Achieving Stage 1 Meaningful Use with OfficeMate/ExamWRITER

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OfficeMate/ExamWRITER v11.1 has achieved ONC HIT 2014 Edition Complete EHR certification, which designates that the software is capable of supporting eligible providers with meeting the Stage 1 and Stage 2 meaningful use measures required to qualify for funding under the American Recovery and Reinvestment Act (ARRA). OfficeMate/ExamWRITER v11.1 was certified by ICSA Labs, an Office of the National Coordinator-Authorized Certification Body (ONC-ATCB), and is compliant in accordance with applicable criteria adopted by the Secretary of Health and Human Services (HHS).

This document will help you understand the Stage 1 core and menu set measures and exclusions in the EHR Incentive Program. It will also show you how to achieve meaningful use and be eligible for incentive money through the functions in OfficeMate/ExamWRITER. For more detailed information about the EHR Incentive Program's core and menu set measures, and for information about registering for the program and submitting attestation documents, go to www.cms.gov/EHRIncentivePrograms.

This document has been updated to reflect the 2014 edition of Stage 1. Some measures have changed and several measures have been renumbered.
NOTE

If you are using an ePrescribing system to meet CPOE, drug-drug and drug-allergy interaction check, and drug formulary check requirements and to generate and transmit permissible prescriptions electronically, it must be a “qualified” eRx system. There are two types of systems: a system for eRx only (standalone) and an electronic health record with eRx functionality (ExamWRITER ePrescribing Interface). Regardless of the type of system that you use, to be considered “qualified” it must be based on all of the following capabilities:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacies and benefit managers (PBMs), if available
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts (defined below)
- Providing information related to lower cost, therapeutically appropriate alternatives (if any). (The availability of an eRx system to receive tiered formulary information, if available, will meet this requirement.)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan, if available

Eyefinity highly recommends that you use the ExamWRITER ePrescribing Interface as your qualified ePrescribing system because it is an integrated solution between ExamWRITER and DrFirst and without it, you will not be able to report your ePrescribing system use from within OfficeMate/ExamWRITER, you will have to manually calculate your meaningful use percentages and self attest to them, and you will also have to rerecord prescriptions that you recorded in ExamWRITER in the standalone system. For more information about the ExamWRITER ePrescribing Interface, go to http://www.officemate.net/examwriter_va_erx.aspx or call the Sales team at 800.269.3666.
Before you can attest meaningful use and receive your incentive money, you must sign up the EHR Incentive Program. This section explains how to register for the program and find your certification number.

- Registering for the Medicare/Medicaid EHR Incentive Program, 3
- Finding the OfficeMate/ExamWRITER EHR Certification Number, 4

Registering for the Medicare/Medicaid EHR Incentive Program

1. Make a note of your National Provider Identifier (NPI), issued by the CMS; Taxpayer Identification Number (TIN) issued by the IRS; and business address and phone number. This information is required.

After registration, you can choose either the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program, subject to the eligibility requirements. Ophthalmologists nationwide are eligible for Medicaid EHR incentive programs. Optometrists are becoming eligible to participate in Medicaid EHR incentive programs in a growing number of states, and should check with their state board of optometry for eligibility.

If you successfully attested to meaningful use in prior years, you must continue your meaningful use throughout the 2013 calendar year. If you are participating for the first time in 2013, or if you previously failed your attestation, you are required to complete only 90 days of meaningful use in 2013. For each year you delay, your incentive potential diminishes.

For more information about the registration and attestation process, go to the Registration and Attestation EHR Incentives Programs page on the CMS website: http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp.
Finding the OfficeMate/ExamWRITER EHR Certification Number

An EHR Certification Number is not required when you initially register for Medicare and Medicaid EHR Incentive Program, but is required when you reach the attestation stage.

3. Click Ambulatory Practice Type.
4. Type OfficeMate in the Search for text box in the center of the page and click Search.
5. In the search result displaying your version of OfficeMate/ExamWRITER, click Add to Cart.
6. OfficeMate/ExamWRITER are eligible to meet 100% of the criteria, but if you are using other components to meet portions of the criteria, search for those products and add them to your cart.

7. Click View Cart.
8. Click the Get CMS EHR Certification ID button.
9. Write down the EHR Certification Number that appears in bold in the middle of the page and return to the Medicare and Medicaid EHR Incentive Program to enter the number in the registration or attestation pages.

NOTES

• You do not need to add DrFirst as a component in your cart. the ONC already knows that you need to use that component with OfficeMate/ExamWRITER to achieve meaningful use.
• If you migrated from another certified EHR to OfficeMate/ExamWRITER during your reporting period, or if you upgraded from one certified version of OfficeMate/ExamWRITER to another (e.g., from v11.1 to v11.2), you will need to add both certified products to your cart.
Preparing for an Audit

Since the EHR incentive programs are government-funded initiatives, audits are an important part of abating fraud and waste in the program. The Centers for Medicare and Medicaid Services is spot checking meaningful use attestations, and they have hired a firm to conduct routine audits.

CMS will not release specific information about the nature of the audits, but they have posted some general guidelines on their Frequently Asked Questions page at https://questions.cms.gov/faq.php?id=5005&faqId=7711. While OfficeMate/ExamWRITER users have nothing to fear from these audits, we encourage you to save materials, files, and communications relative to your meaningful use attestation. Look for Audit Advice throughout this document for information on preparing for a potential audit.

The auditors have been known to ask for items that cannot be obtained retroactively, like screenshots of your certified EHR during your attestation period. We strongly encourage you to heed the audit advice guidance during your attestation period.

