra Information".

**Incompliant Patients:** Number of patients in denominator whose smoking status is not recorded in "Patient Extra Information".
6. **Clinical Decision Support**

(Meaningful Use Core Measure 6 of 17)

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

**Measure:**
- **Measure 1:** Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

- **Measure 2:** The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

**Exclusion:** For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.

**Attestation Requirements:** Yes / No

[View CMS Online Reference...](#)

**Workflow in SequelMed:**

- **Measure 1:**
  In security application if button role (within menu role) assigned to a user has “Activate CDS” selected, that user will be able to see CDS Interventions. Further, if “View Therapeutic Reference Resource” and “View Attributes” is selected in the security application then that user will be able to see Attributes as well as Therapeutic reference resources.

  **Screenshot 6-a:** Activate CDS, Diagnostic & Therapeutic Reference Resource & View Attribute

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  User can create/update the CDS intervention/s in Design for the selected measure. For Example, in case of BMI Management CDS Intervention, any patient greater than the age of 18 with a BMI>40, should be referred to a bariatric specialist.

Here are the steps to create such an intervention:
1. Go to Design and click on CDS Intervention. Now click on “New” icon which will give you a blank CDS Intervention window.
2. In the “Name” field, give this CDS Intervention a name. For example: Vital Signs: BMI Management- as shown in the image below.
3. In the “HM Type” field, select “Clinical Reminder” from the dropdown menu.
4. In the “Reminder” field, type in the reminder that should come up when they system shows this message.
5. In the “Attribute” and “Diag & Therapeutic Ref” field, copy and paste the URL for reference. For BMI Management, the URL for Attribute reference is http://www.qualitymeasures.ahrq.gov/content.aspx?id=46832& and for Diagnostic and Therapeutic reference the URL is http://www.nlm.nih.gov/medlineplus/obesity.html.
6. Attributes can be found from National Quality Measures website via this URL: http://www.qualitymeasures.ahrq.gov
7. Diagnostic and Therapeutic reference resources can be found from Medline via this URL: http://www.nlm.nih.gov
8. In the “Age Group” window, type in the age range in the “From (Years)” and “To (Years)” column.
9. In the “Questions” window, click on the find icon and find the BMI question. Now, click on the operator dropdown menu and select the “>” (greater than) option and type in “40” in the Value column and save it.
When a user (who is allowed to see CDS Interventions from security application) selects a patient who falls under the criteria of a particular CDS Intervention, user will see the CDS Intervention automatically prompted by the system.

Screenshot 6-c: CDS Intervention Alert Window

User can review the attribute or therapeutic information by clicking on the icons on CDS Intervention Alert window as shown in the image above.

System will keep prompting CDS Intervention message unless the user clicks on the “Acknowledge” check box and then clicks on the "Accept" icon at the top left corner of the window. These acknowledged CDS interventions can later on be reviewed in the CDS History icon, in CDS window within patient chart.

- **Measure 2:**
  - Drug-Drug Interaction:

In “Medication Management“ window, while prescribing a drug, EMR automatically checks for “Drug-
Drug interaction".

Screenshot 6-d: Prescribing a drug from Medication Management window

For example, if the patient is already taking “Lasix 20mg tablet” as active medication and now provider selects “Amoxicillin 250mg capsule,” an alert will be generated by the system indicating an interaction. To view drug-interaction details and the severity level click on alert button as shown in the image below:

Screenshot 6-e: Drug-Drug Interaction Alert

For “Drug-Allergy Interaction”, go to “Medication Management” window, and add an allergen in Allergies window.
For example: If a patient is allergic to “Penicillin” and doctor tries to prescribe “Amoxicillin”, system will show an alert. Click on the alert icon to view the details as shown in the image below:

- Drug-Allergy Interaction:
Screenshot 6-f: Drug-Allergy Interaction Alert

Adjust Drug-Drug, Drug-Allergy Interaction Checks:
Under User Settings→Progress Note Settings→Clinical Tab→ User can adjust drug-drug and drug-allergy interaction notifications as shown in the image below:

Screenshot 6-g: Adjust Interaction Checks
7. **Provide patients the ability to view online, download and transmit their Health Record**

(Meaningful Use Core Measure 7 of 17)

**Objective:** Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.

**Measure:**
- **Measure 1:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information.
- **Measure 2:** More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.

**Exclusion:**
Any EP who:
- Neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office contact information," may exclude both measures.
- 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.

