

Patient Chart Manager User Meeting Presentation

Presented by
Brandy Mason, Project Manager
David Herrig, Project Manager
train@primeclinical.com

Welcome to our 2017 PCM User Meeting!





PCM Agenda

- Quality Payment Program Overview: MACRA, MIPS, APMs
- MIPS Advancing Care & Medicaid Meaningful Use Objectives
- CQM Reporting in PCM
- EHR Incentive Programs Audits
- Patient Portal: New Features!
- New & Advanced Features!
- Accessing our Tools & Information on our Website!
- > Q & A

DISCLAIMER





Please note that it is ultimately your responsibility to verify and understand the requirements for the *Quality Payment Program* and/or *Meaningful Use* under the *EHR Incentive Program*. Any information provided by Prime Clinical Systems is provided as a courtesy to help utilize the features available within our program. The information outlined in this presentation is, to the best of our knowledge, accurate and current; however, we encourage you to do your due diligence in verifying this information directly from CMS.

EHR Incentive Program:

EHR Information Center: (888) 734-6433

Website: https://www.cms.gov/Regulations-and-

<u>Guidance/Legislation/EHRIncentivePrograms/index.html</u>

Quality Payment Program:

Service Center: (866) 288-8292 or mailto: QPP@cms.hhs.gov

Website: https://qpp.cms.gov/







Quality Payment Program Overview

MACRA, MIPS & APMs



Quality Payment Program



On October 14,2016, the Department of Health and Human Services issued its final rule with comment period for the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA):

- Creating the Quality Payment Program (QPP) to consolidate three existing programs.
- Ending the Sustainable Growth Rate (SGR) formula for determining the Physician Fee Schedule.
- Medicare clinicians have two tracks for participation in QPP:
 - ✓ Advanced Alternative Payment Models (APMs) or
 - ✓ Merit-Based Incentive Payment System (MIPS)

Important Information: This applies to Medicare Part B clinicians only. Medicaid EPs are not affected.



Quality Payment Program - APMs



Alternative Payment Models (APMs) allow Medicare Part B clinicians to earn an incentive payment for participating in an innovative payment model.

- ➤ An **APM** is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care.
 - APMs can apply to a specific clinical condition, a care episode, or a population.
- ➤ **Advanced APMs** are a subset of APMs, and let practices earn more for taking on some risk related to their patient's outcomes.
 - You may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM.
- For performance year 2017, incentive payments will be made in 2019.

For additional information: https://qpp.cms.gov/learn/apms



Quality Payment Program - MIPS



The Merit-Based Incentive Payment System (MIPS) allows Medicare Part B clinicians to earn a performance-based payment adjustment.

- Consolidates three independent programs to work as one and to ease clinician burden.
 - Physician Quality Reporting System (PQRS)
 - Medicare EHR Incentive Program (aka Meaningful Use)
 - Value-Based Modifier
- Adds a fourth component to promote ongoing improvement and innovation to clinical activities.
- Provides clinicians the flexibility to choose the activities and measures that are the most meaningful to their practice to demonstrate performance.

For additional information: https://qpp.cms.gov/

2017 MIPS Performance Categories





Quality

Replaces the **Physician Quality** Reporting System (PQRS)

Most participants: Report up to 6 quality measures, including an outcome or high priority measure, for a minimum of 90 days.

Groups using the web interface: Report 15 quality measures for a full year.

60% of final score (for 2017)

Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 APM or the Oncology Care Model onesided risk APM: Report quality measures through your APM. You do not need to do anything additional for MIPS quality.

Advancing Care Information

Replaces the Medicare EHR Incentive Program, also known as Meaningful Use

PCM is certified to the 2014 edition. You will submit your data using the 2017 Advancing Care Information Transition Objectives and Measures:

- Security Risk Analysis
- e-Prescribing
- Health Information Exchange
- Patient Specific Education
- Medication Reconciliation
- Provide Patient Access
- View, Download, or Transmit (VDT)
- Secure Messaging
- Immunization Registry Reporting
- Syndromic Surveillance Reporting
- Specialized Registry Reporting (not currently available in PCM)

25% of final score (for 2017)

2017 MIPS Performance Categories





Improvement Activities

New Category

In this new performance category for 2017, clinicians are rewarded for care focused on care coordination, beneficiary engagement, and patient safety.