Gathering License Documents

Ensure that you have copies of your signed license documents and invoices for each of the products used to fulfill meaningful use, which may include the following:

- OfficeMate/ExamWRITER
- DrFirst (for ePrescribing interface)
- Drug-drug–drug-allergy interaction checker (if you are not using the ePrescribing interface)

Documenting Your Installation of Certified Software

Since the license agreements and invoices do not document when you installed or implemented the certified version of any of the software products, the auditors have been asking for screenshots of the certified software in place on a date prior to your attestation period.
Preparing for an Audit

To document that you have installed a certified version of OfficeMate/ExamWRITER, perform the following steps prior to your attestation period:

1. Open OfficeMate or ExamWRITER.

2. Click Help and select About.

3. Press the Print Scrn key.

4. Open a new Word document (or use another word processor or graphics program).

5. Hold the Ctrl key and press the V key. A copy of the screen is pasted into your document.

6. Save the Word document with your other meaningful use documentation.

**NOTE**
Open OfficeMate or ExamWRITER rather than OfficeMate Administration because OfficeMate Administration does not display the current date.
Differences between the 2011 and 2014 Editions

There are several important changes to Stage 1 in 2014. These changes require that you use a 2014 Edition certified EHR, like OfficeMate/ExamWRITER v11.1.

- Requirements for providing electronic copies of health records and electronic access to health information change in 2014. You must provide more than 50% of patients seen the ability to view, download, and transmit their health information online within four business days.

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<tr>
<td>To satisfy this requirement, you must use the new secure messaging portal; you can no longer use Microsoft HealthVault.</td>
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</table>

- The requirements for recording vital signs change in 2014. The age threshold is raised from 2 to 3. Additionally, if you believe certain vital signs are not relevant to your scope of practice, you may claim an eligible exclusion from:
  - height and weight;
  - blood pressure; or
  - height, weight, and blood pressure.

- Some core and menu set measures were removed, and many of the remaining measures have been renumbered:
  - Attesting that you reported clinical quality measures has been removed from the core set (although you are still required to report clinical quality measures as part of meaningful use).
  - Exchanging clinical information has been removed from the core set.
  - Providing timely electronic access has been removed from the menu set.

- Menu set measure exclusions change in 2014. You will no longer be able to satisfy a menu set measure by claiming an eligible exclusion if there are other menu set measures that you can complete by fulfilling them. You are still required to report on menu set 1 (immunizations) or menu set 2 (syndromic surveillance); you may claim an eligible exclusion for one only if you can claim an exclusion for both. Since you are required to report on menu set 1 or 2, you may claim the exclusion even if there are other menu set measures that you can meet by fulfilling them.

- The clinical quality measures (CQMs) change in 2014. You will no longer be able to attest to the 2011 CQMs. OfficeMate/ExamWRITER supports a limited set of CQMs that are applicable to the eyecare industry. You will need to report on nine CQMs.
Achieving Stage 1 Meaningful Use with OfficeMate/ExamWRITER

Core Measures

You must meet all of the core measures listed below. Note that a permissible exclusion can count as having met the objective.

If a measure specifies that you need to demonstrate more than a specific percentage (e.g., 50%), you must exceed that percentage (e.g., 51%) to fulfill the measure.

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<tr>
<th>Objective</th>
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| (1) Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. | More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE. | Any EP who writes fewer than 100 prescriptions during the EHR reporting period. | 1. Open a patient's exam record in ExamWRITER.  
2. Press F6 to open the Medication Order window.  
3. If you are using the ExamWRITER ePrescribing Interface, follow the instructions below; otherwise, go to step 4. For more information about using the ExamWRITER ePrescribing Interface, view the ExamWRITER ePrescribing Help at [http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm](http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm).  
   a. Click the eRX icon.  
   b. Click the Pharmacy link to select the pharmacy where you want to send the patient's medication order.  
   c. Click Prescribe in the main navigation bar.  
   d. Search for and select a medication.  
   e. Select the appropriate option to send and print the order.  
4. If you are using the Medication Order window in ExamWRITER, follow the instructions below:  
   a. Click Save Med. Order to add the medication order to the Current Therapeutic Rx table.  
   b. Click Print w/Sig/Exit or Print no Sig/Exit to print the medication order and exit the window. | Doctor  
 Technician  
 Scribe |
Achieving Stage 1 Meaningful Use with OfficeMate/ExamWRITER

Core Measures

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<tr>
<td>(2) Implement drug-drug and drug-allergy interaction checks.</td>
<td>The EP has enabled this functionality for the entire EHR reporting period.</td>
<td>No exclusion.</td>
<td>When you use the ExamWRITER ePrescribing Interface, you automatically send patient medication allergy and medication history textual information (without codes) from ExamWRITER to the interface. When you prescribe a medication that interacts negatively with another medication or patient medication allergy, a warning message may appear. Drug-drug interaction and drug-allergy warnings may not appear, however, if the medication has a red triangle to the left of its name; these triangles indicate that the medication was entered by hand, rather than selected from a list, was transferred with a code that the ExamWRITER ePrescribing Interface did not recognize, or was transferred as textual information from ExamWRITER to the interface. To receive more conclusive warning messages, click Manage Medications and reselect the patient’s other medications or medication allergies from the medication list. For more information about using the ExamWRITER ePrescribing Interface, view the ExamWRITER ePrescribing Help at <a href="http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm">http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm</a>.</td>
<td>Doctor, Technician, Scribe</td>
</tr>
</tbody>
</table>

Audit Advice: The firm conducting the meaningful use audits has been known to ask for screenshots documenting the presence of drug-drug–drug-allergy checking during the attestation period. To document the presence of this feature, perform the following steps:

1. Open the ePrescribing interface window and display a drug-drug–drug-allergy interaction check.
2. Press the Print Scrn key.
3. Open a new Word document (or use another word processor or graphics program).
4. Hold the Ctrl key and press the V key. A copy of the screen is pasted into your document.
5. Save the Word document with your other meaningful use documentation.
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| (3) Maintain an up-to-date problem list of current and active diagnoses. | More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data. | No exclusion. | When you record diagnosis codes in ExamWRITER, they are automatically listed on the Exam Hx tab in the patient's Patient Information Center window. You can maintain this list and add diagnosis codes documenting the patient's existing diagnoses by following the instructions below:  
1. Open the patient's Patient Information Center window in ExamWRITER.  
2. Click the Exam Hx tab.  
3. Search for a diagnosis code and double-click on it in the Diagnosis table.  
4. Record the diagnosis date, status, and status date.  
5. Click Save to add the diagnosis to the Current Problem List table.  
6. Click Save/Exit. | Doctor  
Technician  
Scribe |
### Core Measures

#### (4) Generate and Transmit Permissible Prescriptions Electronically (eRx).

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| (4) Generate and Transmit Permissible Prescriptions Electronically (eRx). | More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. | Any EP who writes fewer than 100 prescriptions during the EHR reporting period. Also, any EP who does not have a pharmacy within their organization and for whom there are no pharmacies that accept electronic prescriptions within 10 miles of their practice location at the start of the EHR reporting period. | To generate and transmit prescriptions electronically, follow the instructions below and use the ExamWRITER ePrescribing Interface. For more information about using the ExamWRITER ePrescribing Interface, view the ExamWRITER ePrescribing Help at http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm.  
1. Open a patient's exam record in ExamWRITER.  
2. Press **F6** to open the Medication Order window.  
3. Click the eRX icon.  
4. Click the Pharmacy link to select the pharmacy where you want to send the patient's medication order.  
5. Click **Prescribe** in the main navigation bar.  
6. Search for and select a medication.  
7. Select the appropriate option to send and print the medication order. | Doctor Technician |
### Core Measures

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| (5) Maintain active medication list.          | More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. | No exclusion               | 1. In ExamWRITER, click **Tools** and select **Medication Maintenance**.  
2. Add, modify, and delete medications in the Medication/Allergen Maintenance window and click **Save/Exit**.  
3. Open a patient’s exam record in ExamWRITER.  
4. Click the **Patient Hx - ROS** tab.  
5. Click the **Patient History** category bar.  
6. Select the **Medications - Systemic/Ocular/Allergies [MU]** check box and click **Process**.  
7. Double-click the medication name to select it. If the patient is not currently prescribed any medications, you **must** click **No SYSTEMIC Medications [MU]** or **No OCULAR Medications [MU]**.  
8. Click **Save/Exit**. | Office Manager  
Doctor  
Technician  
Scribe |
### Core Measures

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<tr>
<td>(6) Maintain active medication allergy list.</td>
<td>More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.</td>
<td>No exclusion.</td>
<td>1. In ExamWRITER, click <strong>Tools</strong> and select <strong>Medication Maintenance</strong>. &lt;br&gt;2. Add, modify, and delete medications in the Medication/Allergen Maintenance window and click <strong>Save/Exit</strong>. &lt;br&gt;3. Open a patient's exam record in ExamWRITER. &lt;br&gt;4. Click the <strong>Patient Hx - ROS</strong> tab. &lt;br&gt;5. Click the <strong>Patient History</strong> category bar. &lt;br&gt;6. Select the <strong>Medications - Systemic/Ocular/Allergies [MU]</strong> check box and click <strong>Process</strong>. &lt;br&gt;7. Double-click the medication name to select it. If the patient has no known medication allergies, you must click <strong>No Medication Allergies [MU]</strong>. &lt;br&gt;8. To denote if the patient is allergic to a medication, select the <strong>Allergic</strong> check box next to the medication, click in the blank text box in the Reaction window, select as many reactions as necessary, right-click in the Reaction window, select an onset date from the <strong>Onset</strong> calendar, and click <strong>Save</strong>. &lt;br&gt;9. Click <strong>Save/Exit</strong>.</td>
<td>Office Manager&lt;br&gt;Doctor&lt;br&gt;Technician</td>
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</table>
| (7) Record all of the following demographic s: | More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data. | No exclusion. | 1. Open the patient's Demographic window in OfficeMate or Patient Information Center window in ExamWRITER.  
2. Select the patient's preferred language from the Preferred Language drop-down menu.  
3. Select the patient's gender from the Sex radio buttons.  
4. Select the patient's race from the Race drop-down menu.  
5. Select the patient's ethnicity from the Ethnicity drop-down menu.  
6. Select the patient's date of birth from the Date of Birth calendar. | Front Desk |
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Core Measures

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| (8) Record and chart changes in the following vital signs:                | For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data. | Any EP who sees no patients 3 years or older is excluded from recording blood pressure; 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. | 1. Open a patient's exam record in ExamWRITER.  
2. Click the Exam - Special Tests tab.  
3. Click the yellow Vital Signs button.  
4. Click your cursor in the Height (inches) box, record the patient's height in the Height window, and click Save/Exit.  
5. Click your cursor in the Weight (pounds) box, record the patient's height in the Weight window, and click Save/Exit.  
6. Click your cursor in the Blood Pressure box, record the patient's Systolic, Diastolic, and Pulse in the Blood Pressure/Pulse window, and click Save/Exit. | Doctor  
Technician |

The BMI is automatically calculated for you next to the BMI box. Click the Growth Chart buttons to view height, weight, and BMI growth charts for children 2–20 years.