**Attestation Requirements:** Numerator & Denominator OR Exclusion

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**Workflow in SequelMed:**

There are two parts of this measure. For measure 1, Practice needs to provide ability to the patient to view online, download or transmit their health record. For this, EMR user can open up patient’s demographic page and click on the email hyperlink field, which opens up patient portal account setup window.

On patient portal account setup window, user can check the “Online Patient Health Record” box as shown in the image below and will increment the numerator in the report.
For measure 2, Patient can login to patient portal and can click on view, download, or transmit under the "Health Record" tab in order to view, download or transmit the health record as shown in the image below:

Meaningful Use Reports Review:

- **Measure 1:**

  **Denominator:** Any patient who has a visit (Office visit or EC visit) in the reporting period.

  **Numerator:** Number of patients in the denominator who has patient portal account created within 4 business days of clinical visit and "Online Patient Health Record" check box is checked.

  **Un-compliant Patients:** Number of patients in the denominator who has patient portal account created within 4 business days of clinical visit but "Online Patient Health Record" check box is not checked.
• **Measure 2:**

**Denominator:** Any patient who has a visit (Office visit or EC visit) in the reporting period.

**Numerator:** Any patient who logs in to the portal account and clicks on "View, Download or transmit" option under health record.

**Un-compliant Patients:** Any patient who has a visit in the reporting period but patient has not viewed or downloaded or transmitted their health record.
8. Clinical Summaries

(Meaningful Use Core Measure 8 of 17)

**Objective:** Provide clinical summaries for patients for each office visit.

**Measure:** Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.

**Exclusion:** Any EP who has no office visits during the EHR reporting period

**Attestation Requirements:** Numerator & Denominator OR Exclusion.

[View CMS Online Reference...](#)

**Workflow in SequelMed:**

After an office visit is signed off, user can open that signed off visit and select “clinical summary” from “Export Summary” dropdown on signed off visit or from the patient chart, print it and give it to the patient. This will auto-populate along with the date in visit extra info that clinical summaries were provided to patient.

[Screenshot 8-a: Clinical summary option from Signed off Visit.](#)
Screenshot 8-b: Clinical summary option from Patient Chart.

Screenshot 8-c: Clinical summaries in visit extra info.
Alternatively, in order to further automate the process, user can check the “Online Clinical Summaries” check box on patient portal account setup window, so that patients can instantly view their clinical summaries online via patient portal. This will auto populate that clinical summaries were provided in visit extra info on each visit as shown in the image below:

Screenshot 8-d: Clinical summary if the patient has account on patient portal.

Meaningful Use Reports Review:

**Denominator:** Number of visits (office visit or EC visit) for the patient in the reporting period.

**Numerator:** Number of visits (office visit or EC visit) in the reporting period for which clinical summaries “Provided to Patient” and the “appropriate Date” is selected in “Visit Extra Info” under the “Encounter Form” tab.

**Un-compliant Patients:** Number of visits (office visit or EC visit) in the reporting period for which clinical summaries “provided to patient” and the appropriate date is not selected.
9. Protect Electronic Health Information

(Meaningful Use Core Measure 9 of 17)

Objective: Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.

Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.

Exclusion: No exclusion.

Attestation Requirements: Yes / No

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Workflow in SequelMed:

NOTE: As per CMS, It is solely the responsibility of the providers to have a complete security risk analysis conducted. Conducting a security risk analysis is required when certified EHR technology is adopted in the first year. Each year or when changes to your practice or electronic systems occur, review and update the prior analysis for changes in risks. Under meaningful use, reviews are required for each EHR reporting period. For EPs, the EHR reporting period will be 90 days or a full calendar year, depending on the EP's year of participation in the program.

A security risk analysis is a systemic and ongoing process of both:
1. Identifying and examining potential threats and vulnerabilities to protected health information in your medical practice
2. Based on threats and vulnerabilities identified in step 1 above, Implementing changes to make patient health information more secure and then monitoring the results (i.e. risk management)

For ASP model (i.e. when Sequel is hosting), Sequel plays its own role of making sure that physical and technical safeguards were examined and found secure. Practices have to take their own security measures (For example, making sure that faxes are authenticated, patient information is not stored locally, while exporting patient chart it should be encrypted, after scanning patient information it should be promptly shredded etc.) and make sure that all security measures and components are in place.

For Client Server model (i.e. when Client is hosting), practices have to make sure that their physical, administrative and technical safeguards were examined and found secure including but not limited to windows service pack updates, antivirus periodic scans and updates, server log analysis to ensure security, review of policy and procedures to ensure consistency and effectiveness etc. These measures along with the practice measure points discussed above are all monitored on a regular basis and applied as per requirement to ensure maximum stability and security.
10. Clinical Lab Test Results

(Meaningful Use Core Measure 10 of 17)

Objective: Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data.