15% of final score (for 2017)

Cost

Replaces the Value Based Modifier **o% of final score** (for 2017) **Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days.

Groups with 15 or fewer participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

No data submission required. Calculated from claims.



Quality Payment Program



Who is Eligible to participate in MIPS?

- ➤ You are part of the Quality Payment Program if you bill more than \$30,000 to Medicare and provide care to more than 100 Medicare patients per year, and are a:
 - Physician
 - Physician Assistant
 - Nurse Practitioner
 - Clinical Nurse Specialist
 - Certified Registered Nurse Anesthetist
- If 2017 is your first year participating in Medicare, then you're not in the MIPS track of the Quality Payment Program.

NOTE: MIPS does not apply to hospitals or facilities.





The Quality Payment Program starts January 1 2017, but offers the flexibility of starting at any time between January 1 and October 2, 2017. For all *Pick Your Pace* participation options:

- ✓ The performance period is between January 1, 2017 and December 31, 2017.
- ✓ Performance data is sent by March 31, 2018 deadline.
- ✓ The first payment adjustments based on performance data are effective January 1, 2019.
- > Providers can report as an **Individual** or as a **Group**.
- Submission options available vary by performance category:
 - EHR Vendor
 - Claims
 - Qualified Clinical Data Registry (QCDR)
 - Qualified Registry
 - CMS Web Interface (for groups of 25+)





- ➤ *Pick Your Pace* in MIPS: If you choose the MIPS path of the Quality Payment Program, you have three options.
 - 1. **Test:** Submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017) to avoid a downward payment adjustment.
 - 2. **Partial:** Submit 90 days of 2017 data to Medicare to earn a neutral or small positive payment adjustment.
 - **Full:** Submit a full year of 2017 data to Medicare to earn a moderate positive payment adjustment.

NOTE: The maximum payment adjustment for MIPS participation in 2017 will be positive or negative 4% in 2019. Based on Final Score, clinicians may be eligible for an exceptional performance bonus.





- -OR-
- Not participating in the Quality Payment Program:
 - If you don't send any 2017 data, then you receive a negative 4% payment adjustment in 2019.
- -OR-
- > Participate in the Advanced APM path:
 - If you receive 25% of Medicare payments or see 20% of your Medicare patients through an APM in 2017, then you earn a 5% incentive payment in 2019.



Reporting as an Individual:

- o If you send MIPS data in as an individual, your payment adjustment will be based on your performance.
- o An individual is defined as a single National Provider Identifier (NPI) tied to a single Taxpayer Identification Number.
- o You'll send your individual data for <u>all</u> MIPS performance categories.

Reporting as a Group:

- o If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance.
- A group is defined as a set of clinicians (identified by their NPIs) sharing a common Taxpayer Identification Number, no matter the specialty or practice site.
- Your group will send in group-level data for <u>all</u> MIPS performance categories.
- o To submit data through the CMS web interface, you must register as a group by June 30, 2017.

2017 Reporting Options



MIPS Data Submission Options

- ➤ You must pick <u>one</u> submission option for each MIPS Category.
- ➤ If clinicians participate as a group, all MIPS performance categories will be reported as a group.

MIPS Category	Individual Reporting	Group Reporting	
Quality	 Qualified Clinical Data Registry (QCDR) Quality Registry EHR Claims 	 QCDR Quality Registry EHR Administrative Claims CMS Web Interface (groups of 25+) CAHPS for MIPS Survey 	
Improvement Activities	AttestationQCDRQualified RegistryEHR Vendor	AttestationQCDRQualified RegistryEHR Vendor	
Advancing Care Information	AttestationQCDRQualified RegistryEHR Vendor	AttestationQCDRQualified RegistryEHR VendorCMS Web Interface	



Medicaid Meaningful Use and Medicare MIPS Advancing Care Measures

Medicare MIPS vs. Medicaid MU





- Medicare MIPS: (2017 Advancing Care Information Transition)
 - Medicare Part B clinicians participating in the MIPS track of the Quality Payment Program will report measures and objectives under the performance category **Advancing Care Information** (which replaces the Medicare EHR Incentive Program).
- Medicaid EHR Incentive Program: (2017 Modified Stage 2)
 - Eligible hospitals and EPs that attest directly to a state Medicaid EHR Incentive Program will continue to attest under the measures and objectives as finalized in the 2015 EHR Incentive Programs Final Rule (Meaningful Use).
 - For all returning & new participants, the reporting period is a minimum of any continuous 90-days between January 1 and December 31, 2017.
 - For 2017 reporting period, the attestation deadline is February 28,2018





For scoring purposes, in the Advancing Care Information performance category, MIPS eligible clinicians may earn a maximum score of up to 155%, but any score above 100% will be capped at 100%. This structure was deliberately created to ensure that clinicians have flexibility to focus on measures that are the most relevant to them and their practices.