Audit Advice: If you believe certain vital signs are not relevant to your scope of practice, you may claim an eligible exclusion from

- height and weight;
- blood pressure; or
- height, weight, and blood pressure.

By recording the vital signs for any of your patients, the auditors may interpret that as conceding the measurement is within the scope of your practice, and therefore, ineligible for the exclusion. If you claim an exclusion and are later audited, you may need to explain any vital signs that you recorded during your reporting period.

The calculator includes historical data. If your practice used to record vital signs, that information still resides in your patient records and is picked up by the calculator. If you are audited, you may be asked to provide a letter stating that you used to collect vital signs but you no longer do so because vital signs are irrelevant to your scope of practice.
### Objective

(9) Record smoking status for patients 13 years old or older.

### Measure

More than 50 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.

### OfficeMate/ExamWRITER Instructions

1. Ensure that you have services linked to the 4004F and 1036F CPT codes in the OfficeMate/ExamWRITER Products window.
2. Open a patient’s exam record in ExamWRITER.
3. Click the **Patient Hx - ROS** tab.
4. Click the **Patient History** category bar.
5. Select the **Social [MU]** check box and click **Process**.
6. Record the patient’s smoking status using the check box at the top of the Social History window or the radio buttons in the **Tobacco Use [MU]** box. If the patient is a smoker, you must select the patient’s tobacco use and either the **Counseling Intervention Recommended** or **Pharmaceutical Intervention Recommended** check box.
7. Click **Process**.

### Responsible Role

Doctor

Technician
Core Measures

(10) Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.

(Formerly core measure 11)

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<tbody>
<tr>
<td>Implement one clinical decision support rule.</td>
<td>No exclusion.</td>
<td>By default, we turned on a clinical decision support rule for macular degeneration for you. As long as you finalize one exam where macular degeneration is indicated, you'll fulfill the measure. To create additional clinical decisions support rules, perform the following steps:</td>
<td></td>
<td>Doctor</td>
</tr>
<tr>
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<td></td>
<td>1. In ExamWRITER, click Tools and select Clinical Decision Support.</td>
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<tr>
<td></td>
<td></td>
<td>2. Click New to create a new condition.</td>
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<td></td>
<td></td>
<td>3. Type a name in the Condition Name text box.</td>
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<td>4. Record one or more criteria, such as a diagnosis code, and type a requirement in the Requirement text box, such as an action to take, and type a link to a Web site, if desired.</td>
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<td>5. Click Save.</td>
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<td></td>
<td></td>
<td>When you finalize an exam, if the criteria that you set up matches the patient's problem list, medication list, demographics, or laboratory test results, you receive a patient alert to take an action. Note that there is already a default clinical decision support rule set up, per the recommendation of Nutraceuticals, for macular degeneration.</td>
<td></td>
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(Formerly core measure 11)
### Objective

(11) 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.

(Formerly core measure 12)

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| (11)      | More than 50 percent of all unique patients are provided an electronic copy of their health information within 4 business days. | Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information, may exclude the measure. | To satisfy this requirement, you must use the new secure messaging portal; you can no longer use Microsoft HealthVault.  
1. Open the patient’s exam.  
2. Click Patient Hx.  
3. Click the Demographics tab and verify the patient’s Name, Date of Birth, and E-Mail Address.  
4. Click the eDocuments tab.  
5. Select the Clinical Summary (open exam) radio button.  
6. Select the Patient Requested check box.  
7. Click Create CDA.  
   The Edit Clinical Summary window opens. The Original Document section reflects all of the data in the clinical summary that is capable of being shared with the patient. The Final Document section reflects only the data that you have selected to share with the patient. By default, all of the data is selected.  
8. To exclude certain data, deselect the appropriate check boxes in the Original Document section.  
9. Once you have selected only the data that you want to send the patient, click Save.  
10. Click OK to dismiss the success message.  
   The Patient Electronic Documents list refreshes and displays the clinical summary document that you created at the top.  
11. Select the clinical summary from the Patient Electronic Documents list.  
12. Select Patient from the Send To radio buttons.  
13. Click Secure Send.  
14. Click OK to dismiss the message confirmation.  
   The patient will receive an email explaining that new records are available from your practice. If the patient has not logged into the secure messaging portal before, he or she will receive a second email explaining how to log in for the first time. | Doctor  
Technician  
Front Desk |
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<td>(12) Provide clinical summaries for patients for each office visit. (Formerly core measure 13)</td>
<td>Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.</td>
<td>Any EP who has no office visits during the EHR reporting period.</td>
<td>1. Open a patient’s exam record in ExamWRITER. 2. Click Print and select Clinical Summary [MU]. If no information is processed in the Special Testing, Surgery, or Plan sections of the exam, a clinical summary will not print, and the patient will not count toward the 50 percent threshold.</td>
<td>Doctor, Technician, Front Desk</td>
</tr>
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### Core Measures