Measure: More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.

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

Attestation Requirements: Numerator & Denominator OR Exclusion

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Workflow in SequelMed:

In SequelMed EHR, lab results can be incorporated manually or automatically as structured data.

In order to incorporate lab test results as structured data manually, select the lab order and click enter results (if lab order is not present, you can order a lab first).

If you have electronic result interface with a lab, system automatically pulls those results and incorporates them as structured data in EHR. If there is any unsolicited result, system automatically creates a lab test order and then incorporates those results as structured data.

Screenshot 10-a: Manual Lab Result Entry
In case of interface the results will appear in a structured data format as shown in the image below:

Screenshot 10-b: Structured Lab Results in Pending Dr. Review

Results will be available on dashboard when entered manually or received electronically via result interface.

Screenshot 10-c: Structured Lab Results on dashboard
Meaningful Use Reports Review:

**Denominator:** Number of lab tests ordered during the EHR reporting period.

**Numerator:** Number of lab tests ordered in the denominator which has result value in the lab result value field.

**Un-compliant Patients:** Number of lab tests which have no lab result value in result value field.
11. **Patient Lists**

(Meaningful Use Core Measure 11 of 17)

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

**Measure:** Generate at least one report listing patients of the EP with a specific condition.

**Exclusion:** No exclusion

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**Attestation Requirements:** Yes / No

**Workflow in SequelMed:**

In SequelMed EHR, user can generate patient list based upon a specific condition. In order to generate such patient list user can go to batch→“Patient List”. Now specify condition (diagnosis) and then click “Find” to generate list of patients based on the criteria that was entered.

This list can made more specific by entering additional find criteria like ethnicity, race, age, gender etc.

Screenshot 11-a: Clinical Data Report
12. **Patient Reminders**

(Meaningful Use Core Measure 12 of 17)

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

**Measure:** More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.

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

**Attestation Requirements:** Numerator & Denominator OR Exclusion

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**Workflow in SequelMed:**

SequelMed EHR can prompt the reminders to the user to be sent to the patients. In order for patient reminders to work, preferred communication must be recorded in patient’s record and a CDS Intervention should be linked to the patient.

This measure’s workflow has two steps:

Step 1 - Patient’s “Preferred Communication” method should be recorded in patient demographics as shown in the image below:

Screenshot 12-a: Preferred Communication
Step 2 – Now, link “CDS Intervention” to the patient either via clinical visit (Office visit) or from the health maintenance window in patient chart.

(For example – Colonoscopy every 5 years)

Screenshot 12-b: Add CDS Intervention

To see patient reminders user can go to Batch→ “CDS Intervention/Reminders”, select a date range and run a report. The system will give you a list of patients who are due for any intervention during the selected time period.

User can now select an intervention/reminder and click on communication reminder icon. Based upon the appropriate preferred communication method, record in patient’s record, EHR will either create a new message (for phone, text or portal). In case of Letter, click on “Patient Letter” icon, select the appropriate letter and print it.
In case of portal, “Patient View” box would be checked by default which means that once this message is saved it would be available to the patient on patient portal.

Meaningful Use Report Review:-

**Denominator:** Number of patients who have 2 or more visits (Office visit or EC visit) 24 months prior to the start of reporting period.

**Numerator:** Number of patients in the denominator with a reminder communicated.

**Un-compliant Patients:** Number of patients in the denominator with no patient reminder communicated.
13. **Patient-specific Education Resources**

(Meansful Use Core Measure 13 of 17)

**Objective:** Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.

**Measure:** Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.

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

**Attestation Requirements:** Numerator & Denominator OR Exclusion.

[View CMS Online Reference...](#)

**Workflow in SequelMed:**

During a clinical visit (Office visit), in the “Plan” section, user can select related health education that pertains to the patient’s problem, print it and hand it over to the patient. Anytime patient health education is added to the clinical visit will automatically increment the numerator.

**Screenshot 13-a: Patient-Specific Education Resources**
User can also select/highlight the problem in the problem list window in patient chart, click on “Patient Education” or “Online Patient Education”, print it and give it to the patient. In this case, printing will increment the numerator in the report.

Screenshot 13-c: Online Health Education for Problem List:
Similarly, User can also select/highlight the medication in the Current Medication window in patient chart, click on “Patient Education” icon or “Online Patient Education” icon, print it and give it to the patient. In this case, printing will increment the numerator in the report.