The Advancing Care Information score is the combined total of the following three scores:

- Required Base Score (50%)
- Performance Score (up to 90%)
- Bonus Score (up to 15%)



Maximum Score: 50% + 90% + 15% = 155%





How is the Base Score Calculated?

MIPS eligible clinicians need to fulfill the requirements of all the base score measures in order to receive the 50% base score. Failure to meet these measures will result in a base score of **o**% and an Advancing Care Information performance category score of zero.

In order to receive the 50% base score (full credit), MIPS eligible clinicians must submit a "yes" for the security risk analysis measure, and at least a 1 in the numerator for the numerator/denominator of the remaining measures.

The base score 2017 Advancing Care Information transition measures are:

- 1. Security Risk Analysis
- 2. e-Prescribing
- 3. Provide Patient Access
- 4. Health Information Exchange







How is the Performance Score Calculated?

The performance score is calculated by using the numerators and denominators submitted for measures included in the performance score, or for one measure, by the yes or no answer submitted.

The potential total performance score is 90%. For each measure with a numerator/denominator, the percentage score is determined by the performance rate. Most measures are worth a maximum of 10 percentage points, except for two measures reported under the 2017 Transition measures, which are worth up to 20 percentage points.

Performance Rates for Each Measure Worth Up to 10%				
Performance Rate 51-60 = 6%				
Performance Rate 61-70 = 7%				
Performance Rate 71-80 = 8%				
Performance Rate 81-90 = 9%				
Performance Rate 91-100 = 10%				



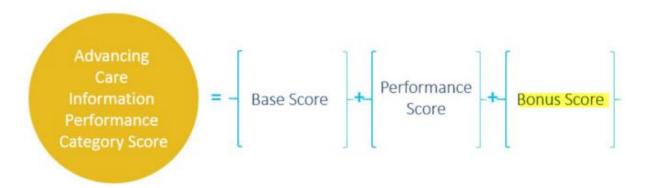




How is the Bonus Score Calculated?

MIPS eligible clinicians can earn bonus percentage points by doing the following:

- ➤ Reporting "yes" to 1 or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure will result in a 5% bonus.
- ➤ Reporting "yes" to the completion of at least 1 of the specified Improvement Activities using CEHRT will result in a 10% bonus.





2017 Objectives for MIPS Advancing Care & Medicaid Meaningful Use



MIPS/MU	Protect Patient Health Information (Security Risk Analysis)*
MU only	Clinical Decision Support Rule
MU only	Computerized Provider Order Entry (CPOE)
MIPS/MU	e-Rx*
MIPS/MU	Health Information Exchange (Summary of Care)*
MIPS/MU	Patient-Specific Education Resources
MIPS/MU	Medication Reconciliation
MIPS/MU	Provide Patient Access (Patient Portal)*
MIPS/MU	Secure Electronic Messaging
MIPS/MU	Public Health Reporting

^{*} Required Measure for MIPS Advancing Care Information Base Score





Objective	Description
MU and MIPS *MIPS Required Measure	Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the
Protect Patient Health Information (Security Risk)	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
YES/NO	security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.
	Exclusion: No exclusion.

- This measure must be complete at least <u>once</u> during your attestation period.
- ➤ PCS has provided Security Risk templates for your practice to complete and keep on file to complete this measure.
- ➤ Templates can be found on our website, <u>www.primeclinical.com</u> > *Meaningful Use /QPP Tools* > *Meaningful Use/QPP*.