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<th>Responsible Role</th>
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</thead>
<tbody>
<tr>
<td>(13) Protect electronic health information created or maintained by the</td>
<td>Conduct or review a security risk analysis in accordance with the</td>
<td>No exclusion.</td>
<td>Important Note: OfficeMate/ExamWRITER received ONC HIT 2014 Edition Complete EHR certification and therefore contains the following features to protect your electronic health information. You may use some or all of these features as part of your comprehensive security plan.</td>
<td>Office Manager</td>
</tr>
<tr>
<td>certified EHR technology through the implementation of appropriate</td>
<td>requirement(s) under 45 CFR §164.308(a)(1) and implement security</td>
<td></td>
<td>If desired, set up security in OfficeMate/ExamWRITER by following the instructions below. For more detailed instructions, see the <em>OfficeMate Administration User's Guide</em>.</td>
<td></td>
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<tr>
<td>technical capabilities. (Formerly core measure 15)</td>
<td>updates as necessary and correct identified security deficiencies as</td>
<td></td>
<td>1. In OfficeMate/ExamWRITER Administration, click <strong>Setup</strong> and select <strong>Security</strong>.</td>
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<td></td>
<td>part of its risk management process.</td>
<td></td>
<td>2. Click <strong>Role Maintenance</strong> and set up a new role or modify the name and description or copy an existing role. You can set up as many roles as desired.</td>
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<td>3. Select a role on the left side of the window and define its details. The roles can be as broad or as limiting as you desire.</td>
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<td></td>
<td>4. Click the <strong>Users</strong> tab and assign users to the roles that you created. You can assign as many roles as desired to users. All users will initially be automatically assigned to a default administrator role, which allows them access to all products, modules, and tasks in all locations, until you modify their role assignments. To grant users read-only emergency access to ExamWRITER, select the <strong>Allow Emergency Access</strong> check box; users with emergency access must identify the emergency situation when logging into ExamWRITER and type their reason for using the emergency access login.</td>
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<td>5. Click the <strong>Preferences</strong> tab and set up security preferences for your locations.</td>
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<td>6. Click <strong>Secure Reports</strong> and restrict user access to reports.</td>
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<td></td>
<td>7. Click <strong>Print</strong> to print the Security Roles Report that displays the roles that you set up.</td>
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<td></td>
<td></td>
<td></td>
<td>8. Click <strong>Close</strong>.</td>
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</table>
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. (Formerly core measure 15)

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<tr>
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<tr>
<td>(13 Continued)</td>
<td>Conduct or review a security risk analysis in accordance with the requirements under 45 CFR §164.308(a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process. (Continued)</td>
<td>No exclusion.</td>
<td>If desired, encrypt patient and provider protected health information (PHI) in your database by following the instructions below. Note that passwords are encrypted within the database regardless of whether the rest of the database is encrypted or not; this functionality requires no action on your part. 1. Back up your data! 2. In OfficeMate/ExamWRITER Administration, click <strong>Setup</strong> and select <strong>Encrypt/Decrypt Database</strong>. 3. Click <strong>Generate Key</strong>. 4. Click <strong>Save Key</strong>. 5. Click <strong>Encrypt</strong>.</td>
<td>Office Manager</td>
</tr>
</tbody>
</table>

If desired, view the activities of OfficeMate/ExamWRITER users in your practice, track changes made to a particular patient's record, and view changes made to a specific exam, follow the instructions below:

1. In OfficeMate/ExamWRITER Administration, click **Setup** and select **Audit Log Management**.
2. Select the **Event Types** check boxes, as needed.
3. Click **Save/Exit**.
4. In OfficeMate/ExamWRITER Administration, click **Setup** and select **Audit Log Review**.
5. Record search criteria in the top of the window and click **Search** to find logs that meet your search criteria. Click **Print** to print the audit log search results or double-click on a log to view more details about it. To verify the integrity of an audit log entry that you have opened, click **Validate**.
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</table>
| (13) (Continued) Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. (Formerly core measure 15) | (Continued) Conduct or review a security risk analysis in accordance with the requirements under 45 CFR §164.308(a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process. | (Continued) No exclusion. | If desired, encrypt documents by following the instructions below:  
1. Open the patient’s Patient Information Center window in ExamWRITER.  
2. Click the eDocuments tab.  
3. Select a document that you have already created.  
4. Select a location where you want to save the encrypted document in the Save to text box in the Encrypt Document box.  
5. Type any encryption key in the Encryption Key text box.  
6. Click Encrypt. The encrypted file is saved as an .exe file in the location that you selected and displayed in the Patient Electronic Documents table.  
If desired, validate that no one has tampered with a file by following the instructions below:  
1. In ExamWRITER, click Tools and select Process Hash File.  
2. Click Browse next to the File name to Generate Hash text box and select the file that you want to check.  
3. Type a hash file name in the Hash File Name text box or click Browse and navigate to and select an existing hash file.  
4. Click Generate Hash.  
5. Click Exit.  
7. Click Browse next to the File name to Generate Hash text box and select the file that you want to compare.  
8. Click Browse next to the Hash File Name text box and navigate to and select an existing hash file with a hash value.  
9. Click Compare Hash. | Office Manager  
Technician  
Front Desk |
## Core Measures

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</table>
| (13 Continued) Proct electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. (Formerly core measure 15) | (Continued) Conduct or review a security risk analysis in accordance with the requirements under 45 CFR §164.308(a)(1) and implement necessary security updates as needed and correct identified deficiencies as part of its risk management process. | (Continued) No exclusion. | **Audit Advice:** Document and date your security risk analysis each year. You cannot fulfill this measure simply by turning a security feature on or off. Your practice must conduct, at least once per annum, a comprehensive security risk analysis in accordance with the requirements under HIPAA (45 CFR §164.308(a)(1)) and correct identified security deficiencies. OfficeMate/ExamWRITER includes some features, which you may choose to enable as part of your overall security plan, but you cannot stop there. Questions you would need to answer as part of a security audit include, but are not limited to:  
- Does the practice have antivirus or antimalware software installed, enabled, and current on every computer and server? Are operating system security patches up-to-date and installed on every workstation and the server?  
- Is the practice’s network protected by a firewall? How often are the settings verified?  
- Are mobile phones, tablets, laptops, desktops, and other devices used to access and transmit PHI password protected and encrypted?  
- Where is PHI collected, stored, maintained, and transmitted? What are the potential security threats and how likely are those threats?  
- Does the practice have business associate contracts with all vendors that outline who is responsible and how PHI is protected?  
- Is everyone in the practice trained in HIPAA? How is that education kept current?  
- Does the practice have written, up-to-date policies and procedures in place regarding protecting PHI?  
- How is the practice prepared to protect and restore PHI in case of natural or man-made disaster?  
- How are off-site backups protected?  
HIPAA rules strictly forbid us or you from distilling the security analysis down to a simple checklist. Security needs vary drastically from practice to practice. Refer to the [ONC Guide to Privacy and Security of Health Information](http://www.healthit.gov/sites/default/files/pdf/privacy/privacy-and-security-guide.pdf) for further guidance. | Office Manager  
Technician  
Front Desk |
Menu Set Measures