Screenshot 13-d: Online Health Education for Medication:

Similarly, User can also select/highlight the lab test in the Lab Management, click on “Patient Education” icon or “Online Health Education” icon, print it and give it to the patient. In this case, printing will increment the numerator in the report.
Meaningful Use Report Review:

Denominator: Any patient who has a visit (Office visit or EC visit) during the reporting period.

Numerator: Any patient who has a visit (Office visit or EC visit) during the reporting period and had a Health Education document attached to the visit in the “Plan” section under “Health Education” OR

Health education has been printed and provided to patient for problem or medication or lab tests through patient education or online patient education icon.

Un-compliant Patients: Any patient who has a visit (Office visit or EC visit) during the reporting period, but does not have a Health Education document attached to their visit OR

Health education has not been provided to patient for problem or medication or lab test through patient education or online patient education icon.
14. Medication Reconciliation

(Meaningful Use Core Measure 14 of 17)

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

Measure: The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

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

Attestation Requirements: Numerator & Denominator OR Exclusion

View CMS Online Reference...

Workflow in SequelMed:

There are two ways to do medication reconciliation in SequelMed EHR. By importing a medication list through CCD or manually doing medication reconciliation and checking medication reconciliation check box in progress note→plan→medication.

When a patient transitions from one healthcare setting to another, medication reconciliation must be performed. For a patient who was sent to the provider using SequelMed EHR, User can select the referring provider in the “Referring provider” dropdown or can check the “Transfer of Care(In)” box in visit extra info window during an office visit as shown in the images below.

Screenshot 14-a:
For “Medication Reconciliation,” user can reconcile medications by comparing medication information provided by the patient to the provider. User can import the electronic CCD in patient chart by clicking on “Import” option as shown in the image below:

Screenshot 14-b:

After importing the file user can click on “Reconcile” icon as shown in the image below. This opens up the Reconcile CCD window where user can reconcile the medications. System lists medications present in current medication list in HER as well as medications in CCD and show them. On a single window, user can then accept or remove medications from HER and/or CCD which strikes out the medication indicating that it will be removed, select the visit date and then click save. This will auto-populate “Yes” for Medication Reconciliation under “Visit Extra Info”.

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If user has manually reconciled the list of medications for the patient, then user can check off the med reconciliation check box in the plan section which auto-populates “yes” from “Med Reconciliation” in “Visit Extra Info” tab as shown in the images below:

Screenshot 14-d: Recording Medication Reconciliation in the plan section
Screenshot 14-e: "Medication Reconciliation" from "Visit Extra Info" window

**Meaningful Use Report Review:-**

**Denominator:** Any patient who has a visit (office visit or EC visit) during the reporting period and “Transfer of Care (In)” or referring provider has been selected in the visit extra info.

**Numerator:** Any patient who has a visit (office visit or EC visit) during the reporting period where “Yes” is selected from the "Med Reconciliation“ dropdown under "Visit Extra Info".

**Un-compliant Patients:** Any patient who has a visit (office visit or EC visit) during the reporting period and “Transfer of Care (In)” or referring provider has been selected in the visit extra info but “Yes” is not selected from the "Med Reconciliation“ dropdown under "Visit Extra Info".
15. **Summary of care**

*(Meaningful Use Core Measure 15 of 17)*

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

**Measure:** EPs must satisfy both of the following measures in order to meet the objective:

**Measure 1:**
- The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.

**Measure 2:**
- The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.

**Measure 3:**
An EP must satisfy one of the following criteria:
- Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2).

OR

- Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

**Exclusion:** Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

**Attestation Requirements:** Numerator & Denominator OR Exclusion

[View CMS Online Reference...](#)

**Workflow in SequelMed:**

This measure has three parts. User can either check the “Transfer of Care (OUT)” box in “Visit Extra Info” or link the “referring provider” to the clinical visit (Office visit) under plan section for a visit to be counted in the
For measure 1 (first part), once the clinical visit is signed off, user can click on “Export Summary” dropdown and select “Summary of Care” option. This will open up the summary of care record.
window, where user has the option to print, download or email. Either one of these options will auto-populate Summary of Care “Provided to Patient” in Visit extra information.

Screenshot 15-c: Exporting summary of care record from signed-off patient visit

For measure 2 (second part), users can click on send email check box, enter the secure email address and then click on “send email” icon as shown in the image below:

Screenshot 15-d: Send Email

For measure 3 (third part), users can either click on “Download” icon or “Send Email” icon on “Summary of Care” window as shown in the image above. Whether downloaded or emailed, this file can then be used to perform a test by electronically exchanging with a recipient who has an EHR technology that was developed by a different EHR technology developer or with a CMS designated test EHR.
Screenshot 15-e: Summary of Care record in Visit Extra Info

Meaningful Use Report Review:

- **Measure 1:**
  
  **Denominator:** Any patient who has a visit (Office visit or EC visit) during the reporting period and “Transfer of Care (out)” or referring provider has been selected in “Patient Referral” section in clinical visit plan section.