Objective: Protect Patient Health Information

Security Risk Templates

- 1. Administrative Safeguard Checklist
- 2. Physical Safeguard Checklist
- 3. Risk Analysis
- 4. Technical Safeguard Checklist
- ▶ Before you conduct your first Security Risk, please review our document "How to Conduct a Security Risk". This document will assist you with completing the templates.
- We also have another document available, "Sanction Policy" which can assist you with implementing an In-House policy within your organization.
- Once you have completed the Security Risk templates, you have met this measures. When attesting, mark YES.
- NEW! Downloadable ONC Security Risk Assessment Tool to guide you through the assessment process.
- There is not an exclusion for this measure.





Objective	Description
MU Only	In order for EPs to meet the objective they must
Clinical Decision Support YES / NO	satisfy both of the following measures: 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.

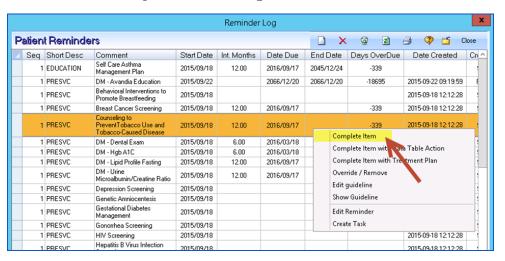




Objective: Clinical Decision Support

Workflow has not changed for this Objective.

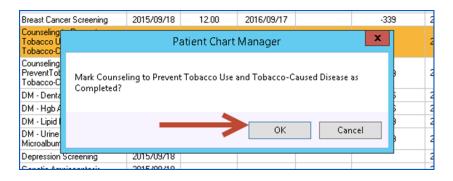
- Setup is required before you implement this measure in PCM.
- Please refer to our online documentation found on our website, <u>www.primeclinical.com</u> > Meaningful Use/QPP Tools > Meaningful Use/QPP.
- For a patient that meets the criteria within the guideline, the Preventive Service/guideline will be added to their list of reminders.
- Open the Patient's Reminders to review the intervention.
- Right Click on the row to *Show Guideline*.
- From the same menu, you can complete the item







Objective: Clinical Decision Support



- Once you have marked the item complete, the item will automatically update in the *Patient Data Tables > Prev Services Hx* as Completed.
- Now there is a record that you have completed a Clinical Decision Support Rule for a patient.
- When attesting, mark YES.

Prev Services Hx							
DATE	PROVINIT	TOPIC	STATUS	NOTES	COMPLETED BY	DATE COMPLETED	REASON
10/14/2015	SMS180	Counseling to Prevent Tobacco Use and Tobacco-Caused Disease	Completed		SMS180	10/14/2015	
11/5/2014	SMS180	Breast Cancer Screening	Completed		SMS180	11/05/2014	





Objective	Description	
MU Only	An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures	
Computerized	for this objective.	
Provider Order		
Entry	Measure 1: More than 60% of medication orders created by the EP during the EHR reporting period are recorded using	
CPOE	CPOE.	
	Exclusion 1: Any EP who writes fewer than 100 medication	
60% Med Orders	orders during the EHR reporting period.	
30% Lab Orders		
30% Radiology	Measure 2: More than 30% of laboratory orders created by the	
Orders	EP during the EHR reporting period are recorded using CPOE. Exclusion 2: Any EP who writes fewer than 100 lab orders during the EHR reporting period.	
	Measure 3: More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE. Exclusion 3: Any EP who writes fewer than 100 radiology orders during the EHR reporting period.	





Objective: Computerized Provider Order Entry (CPOE)

Workflow has not changed for this Objective.

- Setup is required before you implement this measure in PCM.
- Please refer to our online documentation found on our website, <u>www.primeclinical.com</u> > Meaningful Use/QPP Tools > Meaningful Use/QPP.

How is a CPOE Medication Order Created in PCM?

• Medications that are Seq 1. Any prescription that is generated using the Prescription Writer module; this can be a prescription that is Printed, Phoned, Faxed OR sent electronically.

How is a CPOE Laboratory Order Created in PCM?

- a) Use the Order Entry screen from the patient's Req Log
- b) Use the 'Apply Orders' option from within a pen document
- c) Apply the LAB Order from the Treatment Plan within the note
- d) Use Requisition Documents that have been flagged as LAB Type
- e) *Use a LAB Order form scanned in SCAN/FAX/PDF and flagged as a Lab Type Doc *This will add patient to the denominator, but NOT the numerator!*





Objective: Computerized Provider Order Entry (CPOE)

What is a CPOE Radiology Order in PCM?

