Patient List

Select **Patient List** from the **Reports** menu.

Print an ordered list of patients. For each patient, you have the option of including the phone number, patient ID#, and/or (aged) account balance in the report. The account balance is broken down by patient and insurance company. The list includes all patients & is ordered alphabetically by default. Use data filters to restrict the search & select sorting criteria. You can create sortable lists by sending the output to your Screen as a print destination.

Automated Measure Calculation

You should run this report at regular intervals to monitor your progress. For each criterion below, the calculation parameters used by ECLIPSE are delineated so you understand how to enter data to fulfill "Meaningful Use" guidelines. Note that you can filter the patient database to determine your percentages. Please remember that these criteria were not determined by us and note that ECLIPSE must sometimes make a "best guess" based on data that you have entered into the system. Here are a few examples to illustrate:

- You have a multi-disciplinary practice that includes Physical Therapists. "Meaningful Use" calculations do not include PT patients and may affect one or more measures. How do you exclude them?
  - Consider using a filtered range for **Referral (billing)** of 0 by simply checking the filter. (Patients with no billing referral assignment will be included.) These days, a Billing Referral should only exist for physical therapy patients. Optionally use the **Released from care** and/or **Inactive** filters to achieve the same result.
- You have several hundred inactive patients and you don't want to skew the percentages.
  - Use the **Patient name (active)** index -- which is the default. Make sure you use the **Inactive** and **Released from care** checkboxes on the patient's **Personal** tab. Optionally select **Globally Mark Patients Inactive** from the File | Utilities menu.
  - Alternatively, use the **Last visit date** filter and select a range of your choosing (e.g. the reporting period).

Any of the above are valid examples of how you can use your data filters alone or in combination to control the calculations for a database that precedes the requirements. Each measure is described below along with what you must do in ECLIPSE to ensure that measure is addressed. Also note that if you have attested that a specific measure does not apply to you, simply ignore the calculation for that measure.

**Snapshot**

*Please keep in mind that when you generate this report, it's a snapshot of a moment in time. Unless your data remains static, the report can't be re-generated at a later time with an expectation that it will yield the same result. Why? Unlike your office statistics, which provide a snapshot of a given date or date range, most Meaningful Use criteria are not date dependent. Thus, any time you add data to ECLIPSE, you might be “changing the past” in the event you attempted to re-generate a specific measure for a prior time frame. For example, a problem list entry is not date/time dependent. Thus, once it's entered,
the criteria are satisfied for that patient forever and count as of the day the patient was originally added
to ECLIPSE. It's not required that we check whether the problem was added during a particular time
frame. Note that this actually makes it easier for you to meet Meaningful Use criteria. Finally, we
suggest you print the snapshot report you use for attestation and keep it with your records.

**Problem List**

All patients within the search filter are included in the total (denominator).

At least one entry must appear on the patient's **Problem List**. The Problem List is located on the
**History** tab within the patient's **EHR** tab. Though the patient's primary diagnosis (at least) should be
entered on this tab along with conditions treated by other health care providers, you can simply create an
entry of "None" for each patient to satisfy the criteria.

*To determine which patients are missing an entry* in their Problem List, run this report with the **Problem**
filter checked and empty (i.e. don't enter any text). The report will include only patients who do not have
*any* entries on their Problem List.

**Requirement:** More than 80% of all unique patients have at least one entry or an indication that no
problems are known.

**Medication List**

All patients within the search filter are included in the total (denominator).

At least one entry must appear on the patient's **Medications** list. The Medication list is located on the
**History** tab within the patient's **EHR** tab. You can simply create an entry of "None" for each patient to
satisfy the criteria.

*To determine which patients are missing an entry* in their Medication List, run this report with the **Medication**
filter checked and empty (i.e. don't enter any text). The report will include only patients who do not have
*any* entries on their Medication List.

**Requirement:** More than 80% of all unique patients have at least one entry (or an indication that the
patient is not currently prescribed any medication).

**Medication Allergy List**

All patients within the search filter are included in the total (denominator).

At least one entry must appear on the patient's **Allergies** list. The Medication list is located on the
**History** tab within the patient's **EHR** tab. You can simply create an entry of "None" for each patient to
satisfy the criteria.

*To determine which patients are missing an entry* in their Allergy List, run this report with the **Allergies**
filter checked and empty (i.e. don't enter any text). The report will include only patients who do not have
*any* entries on their Allergy List.

**Requirement:** More than 80% of all unique patients have at least one entry (or an indication that the
patient has no known medication allergies).
**Record Demographics**

All patients within the search filter are included in the total (denominator).

If you have entered at least one of the following on the patient's **Personal** tab, you are deemed to have satisfied the criteria for this measure:

- Race
- Ethnicity
- Language

**Requirement:** More than 50% of all unique patients have demographics recorded.

**Provide Education Resources**

All patients within the search filter are included in the total (denominator).

The **Educational** tab can be accessed from the on the **History** tab within the patient's **EHR** tab. You can satisfy this criteria for any patient by accessing (at least once) an educational resource by pressing the **Search Krames** button. Access requires internet access and a license for the content. If you do not have a license, instructions will appear when the button is pressed.

**Requirement:** More than 10% of all unique patients during the EHR reporting period are provided patient-specific education resources.

**Provide patient with timely electronic access**

All patients within the search filter are included in the total (denominator).

This criterion can be satisfied in one of two ways:

- From the **History** tab within the patient's **EHR** tab, press the **Export** button and choose **CCR Document to file/email**. Email the document to the patient.
- From the **History** tab within the patient's **EHR** tab, press the **Export** button and choose **CCR Document to patient's Google Health record**. (8/1/2011 update: Google Health will be discontinued on 1/1/2012. At that time new PHR affiliations will likely be made available as well).