  **Numerator:** Any patient who has a visit (Office visit or EC visit) during the reporting period where Summary of Care “Provided on transition” is selected under “Visit Extra Info”.

  **Un-compliant Patients:** Any patient who falls in the denominator criteria but Summary of Care “Provided on transition” is not selected under “Visit Extra Info”.

- **Measure 2:**
  
  **Denominator:** Any patient who has a visit (Office visit or EC visit) during the reporting period and “Transfer of Care (out)” or referring provider has been selected in “Patient Referral” section in clinical visit plan section.

  **Numerator:** Number of patients in denominator for whom Summary of Care was emailed.

  **Un-compliant Patients:** Number of patients in denominator for whom Summary of Care was not emailed.
16. Immunization Registries Data Submission

(Meaningful Use Core Measure 16 of 17)

**Objective:** Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

**Measure:** Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.

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

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

**Attestation Requirements:** Yes / No / Exclusion

[View CMS Online Reference...]

**Workflow in SequelMed:**

In SequelMed EHR, you can create electronic data to be submitted to immunization registries. In order to create this data you must have entered immunizations on patients in EHR. For this measure, please order an immunization on a patient which can be done from patient chart or during clinical visit (office visit) in plan section.

[Screenshot 16-a: Record / Apply Immunization]
Now, in order to submit the file to immunization registry, go to “Batch” → “Immunization” and click “Find“. Select the required immunization(s), click on "Immunization Output" drop down, and click on “HL7” (available on the main toolbar). This will save the file locally on your desktop, which can then be uploaded to your state’s immunization registry web portal.

Screenshot 16-b: HL7 generation.
17. **Secure Electronic Messages**

(Meaningful Use Core Measure 17 of 17)

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

**Measure:** A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

**Exclusion:** Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

**Attestation Requirements:** Denominator & Numerator OR Exclusion

[View CMS Online Reference...](#)

**Workflow in SequelMed:**

Patient should login to patient portal, click new message on left navigation bar, select the provider to whom the message needs to be sent to, type the message and click send message.

**Screenshot 17-a:** New message from patient portal
Meaningful Use Report Review:

**Denominator:** Any patient who has a visit (office visit or EC visit) during the reporting period.

**Numerator:** Any patient who has account on patient portal and sends the secure electronic message to the provider from patient portal.

**Un-compliant Patients:** Any patient who has a visit during the reporting period and secure message has not been sent to provider from patient portal.
Meaningful Use Menu Set Measures

1. Syndromic Surveillance Data Submission

(Meaningful Use Menu Measure 1 of 4)

Objective: Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.

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

- The EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period;
- The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period;
- The EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or
- The EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

View CMS Online Reference...

Workflow in SequelMed:

In order to report syndromic surveillance data to public health agencies, users can click “Export Surveillance” icon on a signed off progress note. Once this is clicked, EHR prompts the user to save surveillance file. Select appropriate path to save this file. Once the file is saved, it can then be uploaded on the state public health agency web portal.

Screenshot- 1 a: Export Surveillance
2. **Electronic Notes**

(Meaningful Use Menu Measure 2 of 4)

**Objective:** Record electronic notes in patient records.

**Measure:** Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.

**Exclusion:** No exclusion.

**Attestation Requirements:** Denominator & Numerator

[View CMS Online Reference...]

**Workflow in SequelMed:**

Create a clinical visit (office visit) during the reporting period. This clinical visit will be counted as an electronic note for this measure.

**Screenshot 2-a: Office Visit**

![Office Visit Screenshot]

**Meaningful Use Report Review:**

**Denominator:** Any patient who has a clinical visit (office or encounter visit) during the reporting period.

**Numerator:** Any patient who has clinical visit (office visit) during the reporting period.

**Un-compliant Patients:** Any patient who has an encounter visit during the reporting period.
3. **Imaging Results**

*(Meaningful Use Menu Measure 3 of 4)*

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

**Measure:** More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.

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

**Attestation Requirements:** Denominator & Numerator OR Exclusion

*View CMS Online Reference...*

**Workflow in SequelMed:**

Order a radiology type test for the patient. Only radiology type tests will be counted towards this measure.