You must meet *five of the nine* menu set measures listed below, one of which must be objective 1 (submitting electronic data to immunization registries) or objective 2 (submitting electronic syndromic surveillance data). Note that a permissible exclusion can count as having met the objective; however, beginning in 2014, you will no longer be permitted to count exclusions toward the minimum requirement of meeting five menu set measures if there are other menu set measures that you can meet.
<table>
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<tr>
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</table>
| (1) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. (Formerly menu measure 9) | Performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the registries to which the EP submits information can receive the information electronically), except where prohibited. | An EP who administers no immunizations during the EHR reporting period, practices where no immunization registry has the capacity to receive the information electronically, or practices in an area where submitting such data is prohibited by law. | 1. Open the patient’s Patient Information Center window in ExamWRITER.  
2. Click Immunization.  
3. Record vaccines that the patient has previously received and then click Save.  
4. Click Exit.  
5. In OfficeMate/ExamWRITER Administration, click Reports from the main window toolbar.  
6. Select Immunization Registry.  
7. Record the sending and receiving facility information, the receiving application, and the reporting date range.  
8. Click Generate HL7 V2.3.1 Immunization Files.  
9. Send the immunization files in the DATA\eDocuments\ImmunizationRegistry folder to the specified receiving facility. The file names follow the format: VXU_V04_231_Patient ID_date | Doctor  
Technician  
Front Desk |
### Menu Set Measures

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<tr>
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</table>
| (2) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice. (Formerly menu measure 10) | Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the agencies to which an EP submits information can receive the information electronically), except where prohibited. | An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period, does not submit such information to any public health agency that has the capacity to receive the information electronically, or practices in an area where submitting such data is prohibited by law. | 1. In OfficeMate/ExamWRITER Administration, click **Reports** from the main window toolbar.  
2. Select **Public Health Surveillance**.  
3. Record the sending and receiving facility information, receiving application, reporting date range, and ICD-9 code being reported.  
4. Click **Generate HL7 V2.3.1 Public Health Files**.  
5. Send the public health files in the DATA\Documents\PublicHealth folder to the specified receiving facility. The file names follow the format: ADT_A28_231_Patient ID_date | Office Manager |
### Menu Set Measures

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<tr>
<td>(3) Implement drug formulary checks. (Formerly menu measure 1)</td>
<td>The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.</td>
<td>Any EP who writes fewer than 100 prescriptions during the EHR reporting period.</td>
<td>When you use the ExamWRITER ePrescribing Interface, the interface conducts drug formulary checks on medications that you select and displays formulary warnings in blue text. For more information about using the ExamWRITER ePrescribing Interface, view the ExamWRITER ePrescribing Help at <a href="http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm">http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm</a>. <strong>Audit Advice:</strong> The firm conducting the meaningful use audits has been known to ask for screenshots documenting the presence of drug formulary checking during the attestation period. To document the presence of this feature, perform the following steps: 1. Open the ePrescribing interface window and display a drug formulary check. 2. Press the <strong>Print Scrn</strong> key. 3. Open a new Word document (or use another word processor or graphics program). 4. Hold the <strong>Ctrl</strong> key and press the <strong>V</strong> key. A copy of the screen is pasted into your document. 5. Save the Word document with your other meaningful use documentation.</td>
<td>Doctor Technician</td>
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</table>
### Menu Set Measures

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<tbody>
<tr>
<td>(4) Incorporate clinical lab test results into EHR as structured data. (Formerly menu measure 2)</td>
<td>More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporate in certified EHR technology as structured data.</td>
<td>An EP who orders no lab tests whose results are either in a positive/negative or numerical format during the EHR reporting period.</td>
<td>There are two parts to this measure: 1. Record the lab order 2. Import the lab results OR enter the lab results manually.</td>
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<td>Record the lab order: 1. Open a patient's exam record in ExamWRITER. 2. Click the <strong>Surgery - Plan - Mgmt</strong> tab. 3. Click the <strong>Patient Management</strong> category bar. 4. Select <strong>Current and Future Orders</strong>. 5. Click <strong>Process</strong>. 6. Select the <strong>Laboratory</strong> radio button. 7. Select orders in the box on the left of the Orders window. 8. Select appropriate <strong>Eye, Timeline, and Action</strong> information. 9. Click <strong>Save(s)</strong>. 10. Click <strong>Process</strong>.</td>
<td>Doctor  Technician  Front Desk</td>
</tr>
</tbody>
</table>
### Objective

(4 continued) Incorporate clinical lab test results into EHR as structured data.

(Formerly menu measure 2)

### Measure

More than 40 percent of all clinical lab test 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

An EP who orders no lab tests whose results are either in a positive/negative or numerical format during the EHR reporting period.