**Requirement:** More than 10% of all unique patients are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the provider's discretion to withhold certain information

**CPOE for medication orders**

All patients with items on their Medication list are included in the search filter provide that at least one entry meets either of the following criteria:

- The medication **Type** (column 3) is set to **Internal EDI**.
- The medication **Type** (column 3) is set to **Internal Paper**.

**Requirement:** More than 30% of unique patients with at least one medication in their medication list
have at least one medication order entered using CPOE.

**Generate & transmit prescriptions electronically**

All patients with items on their Medication list are included in the search filter provide that at least one entry meets either of the following criteria:

- The medication Type (column 3) is set to Internal EDI.
- The medication Type (column 3) is set to Internal Paper.

Patients within this group who have at least one electronic prescription (i.e. a "Type" of Internal EDI) are considered to meet the criteria.

**Requirement:** More than 40% of all permissible prescriptions written by the provider are transmitted electronically using certified EHR technology.

**Vital signs (age 2 and older)**

All patients within the search filter who are at least 2 years of age when the report is created (based on the current date) are included in the total (denominator).

At least one entry must appear on the patient's Vitals list. Vitals are located on the History tab within the patient's EHR tab. You can simply create an entry of "None" for each patient to satisfy the criteria.

**Requirement:** More than 50% of all unique patients age 2 and over: height, weight and blood pressure are recorded.

**Smoking status (age 13 and older)**

All patients within the search filter who are at least 13 years of age when the report is created (based on the current date) are included in the total (denominator).

This criterion can be satisfied in one of two ways:

- At least one entry must appear on the patient's Vitals list. Vitals are located on the History tab within the patient's EHR tab. You can simply create an entry of "None" for each patient to satisfy the criteria.
- At least one entry must appear on the patient's Social History list. Social History is located on the History tab within the patient's EHR tab. You can simply create an entry of "None" for each patient to satisfy the criteria.

**Requirement:** More than 50% of all unique patients 13 years old or older have smoking status recorded.

**Incorporate Lab Results**

All patients within the search filter are included in the total (denominator).

At least one entry must appear on the patient's Reported Tests list. Reported Tests are located on the History tab within the patient's EHR tab. You can simply create an entry of "None" for each patient to satisfy the criteria.
To determine which patients are missing an entry in their list of Reported Tests, run this report with the Lab Results filter checked and empty (i.e. don't enter any text). The report will include only patients who do not have any entries on their list of Reported Tests.

**Requirement:** More than 40% of all clinical lab tests results ordered by the provider during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated.

**Electronic copy of health info (where requested)**

All patients within the search filter for whom a service entry has been tagged with a CCR request are included in the total (denominator).

- Any service entry can be edited during or after daysheet entry. Simply mark the CCR request checkbox to note the patient's request for calculation purposes.

First, there are multiple ways to generate a clinical summary. For any patient, you must use at least one of these methods on a single occasion.

- From the Ledger tab, press the Print button. From the resulting Print dialog's Other tab, press the Print button within the Basic patient information group box.
- From the History tab within the patient's EHR tab, press the Export button and choose any item.

**Requirement:** More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.

**Clinical summary within 3 days of visit**

All patients within the search filter are included in the total (denominator).

First, there are multiple ways to generate a clinical summary. For any patient, you must use at least one of these methods within 3 days of an office visit on a single occasion (i.e. once during the date range -- usually the calendar year -- that's being checked). It is not required that you do this for each & every visit.

- From the Ledger tab, press the Print button. From the resulting Print dialog's Other tab, press the Print button within the Basic patient information group box.
- From the History tab within the patient's EHR tab, press the Export button and choose any item.

**Requirement:** Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.

**Send reminders to patients**

All patients younger than 6 or older than 64 years of age within the search filter are included in the total (denominator).

There are multiple ways to generate a reminder. It is only required that you do this at least once for any patient:
• Generate a text message from the scheduler.
• Generate a Recall list that includes the patient from the Report menu.

Requirement: More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period

Medication reconciliation (primarily for referred patients)

To be counted in the total (denominator) for this criterion:

• There must be a Billing Referral assigned on the patient's Case tab. Unless you routinely treat patients under the billing supervision of another health care provider, this value will typically be 0.
• If a Billing Referral exists, the NPI is compared to the assigned provider to ensure that the NPI's are different.

OR

• Simply perform a reconciliation as described below to add any patient to the total. Please note that this criterion is generally predicated on the concept of a patient whose care has transferred from another physician to you. It's not required that you routinely perform a medication reconciliation on a cross-section of your patients.

To meet the criterion for a patient who satisfies either of the above requirements,

• From the History tab within the patient's EHR tab, right click for a context sensitive menu. Select any item from the menu and review the list (which may not have changed).

Requirement: The provider performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the provider.

Summary of care for patients referred out

To be counted in the total (denominator) for this criterion:

• Patient must be marked as Released from care on the Personal tab.
• On the date of the patient's last visit, there must be a corresponding outgoing referral noted within the Referrals list on then EHR's History tab.

For the patient to then meet the criterion, it's expected that at least one of the procedures below was followed:

• From the Ledger tab, press the Print button. From the resulting Print dialog's Other tab, press the Print button within the Basic patient information group box.
• From the History tab within the patient's EHR tab, press the Export button and choose any CCR item (e.g. CCR Document to file/email).

Requirement: The provider 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% of transitions of care and referrals.