**Screenshot 3-a: Radiology Order Entry from Lab Management.**

Now in order to incorporate radiology test results manually, select the radiology order and click enter results (if lab order is not present, you can order a lab first). Now click on the document tab and either attach a document or import an image to the radiology result. This will increment the numerator for this measure.
Screenshot 3-b: Entering result from documents tab in result window.

Meaningful Use Report Review:

**Denominator:** Number of radiology tests ordered by EP during the reporting period.

**Numerator:** Number of radiology tests ordered by EP during the reporting with which result document has been attached.

**Un-compliant Patients:** Number of radiology tests ordered by EP with which result document has not been attached.
4. **Family Health History**

*(Meaningful Use Menu Measure 4 of 4)*

**Objective:** Record patient family health history as structured data.

**Measure:** More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.

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

**Attestation Requirements:** Denominator & Numerator OR Exclusion

   View CMS Online Reference...

**Workflow in SequelMed:**

Select a patient and open up a clinical visit (office visit). In the visit, user can go to History section and can record family history for one or more first-degree relatives.

Screenshot 4-a: Family history

Meaningful Use Report Review:

**Denominator:** Any patient who has visit (Office visit or EC visit) in the reporting period.

**Numerator:** Any patient who has visit (Office visit) in the reporting period and family history has been recorded for one or more first-degree relatives in the history section of clinical visit and the visit should be signed off.

**Un-compliant Patients:** Any patient who has visit (Office visit or EC visit) in the reporting period and family history has not been recorded for one or more first-degree relatives in the history section of clinical visit.
Clinical Quality Measures (CQMs)

Clinical quality measures, or CQMs, are tools that help measure and track the quality of health care services provided by eligible professionals (EPs). These measures use data associated with provider’s ability to deliver high-quality care or relate to long term goals for quality health care.

In 2014, all providers will be required to report on 9 measures.

There is also a new requirement in 2014 that the quality measures selected must cover at least 3 of the 6 available National Quality Strategy (NQS) domains which are:

1. Efficient Use of Healthcare Resources
2. Clinical Process/Effectiveness
3. Patient Safety
4. Population/Public Health
5. Patient and Family Engagement
6. Care Coordination

For 2014, CMS has identified two recommended core sets—one for adults and one for children (each one has nine individual measures)—that focus on high-priority health conditions and best-practices for care delivery.

With respect to SequelMed EHR, there are two kinds of CQM’s. For one, there needs to be questions added to a template which a physician can answer and other, for which no questions are needed and system automatically detects appropriate condition. Both of these are explained below:

In SequelMed EHR, for certain CQMs like “BMI management” (CMS 138 or NQF 0028), there will be questions added to a provider’s template which will not only document the action (by checking off the question check box) but would also record and calculate for reporting purpose.

For others like “Use of High Risk Medication in the Elderly” (CMS 156v1 or NQF 0022), if age of patient is greater than 66 and a high risk medication is prescribed, system will automatically record and calculate for reporting purpose. In such cases, there will be no questions added to the template.

In order to generate a PQRI/CQM report, go to Batch→PQRI, select the provider and date range and click find. Now click on “Apply PQRI icon” and apply PQRI for the selected provider. Now click on Report icon, select the date range, generate QRDA III report and submit for attestation.

Here is a list of 64 available CQM’s sorted based on 6-NQS domains:

<table>
<thead>
<tr>
<th>NQF ID</th>
<th>CMS ID</th>
<th>Type</th>
<th>Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFFICIENT USE OF HEALTHCARE RESOURCES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0002</td>
<td>CMS146v1</td>
<td>Pediatric Core</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
</tr>
<tr>
<td>0052</td>
<td>CMS166v1</td>
<td>Adult Core</td>
<td>Use of Imaging Studies for Low Back Pain</td>
</tr>
<tr>
<td>0069</td>
<td>CMS154v1</td>
<td>Pediatric Core</td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
</tr>
<tr>
<td>0389</td>
<td>CMS129v1</td>
<td>Alternate</td>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
</tr>
</tbody>
</table>