### OfficeMate/ExamWRITER Instructions

Import lab results that you receive electronically in the HL7 format:

1. Click the **Patient Hx** icon.
2. Click the **eDocuments** tab.
3. Click **Import Lab Results**.
4. Browse for the HL7 lab results file and click **Open**.
   - The Importing Patient Match window opens and displays the name, date of birth, and gender of patient you have open in ExamWRITER and of the patient listed in the lab results file.
5. Verify that you are importing the correct patient’s lab results.
   - Click **Import** if the patient matches.
   - Click **Select Another File** if the patient does not match.
   - ExamWRITER displays the contents of the lab results file for your review.
6. Click **Import**.
7. On the Patient Information window, click **Enter Lab Results**.
8. Double-click the lab results listed under **Lab Order Results**.
9. Select the **Order Link** by clicking the ellipsis (…) and selecting the exam where the lab tests were ordered.
10. Click **Save**.

### Responsible Role

Doctor
Technician
Front Desk
Objective | Measure | Exclusion | OfficeMate/ExamWRITER Instructions | Responsible Role
--- | --- | --- | --- | ---
(4 continued) Incorporate clinical lab test results into EHR as structured data. | More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format during the EHR reporting period. | An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period. | Record lab results manually. There are two main steps required to record lab results. First, create the lab test report. Second, record the individual elements within that test.
1. Perform the following steps to record the lab report:
   a. Click the Patient Hx icon.
   b. Click Enter Lab Results.
   c. Click New in the middle of the window.
   d. Select the Test Name.
   e. Select the Test Type and Code Type from the drop-down menus and enter the Code.
   f. Select the Order Link by clicking the ellipsis (…) and selecting the exam where the lab tests were ordered.
   g. Record the lab details in the appropriate fields.
2. For each element reported on the lab result, perform the following steps:
   a. Click New at the bottom of the window.
   b. At minimum, type the Element, Result Value, and UOM (unit of measure).
   c. Select a Test Date.
   d. Click Save at the bottom of the window.
3. Click Save in the middle of the window.
### Menu Set Measures

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</table>
| (5) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. (Formerly menu measure 3) | Generate at least one report listing patients of the EP with a specific condition. | No exclusion. | 1. In ExamWRITER, click **Tools** and select **Patient Search**.  
2. Select your search criteria and click **Search**.  
3. Click **Print** to document your use of patient lists. | Office Manager |

**Audit Advice:** The firm conducting the meaningful use audits has been known to ask for evidence of your patient search during the attestation period. To document that you used this feature, print at least one patient list during your attestation period.
### Objective | Measure | Exclusion | OfficeMate/ExamWRITER Instructions | Responsible Role
--- | --- | --- | --- | ---
(6) Send reminders to patients per patient preference for preventive/follow-up care. (Formerly menu measure 4) | More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. | An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology. | Note: Only recalls printed for patients for whom you have recorded an exam in the past three years will be counted in your CMS meaningful use report. Create recall letters and postcards by following the instructions below: 1. Click **Tasks** on the main window toolbar and select **Maintain Documents**. 2. Click **Setup** and select **Letters** or **PostCards**. 3. Click the **OfficeMate Documents** folder. 4. Click the **Recall** folder. 5. To edit an existing recall document, select it from the **Recall** folder. To create a new recall document, click **File** and select **New**. 6. Type a title for the new recall document in the **Title** box. 7. Click **OK**. 8. Type the recall document in the word processing window. 9. Click **Insert**, select **Merge Fields**, select merge fields, and click **Insert**. 10. Click **File** and select **Save**. Create recall schedules by following the instructions below: 1. In OfficeMate/ExamWRITER Administration, click **Setup** and select **Customization**. 2. Click the **Recall** tab. 3. Click **New Recall**. 4. Type the name of the new recall schedule in the **Recall Type** text box. 5. Type the number of months until the patient will be recalled in the **Months to Next Recall** text box. 6. Record appropriate information in the **Recall Notice Mailing Schedule** table. 7. Click **OK**. | Office Manager Front Desk
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<tr>
<td>(6 Continued) Send reminders to patients per patient preference for preventive/follow-up care. (Formerly menu measure 4)</td>
<td>(Continued) More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.</td>
<td>(Continued) An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.</td>
<td>Assign recall dates to patients by following the instructions below: 1. Open a patient’s demographic record in OfficeMate. 2. Select the patient’s provider from the Provider drop-down menu. 3. Select the patient’s communication preference from the Communication Pref. drop-down menu. 4. Click the Recall tab. 5. Select recall types from the Recall Type drop-down menus. 6. Click OK. Print recall correspondence by following the instructions below. 1. In OfficeMate, click Tasks and select Correspondence [MU]. 2. Select Recall [MU]. 3. Select a location from the Location drop-down menu. 4. Type or select dates in the Selection Range From and To boxes. 5. Select the Select all names check box if you want to print recall correspondence for all of the patients in the date selection range. 6. Select a communication preference from the Communication Preference drop-down menu. 7. Click Start Selection. 8. Select the Last Name or ZIP Code Order By radio button to sort the patients alphabetically by last name or numerically by ZIP code. 9. Click Print and then click Print again. 10. Click OK in the Job Completed window. 11. Click Yes in the Correspondence Printing Warning window.</td>
<td>Office Manager  Front Desk</td>
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<tr>
<td>Objective</td>
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| (6 Continued) Send reminders to patients per patient preference for preventive/ follow-up care. | (Continued) More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. | (Continued) An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology. | Pre-appointing Patients, Internal Marketing, and Third-Party Patient Communication Systems  
If you pre-appoint patients, generate recalls through the Internal Marketing report, or use such patient communication services as 4PatientCare, Websystem3, Demandforce, Solutionreach, or any other mechanism, those recalls will not automatically count toward your numerator.  
You may continue to generate recalls through these services, but you will need to also generate recalls in the Process Recalls window. You don’t need to send the recalls that you generate in OfficeMate if you sent them through these other services. To save paper, you can print the recalls to a PDF printer like CutePDF. | Office Manager  
Front Desk |
### Menu Set Measures