- a) Use the Order Entry screen from the patient's Req Log
- b) Use the 'Apply Orders' option from within a pen document
- c) Apply the Radiology Order from the Treatment Plan within the note
- d) Use Requisition Documents that have been flagged as Xray Type
- e) *Use a Radiology Order form scanned in SCAN/FAX/PDF and flagged as a X-ray Type Doc.

 This will add patient to the denominator, but NOT the numerator!
- When attesting, you will be required to enter the denominator & numerator for each passing measure.
- Exclusion: Any EPs who writes fewer than 100 medication, radiology, or laboratory orders during the EHR reporting period.





Objective	Description	
MU and MIPS *MIPS Required Measure	Measure: More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are	
E-Rx	queried for a drug formulary and transmitted electronically using CEHRT.	
MU Requirement: 50%	MU Exclusion: Any EP who: (1) Writes fewer than 100 permissible prescriptions during	
MIPS Base Score: 1 patient	the EHR reporting period. (2) Any EP who 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.	

DENOMINATOR: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.

NUMERATOR: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.

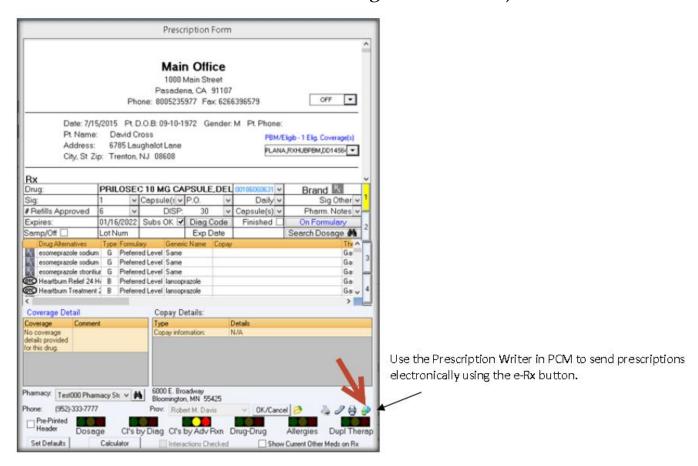
THRESHOLD: The resulting percentage must be more than 50 percent in order for an EP to meet this measure.





Objective: Electronic Prescribing (eRx)

Workflow has not changed for this Objective.



Please refer to our online documentation found on our website, <u>www.primeclinical.com</u> > *Meaningful Use/QPP Tools* > *Meaningful Use/QPP*.





Objective	Description
MU and MIPS *MIPS Required Measure Health Information Exchange MU Requirement	 Measure: The EP that transitions or refers their patient to another setting of care or provider of care must: 1. Use CEHRT to create a summary of care record; and 2. Electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals.
10% MIPS Base Score 1 Patient	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.
Eligible for MIPS Performance Score Up to 20%	

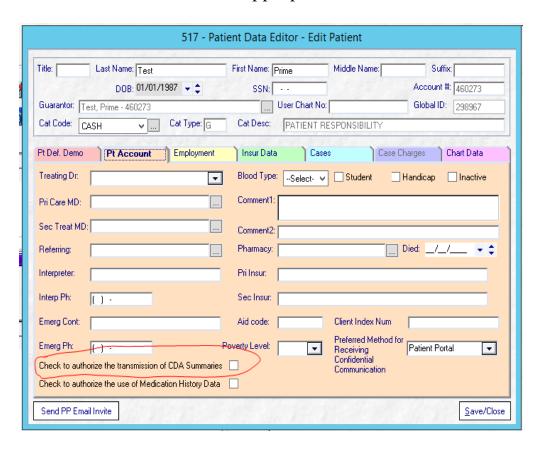
- Please refer to our online documentation found on our website,
 www.primeclinical.com > Meaningful Use/QPP Tools > Meaningful Use/QPP.
- You must transmit the summary of care record via direct messaging.





Objective: Health Information Exchange (HIE)

• IMPORTANT: EACH PATIENT SHOULD BE PROVIDED WITH A CONSENT FORM which allows them to opt out of this type of sharing. If the patient choses to opt out, make sure to un-check the appropriate check box field.