CONFIDENTIAL
<table>
<thead>
<tr>
<th>NQF ID</th>
<th>CMS ID</th>
<th>Type</th>
<th>Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>0004</td>
<td>CMS137v1</td>
<td>Alternate</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
</tr>
<tr>
<td>0018</td>
<td>CMS165v1</td>
<td>Adult Core</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>0031</td>
<td>CMS125v1</td>
<td>Alternate</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>0032</td>
<td>CMS124v1</td>
<td>Alternate</td>
<td>Cervical Cancer Screening</td>
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<td>0034</td>
<td>CMS130v1</td>
<td>Alternate</td>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td>0036</td>
<td>CMS126v1</td>
<td>Pediatric Core</td>
<td>Use of Appropriate Medications for Asthma</td>
</tr>
<tr>
<td>0043</td>
<td>CMS127v1</td>
<td>Alternate</td>
<td>Pneumonia Vaccination Status for Older Adults</td>
</tr>
<tr>
<td>0055</td>
<td>CMS131v1</td>
<td>Alternate</td>
<td>Diabetes: Eye Exam</td>
</tr>
<tr>
<td>0056</td>
<td>CMS123v1</td>
<td>Alternate</td>
<td>Diabetes: Foot Exam</td>
</tr>
<tr>
<td>0059</td>
<td>CMS122v1</td>
<td>Alternate</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
</tr>
<tr>
<td>0060</td>
<td>CMS148v1</td>
<td>Alternate</td>
<td>Hemoglobin A1c Test for Pediatric Patients</td>
</tr>
<tr>
<td>0062</td>
<td>CMS134v1</td>
<td>Alternate</td>
<td>Diabetes: Urine Protein Screening</td>
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<tr>
<td>0064</td>
<td>CMS163v1</td>
<td>Alternate</td>
<td>Diabetes: Low Density Lipoprotein (LDL) Management</td>
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<tr>
<td>0068</td>
<td>CMS164v1</td>
<td>Alternate</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
</tr>
<tr>
<td>0070</td>
<td>CMS145v1</td>
<td>Alternate</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy–Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF &lt;40%)</td>
</tr>
<tr>
<td>0075</td>
<td>CMS182v1</td>
<td>Alternate</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control</td>
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<tr>
<td>0081</td>
<td>CMS135v1</td>
<td>Alternate</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
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<tr>
<td>0083</td>
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<td>Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
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<td>0086</td>
<td>CMS143v1</td>
<td>Alternate</td>
<td>Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</td>
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<tr>
<td>0088</td>
<td>CMS167v1</td>
<td>Alternate</td>
<td>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</td>
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<td>CMS142v1</td>
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<td>Measure Title</td>
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<td>CMS161v1</td>
<td>Alternate</td>
<td>Major Depressive Disorder (MDD): Suicide Risk Assessment</td>
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<td>0105</td>
<td>CMS128v1</td>
<td>Alternate</td>
<td>Anti-depressant Medication Management</td>
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<td>0108</td>
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<td>ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</td>
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<td>Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use</td>
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<td>Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients</td>
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<td>0387</td>
<td>CMS140v1</td>
<td>Alternate</td>
<td>Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer</td>
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<td>HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis</td>
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<td>CMS77v1</td>
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<td>HIV/AIDS: RNA control for Patients with HIV</td>
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<td>Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</td>
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<td>0608</td>
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<td>Pregnant women that had HBsAg testing</td>
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<td>CMS159v1</td>
<td>Alternate</td>
<td>Depression Remission at Twelve Months</td>
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<td>CMS75v1</td>
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<td>Children who have dental decay or cavities</td>
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<td>Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists</td>
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<td>Dementia: Cognitive Assessment</td>
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<td>Hypertension: Improvement in blood pressure</td>
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<td>Alternate</td>
<td>Falls: Screening for Future Fall Risk</td>
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<td>Adult Core</td>
<td>Documentation of Current Medications in the Medical Record</td>
</tr>
<tr>
<td>0564</td>
<td>CMS132v1</td>
<td>Alternate</td>
<td>Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures</td>
</tr>
<tr>
<td>1365</td>
<td>CMS177v1</td>
<td>Alternate</td>
<td>Child and Adolescent Major Depressive</td>
</tr>
<tr>
<td>TBD</td>
<td>CMS179v1</td>
<td>Alternate</td>
<td>ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>POPULATION/PUBLIC HEALTH</strong></td>
</tr>
<tr>
<td>0024</td>
<td>CMS155v1</td>
<td>Pediatric Core</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
</tr>
<tr>
<td>0028</td>
<td>CMS138v1</td>
<td>Adult Core</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td>0033</td>
<td>CMS153v1</td>
<td>Pediatric Core</td>
<td>Chlamydia Screening for Women</td>
</tr>
<tr>
<td>0038</td>
<td>CMS117v1</td>
<td>Pediatric Core</td>
<td>Childhood Immunization Status</td>
</tr>
<tr>
<td>0041</td>
<td>CMS147v1</td>
<td>Alternate</td>
<td>Preventative Care and Screening: Influenza Immunization</td>
</tr>
<tr>
<td>0418</td>
<td>CMS2v1</td>
<td>Adult Core</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
<tr>
<td>0421</td>
<td>CMS69v1</td>
<td>Adult Core</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
</tr>
<tr>
<td>1401</td>
<td>CMS82v1</td>
<td>Alternate</td>
<td>Maternal depression screening</td>
</tr>
<tr>
<td>TBD</td>
<td>CMS22v1</td>
<td>Alternate</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>PATIENT AND FAMILY ENGAGEMENT</strong></td>
</tr>
<tr>
<td>0384</td>
<td>CMS157v1</td>
<td>Alternate</td>
<td>Oncology: Medical and Radiation – Pain Intensity Quantified</td>
</tr>
<tr>
<td>TBD</td>
<td>CMS66v1</td>
<td>Alternate</td>
<td>Functional status assessment for knee replacement</td>
</tr>
<tr>
<td>TBD</td>
<td>CMS56v1</td>
<td>Alternate</td>
<td>Functional status assessment for hip replacement</td>
</tr>
<tr>
<td>TBD</td>
<td>CMS90v1</td>
<td>Adult Core</td>
<td>Functional status assessment for complex chronic conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>CARE COORDINATION</strong></td>
</tr>
<tr>
<td>TBD</td>
<td>CMS50v1</td>
<td>Adult Core</td>
<td>Closing the referral loop: receipt of specialist report</td>
</tr>
</tbody>
</table>
The SequelMed EHR PQRI module facilitates two ways to apply PQRI.