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</table>
| (7) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate. (Formerly menu measure 6) | More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources. | No exclusion. | 1. Open a patient's exam record in ExamWRITER.  
2. Click the Surgery - Plan - Mgmt tab.  
3. Click the Impressions/Assessment category bar.  
4. Select impressions and assessments and click Process.  
5. Click the Coding icon, select diagnosis codes, and click Save/Exit.  
6. Press F6 and record a therapeutic Rx.  
7. Click the Print icon.  
8. Select Patient Report [MU] or Clinical Summary [MU].  
9. Click the Finalize icon.  
10. Select the Exam is Billable/Reportable [MU] check box.  
11. Click Continue. | Doctor Scribe |
### Objective
(8) 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. (Formerly menu measure 7)

### Measure
The EP 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
An EP who was not the recipient of any transitions of care during the EHR reporting period.

### OfficeMate/ExamWRITER Instructions
1. Open a patient’s exam record in ExamWRITER.
2. Click the **Patient Hx - ROS** tab.
3. Click the **Patient History** category bar.
4. Select the **Reviewed [MU]** check box. OR
   Select the **Medications - Systemic/Ocular/Allergies [MU]** or **Allergens - Non Medication** check box and click **Transition of Care Medication Reconciliation [MU]**.
5. Click **Process** or **Save/Exit**.
6. Open a patient’s Patient Information Center in ExamWRITER or Patient Demographics window in OfficeMate.
7. Select the **Professional [MU]** radio button next to **Referred By**.
8. Click the button next to **Referred Name** and find and select a referring professional.
9. Click **OK** or **Save**.

### Responsible Role
- Doctor
- Technician
- Scribe
(9) The EP who transitions or refers their patient to another setting of care or provider of care should provide summary care record for each transition of care or referral. (Formerly menu measure 8)

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</thead>
</table>
| (9) The EP who transitions their patient to another setting of care or    | The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for each transition of care or referrals. | An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period. | You may send an electronic or paper copy of the transition of care document. 1. Record the transition of care. a. Within the patient’s exam, click Patient Hx. The patient’s Patient Information Center window opens. b. On the Exam Hx tab, click New Referral. c. Select the Referring Provider, Refer to Provider, Reason, SNOMED, Referral Date, and Expected Return Date and click Save. d. Click Create CDA Transition of Care and click Exit. e. Click the eDocuments tab. f. Click Show eDocs. 2. Print the transition of care document as needed; otherwise, go to step 3. a. Double-click the CDA Export - Transition of Care from the list of eDocuments. b. Click View. c. Right-click the Transition of Care page and select Print. 3. Optionally, send the transition of care document electronically. a. Double-click the CDA Export - Transition of Care from the list of eDocuments. b. Select the Provider radio button and click Secure Send. The Secure Message window opens. c. Type the provider’s direct mail address or select it from the drop-down menu, type a Subject, type a message, and click Send. Your message and the patient’s CDA are sent securely. | Doctor  
Technician  
Front Desk  
Check Out |

Doctor  
Technician  
Front Desk  
Check Out
Data that you record in OfficeMate/ExamWRITER that displays [MU] next to it are related to meaningful use criteria and are reported in the CMS Meaningful Use Reporting window.

The CMS Meaningful Use Reporting window shows you how you are using your certified software. This window helps you see where you have met meaningful use (MU) requirements and where you have not, and helps ensure you qualify for the incentive payments. This window lists the percentage-based core and menu set objectives. You must meet all of the core objective percentages and five of the menu set objective percentages, one of which must be objective 9 (submitting electronic data to immunization registries) or objective 10 (submitting electronic syndromic surveillance data). Note that a permissible exclusion can count as having met the objective; however, beginning in 2014, you will no longer be permitted to count exclusions toward the minimum requirement of meeting five menu set measures if there are other menu set measures that you can meet.

NOTE Both the CMS Meaningful Use Reporting window and the CMS Quality Reporting window can help you gather meaningful use information and determine if you qualify for stimulus money.

You can use the CMS Meaningful Use Reporting window to perform the following tasks:

- Keep track of the core objectives and their meaningful use criteria.
- Calculate the percentage of a criteria that you meet so that you can report the data in your attestation application.
- Generate a meaningful use report that you can send to the government.

1. Select Reports from the OfficeMate/ExamWRITER main window toolbar, select CMS Meaningful Use Reporting, and select CMS Meaningful Use Reporting - Stage 1.
2. Select a Meaningful Use Criteria line from the left column. The description appears in the right column.
3. Select a date range from the Reporting From Date and Reporting Through Date fields.
4. Select a provider from the Provider drop-down menu.
5. Click **Calculate Percentage** to populate the Calculated Values fields. The calculated values are displayed in the Numerator, Denominator, and Percentage fields.

![Image of software interface]

**NOTE**

Audit Advice: The firm conducting the meaningful use audits has been known to ask for screenshots documenting your meaningful use numerators, denominators, and percentages as they display within the software. For each measure listed in the CMS Meaningful Use Reporting window, perform the following steps:

1. Open the Patient Search window.
2. Hold the **Alt** key and press the **Print Scrn** key.
3. Open a new Word document (or use another word processor or graphics program).
4. Hold the **Ctrl** key and press the **V** key.
   
   A copy of the window is pasted into your document. You can continue to paste all of the windows in this document.
5. Save the Word document with your other meaningful use documentation.
6. Click **Generate MU Report** to generate the Meaningful Use report. The report, an XML-based file, is placed in the DATA\eDocuments folder.