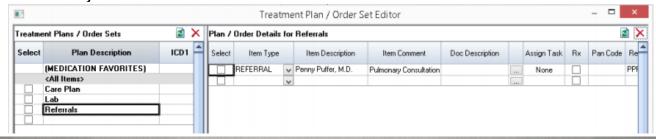




Objective: Health Information Exchange (HIE)

Providers must use a Treatment Plan to receive credit for this Objective.

- Setup is required before you implement this measure in PCM.
- Please refer to our online documentation found on our website, www.primeclinical.com
- Use the Treatment Plan and apply the Item Type REFERRAL to perform all Transitions of Care
- To ensure that MU Credit is given, the following fields must have the most recent data recorded (cannot be blank) prior to performing the Transition of Care:
 - Allergies, Problems and Meds
 - Demographics: Patient name, Sex, Date of birth, Race & Ethnicity and Preferred language
- 1. Open the Treatment Plan
- 2. Select the Item Type REFERRAL
- 3. Select a referring provider for the patient by clicking on the Item Description of the REFERRAL Treatment Plan
- 4. Use the Treatment Plan Item comment to enter a reason for the referral, for example; Pulmonary Consult







Objective	Description
MU and MIPS Patient-Specific Education Resources	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.
MU Requirement: 10% Eligible for MIPS Performance Score Up to 10%	Exclusion: Any EP who has no office visits during the EHR reporting period.

- Please refer to our online documentation found on our website, <u>www.primeclinical.com</u> > *Meaningful Use/QPP Tools* > *Meaningful Use/QPP*.
- In order for the patient to be added to the denominator count, the patient must have been checked in using the Daily Appointment List AND the appointment type must be set to generate a super bill.
- An encounter log entry plus an appointment for the same day of the encounter entry is required because the denominator counts the number of unique patients with office visits seen by the EP during the EHR reporting period.





Objective: Patient Specific Education

Workflow has not changed for this Objective

Use any of the following options for Education Resources:

- ➤ Option 1: Use the Use the Medline Plus button available Diagnosis, Procedures, Medications, HL7 Lab Results, and Lab Orders Requisition Screen OR any of the available right-click "Search With..." menu options from the same locations, but Medline plus is the preferred option
- Option 2: Apply an EDUCATION Type Treatment Plan
- ➤ **Option 3:** Use EDUCATION Type Preventive Services

The education resources information does not have to be stored in the chart, the educational resources may be provided to the patients in a useful format (such as, electronic copy, printed copy, electronic link to source materials, through a patient portal, etc...)





Objective	Description
MU and MIPS	Measure: The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the
Medication	patient is transitioned into the care of the EP.
Reconciliation	
MU Requirement: 50%	Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period.
Eligible for MIPS Performance Score Up to 10%	

• Please refer to our online documentation found on our website, <u>www.primeclinical.com</u> > *Meaningful Use/QPP Tools* > *Meaningful Use/QPP*.



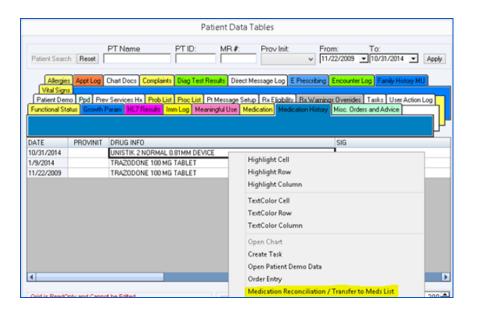


Objective: Medication Reconciliation

Workflow has not changed for this Objective

A. From the Medication History data table:

- After opening the Data Tables from within the patient's chart, Click on Medication History
- 2. Close the disclaimer
- Right click on a medication row and choose the Medication Reconciliation option
- 4. Complete the Medication Reconciliation

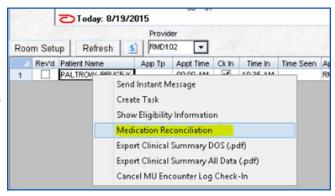




Objective: Medication Reconciliation

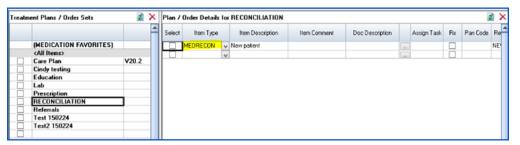
B. From the Daily Appointment Screen:

- 1. Check the patient in
- 2. Right click on the patient's name
- 3. Choose the Medication Reconciliation option
- 4. Complete the Medication Reconciliation



