Meaningful Use Audit
Stage 2 2014: Eligible Professionals

Evident has assembled a list of best practice reports and information that should be kept safely (either printed or electronic) for **at least six years** for Meaningful Use auditing purposes. In the event you are audited, please contact Evident immediately for assistance. This auditing report will be used for anyone achieving Stage 2 in Calendar Year 2014. Please note: the statistics report will be used for auditing of objectives that have associated statistics.

Meaningful Use Statistics Report: This report should be printed/electronically stored to contain the reporting period data that was used for attestation. This report will capture all objectives that have measures that contain statistics. This report will need to be retained in detail and in summary formats.

- **Path to Print Report:** Clinic Base Menu > Other Applications and Functions > Word Processing > Ad Hoc Report > **MU Stage II Statistics Report.**
    - Each objective associated with statistics will be listed. Choose the objective from the Eligible Provider list > Choose the attesting facility > Choose the filter for the professional needed to run the report for > Choose Date Range > Choose Calculate > Choose PDF.

The Meaningful Use Report Filters will need to be set up for each Eligible Professional you are reporting to CMS. Each objective that is reported will need to be calculated, saved in PDF format, and retained for records.

Quality Measures Report: In 2014, there will no longer be a separate objective for reporting clinical quality measures (CQMs) as a part of Meaningful Use. It is important to note, however that eligible professionals will still be required to report on clinical quality measures in order to achieve Meaningful Use. Facilities beyond their first year of reporting will be required to electronically submit CQMs. This report should be printed/electronically stored to contain the reporting period data that was used for Attestation. For further information on where these statistics pull from, please review the Data Collected for Quality Measures document.

- **Path to Print Report (Clinic):** Clinic Base Menu > Other Applications and Functions > Word Processing > Ad hoc Report > **Clinic CQM Report.**
- The report can be run to show all or a selection of quality measures. Choose facility > Choose the filter for the professional needed to run the report for > Choose date range > Configure > Select all desired Quality Measures to calculate > back arrow icon > Totals > PDF.

Core Objectives

Clinical Decision Support: Eligible Professionals must attest to having implemented 5 clinical decision support interventions (with 4 of them correlating with Quality Measures) for the entire length of the reporting period. This will be supported by printing/retaining the CDS Alert Configurations that have been enabled as well.

- **Path to enable CDS Alerts** – Clinic Base Menu > Master Selection > Business Office Tables > Table Maintenance > Clinical> **CDS Alert Configuration.**

In addition to the 5 Clinical Decision support interventions, the eligible professional must have enabled the functionality of drug/drug and drug/allergy interaction checking for the entire EHR reporting period.

- **Path to Enable Drug/Drug and Drug/Allergy Interaction Checks**- Clinic Base Menu > Master Selection > Business Office Tables > Table Maintenance > Clinical > Clinical Monitoring (under Prescription Entry header) > **Allergy** and **Drug** tabs.
- **Path to Screen-print Activated/Deactivated Clinical Monitoring Options**- Clinic Base Menu > Master Selection > Business Office Tables > Table Maintenance > Clinical > Clinical Monitoring (under Prescription Entry header) > **View Audit.**

Risk Analysis and Patient Audit Log (Protect Electronic Health Information): Eligible Professionals must attest to having conducted or reviewed a security risk analysis in accordance with the requirements under HIPAA Security Rule 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies prior to or during the reporting period to meet this measure.

- A copy of Security Risk Analysis performed by a facility or a 3rd party, with noted additions, deficiencies and changes will need to be retained for auditing purposes.

Please review ONC's "Guide to Privacy and Security of Health Information" for further information regarding this objective as well as Evident's Security Objective & Measure Roadmap.

Generate list of Patients by Specific Conditions (Patient List with Clinical Data)-Eligible Professionals must attest to having generated at least one report listing patients with a specific condition to meet this measure. This report can be generated at any time during the reporting period.

- **Path to Print Report:** Clinic Base Menu > Other Applications and Functions > Word Processing > Ad Hoc Report > Report Dashboard. (If report is not present on screen, select Add Report.) > **Patient List with Clinical Data.**

Summary Of Care- Measure 3 of the Summary Of Care objective states the following:

An Eligible Professional must satisfy one of the following criteria:

- Conducts one or more electronic exchanges of a summary of care document, as part of Measure 2, with a recipient who has a different EHR technology that was designed by a different EHR technology developer than the sender's EHR technology.
- If eligible professionals cannot exchange a summary of care document with recipients using different CEHRT in common practice, then they may retain documentation on their circumstances and attest "yes" to meeting measure 3 if they have and are using a certified EHR which meets the standards required to send a CCDA - Attestation

Information that should be retained for this objective:

- Documentation that was used in sending a direct message to a facility/provider that was designed by different EHR technology developer than the senders.

  OR

- If eligible professionals cannot exchange a summary of care document with recipients using different CEHRT in common practice, then they may retain documentation on their circumstances and attest "yes" to meeting measure 3 if they have and are using a certified EHR which meets the standards required to send a CCDA.

Implement Drug Formulary Checks (Used with E-scribe Objective): Eligible Professionals must have this functionality enabled and have access to at least one internal or external formulary for the entire reporting period. This will be supported by printing/retaining a copy of the drug coverage screen through electronic prescription entry. Please note: Evident has drug formulary automatically enabled for drug formulary and eligibility through Electronic Prescription (E-scribe) software. Please retain screen shots of this eligibility checking on some patients within your reporting period.

Immunization Registries Data Submission (If state accepts): Eligible Professionals must perform successful ongoing submission of electronic data from Certified EHR Technology (CEHRT) to an immunization registry or immunization information system for the entire EHR reporting period. The transmission of immunization information must use the HL7 2.5.1 Standards.

- If objective is met, then a letter from the state will need to be retained for records.
- If exempt from objective, documentation from state that the state was not ready will need to be retained for records.

Menu Objectives

Submit Syndromic Surveillance Data to public health agencies (If state accepts): Eligible Professionals must perform successful ongoing submission of electronic data from Certified EHR Technology (CEHRT) to a public health agency for the entire EHR reporting period.

- If objective is met, then a letter from the state will need to be retained for records.
- If exempt from objective, documentation from state that the state was not ready will need to be retained for records.

Report Cancer Cases to public health registry (If state accepts): Eligible Professionals must successfully submit ongoing submissions of cancer case information from CEHRT to a public health central cancer registry for the entire reporting period to meet this objective.

- If objective is met, then a letter from the state will need to be retained for records.
- If exempt from objective, documentation from state that the state was not ready will need to be retained for records.

Report specific cases to a specialized registry (other than a cancer registry) (If state accepts): Eligible Professionals must successfully submit specific case information from CEHRT to a specialized registry for the entire reporting period to meet this measure.

- If objective is met, then a letter from the state will need to be retained for records.
- If exempt from objective, documentation from state that the state was not ready will need to be retained for records.

Please contact Evident Software Support if audited or for further information.

Attestation Disclaimer:

Meaningful Use attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. Evident and TruBridge Meaningful Use certified products, recommended processes and supporting documentation are based on Evident's interpretation of the Meaningful Use regulations, technical specifications and vendor specifications provided by CMS, ONC and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, Evident and TruBridge bear no responsibility for attestation information submitted by the client.