1. **Apply in Batch** - The user may apply and calculate their PQRI measures through a manual batch process.

   A) Go to Batch → PQRI. Now run the report for a specific provider and date range.
   
   B) Click ‘APPLY PQRI’ to initiate batch processing. The ‘Apply PQRI Batch’ window will open.
   
   C) Select the user in the drop-down menu and click on ‘CALCULATE & APPLY PQRI’.
   
   D) System will calculate and apply PQRI to all instances fulfilling following conditions:

   a. *All instances of selected user for which PQRI has not been applied*
   
   b. *All instances of selected User for having Meets Performance status:*

   i. ‘Pending Review’
   
   ii. ‘Not Qualified’.
   
   E) Click to close ‘APPLY BATCH PQRI’ window.
2. **Apply in Patient Chart** - The user may manually apply and calculate PQRI specific to a patient.

   a) Select a patient and click on 📌 PQRI option. This will open a PQRI search window. *All PQRIs which have been previously applied to this patient will show here.*

   b) Click 🗃 ‘APPLY PQRI’ at the top of your screen. An ‘Apply PQRI’ window will open showing all-related clinical quality measures with one of the following ‘Meets Performance’ statuses:

      a. Yes
      b. Not Qualified
      c. Pending for Review
      d. Denominator Exclusion
      e. Denominator Exception
      f. No
SequelMed EHR automatically calculates by using the following criteria:

<table>
<thead>
<tr>
<th>Meet Performance</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>If all the conditions of the CQM are fulfilled the system will mark the ‘Meet Performance’ status as ‘Yes’ and the reason column will be empty.</td>
</tr>
<tr>
<td><strong>Pending Review</strong></td>
<td>If the numerator is not fulfilled, the system will display the failed numerator element in the reason column. (e.g. <strong>N</strong>: Laboratory test result: pap test &lt;=3 years before the “measurement end date”*)</td>
</tr>
<tr>
<td><strong>Denominator Exclusion</strong></td>
<td>Specific exclusion reason will be displayed (e.g. <strong>E</strong>: Diagnosis active: Colorectal cancer).</td>
</tr>
<tr>
<td><strong>Not Qualified</strong></td>
<td>If initial population** criteria is not fulfilled, the system marks the status as ‘Not Qualified’. The reason column will display the data element which did not fulfill.</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>This status will not set itself; instead will be placed in ‘Pending Review’. Furthermore, to record PQRI measures (like PQRI ID # 0059) status ‘No’ will be the preferred choice for users.</td>
</tr>
<tr>
<td><strong>Denominator Exception</strong></td>
<td>Denominator exceptions are those conditions that should remove a patient, procedure or unit of measurement from the denominator only if the numerator criteria are not met.</td>
</tr>
</tbody>
</table>
**QRDA I Report:**

For QRDA I Report, user can go to Batch→PQRI and then click on the `Generate QRDA I Report` icon. This will open Generate PQRI Report window. Now User can click on the `Generate` icon in order to generate the report.

**QRDA III Report**

For QRDA III Report, user can go to Batch→PQRI and then click on the `Generate QRDA III Report` icon. This will open Generate PQRI Reports window. Now User can click on the `Generate` icon to generate report.