C. When Applying a Treatment Plan:

- 1. Open the patient's chart
- 2. From the Req Log/Order Entry OR using the Treatment Plan within a text document
- 3. Apply a Treatment Plan using the Item Type of MEDRECON



Note: The Medication Reconciliation Form will not open, this is just a way for the provider to indicate the medications were reviewed and Reconciliation was performed





Objective	Description
MU and MIPS *MIPS Required Measure (1) Provide Patient	Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.
Access / View, Download, Transmit(VDT)	Measure 1 Exclusion: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."
MU Requirement: Measure 1: 50% Measure 2: 5% (CHANGED)	Measure 2: For an EHR reporting period 5% of all unique patients seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.
MIPS Base Score: 1 patient (Measure 1)	Measure Exclusion 2: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information"; or
Eligible for MIPS Performance Score Up to 20% (1) Up to 10% (2)	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 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

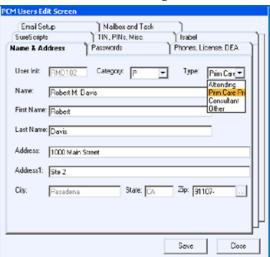
- ➤ Encounter, Final Diagnosis, and Complete CCD must be generated within 4 business days of check-in.
- ➤ Patient must be invited or opted out before, or within 4 business days of check-in.



Objective: Provide Patient Access/View, Download, Transmit (VDT)

I. Initial Setup

- Review all of your PCM users and ensure all of the information is completely entered for each one.
- Note: This is required for populating the Care Team Members in the CDA documents.
- 1. Log in as the PCM ADMIN user
- 2. Review/Edit each user and make sure that the following information is completely updated:
 - User Type:
 - ✓ **Providers**: Attending, Primary Care, Consultant or Other
 - ✓ **T-User**: Resident, Nurse Practitioner, Physician Assistant, Other
 - ✓ **Other Users**: Nurse, Medical Assistant or Other
 - ➤ User Name, Address and Phone Number (Add the following fields):
 - ✓ First Name
 - ✓ Last Name
 - ✓ Address, City, State, Zip
 - ✓ Phone





Objective: Provide Patient Access/View, Download, Transmit (VDT)

Measure 1: Complete CCD (including Encounter and Final Diagnosis) and sending invitation/proper opt-out.

An encounter AND an associated diagnosis must be entered prior to generating CCD documents

The following options are available for creating an encounter; this will add the patient to the denominator:

- When the patient is checked in for an Appointment (appt. type must be set to create a superbill)
- Using the %Diagnosis% place holder in text documents to select an encounter diagnosis (there will be an option to create an encounter, if one does not already exist)
- Using the \$ Charge Entry Screen, New Charge Ticket Option

The following options are available for adding a final diagnosis to the encounter:

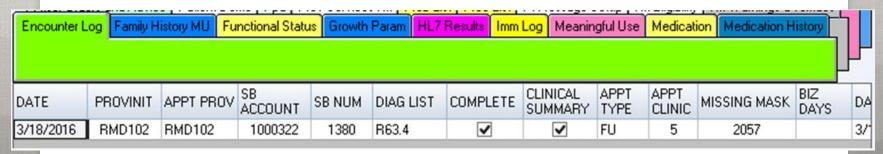
- Using the %Diagnosis% place holder in text documents to select the encounter diagnosis
- While in pen or text document edit mode, from the Patient Data menu, using the Final Diagnosis table to select the encounter diagnosis
- Using the Charge Entry screen to select the encounter diagnosis (there is no need to actually send the charges)



PCM Workflow

PCM Workflow/Measure 1: All patients from the denominator count who have access to patient portal, or who have been sent an invitation within the 4 days of the visit AND have an encounter with an associated diagnosis and a complete CCD within the reporting period will be added to the numerator.

- Verify that an encounter and diagnosis encounter exists for each patient visit and that the fields for patient demographics (DOB, sex, race, ethnicity, language) current problem list, current medication list, and current medication allergy list are not blank and include the most recent information for each patient visit.
- If any of this information is missing, Meaningful Use credit will NOT be given.



Note: This is how patients are added to the denominator for measures where the patient is seen by the EP.



Objective: Provide Patient Access/View, Download, Transmit (VDT)

When an entry is created in the encounter log, it will include the following information:

- ✓ Appointment Provider
- ✓ Responsible Provider
- ✓ Encounter Diagnosis
- ✓ <u>Complete</u> checkbox will be checked if PCM Charge Posting was used
- ✓ <u>Clinical Summary</u> checkbox will be checked if a Summary was printed on check out
- ✓ <u>BIZ Days-</u> if blank means, the Clinical Summary was generated on the day of the visit, next business day will have a 1, then 2, etc....
- ✓ <u>Missing Mask</u> should be blank, if a code is present, this means that required MU information was missing at the time the Clinical Summary was generated.

For example, if Missing Mask column has:

- 2057; Drug Allergy and Patient Gender data is missing (2056 + 1 = 2057)
- 2088; Drug Allergy and Medication List is missing (2056+ 32 = 2088)

Code	Missing (The stored number is the sum of the missing data code(s)					
1	patient Gender					
2	patient DOB					
4	patient Race					
8	patient Ethnicity					
16	patient Language					
32	Medication List					
2056	Drug Allergy					
16448	Problem List					
32896	Missing Smoking Status					



Objective: Provide Patient Access/View, Download, Transmit (VDT)

Required Information Prior to Generating CCDs

- All of the <u>CMS required information below</u> must be present for the Numerator to populate:
 - ✓ Allergies, Problems and Medications, Smoking Status
 - ✓ Demographics → Patient name, sex, DOB, race & ethnicity, preferred language.
- If an encounter and diagnosis is not available, the fields in the CCD will display "No Encounters, Not Applicable".
- CCD will display either "<u>No Known Drug Allergies</u>", "<u>No Known Problems</u>", "<u>No Medications Taken</u>"; specifically indicating the patient was asked and this entry was made.
- If the patient was not asked and the information is missing "<u>Data Not Recorded</u>" will display in the Summary instead.



Objective: Provide Patient Access/View, Download, Transmit (VDT)

The following Tables show in the CCD by default, if the information is not recorded prior to generating the CCD "Data Not Recorded" will be displayed.

•	Medications	•	Immunizations
•	Allergies and Adverse Reactions	•	Procedures
•	Problem List	•	Test Results
•	Vital Signs	•	Social History
•	Care Plan	•	Cognitive and Functional Status
•	Chief Complaint and Reason for Visit	•	Reason for Referral



Objective: Provide Patient Access/View, Download, Transmit (VDT)

Excluding Tables from FHR

- ➤ Per CMS documentation, the provider may withhold from online disclosure any information the provider determines could cause possible harm.
- There is an option in Patient Data Tables to exclude certain tables from FHR, which excludes data on the Summary, but must still show the heading with the following, "Data Excluded from Formal Health Record".

Note: If the tables are excluded, as long as the information has been entered in the system and the data exists at the time of generating the Summary, the CDA will count towards MU.

- ➤ The following tables can be excluded:
 - Allergies
 - Medications
 - Problem List
 - Encounter Log
 - Misc Orders and Advice excludes the Plan of Care section
 - Vital Signs table Vitals/Social History (Smoking Status) are stored in the same table, if the Vital Signs table is excluded, the user generating the Clinical Summary will get a prompt with options to exclude Vitals and/or Social History (smoking)
 - Diagnostic test results- Diagnostic Test/ Reason for Referral are stored in the same table, if the Diagnostic Test Results table is excluded, the user generating the Clinical Summary will get a prompt with options to exclude Diagnostic tests and/or Reason for Referrals



Objective: Provide Patient Access/View, Download, Transmit (VDT)

Patient Opt-Out Option

- Per CMS: For **Measure 1**, patient health information needs to be made available to each patient for view, download, and transmit within **4 business days** of the information being available to the provider for each and **every time** that information is generated whether the patient has been "enrolled" for three months or for three years.
- If a patient elects to "opt out" of participation, that patient must still be included in the denominator.
- If a patient elects to "opt out" of participation, the provider may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access their information, obtain access through a patient-authorized representative, or otherwise opt-back-in without further follow up action required by the provider.



Objective: Provide Patient Access/View, Download, Transmit (VDT)

If the patient opts-out of this objective.....

Please Note the following:

- The patient will not be added to the numerator for Measure 2 because Measure 2 requires that the patient actually logs in to View, Download or Transmit.
- ➤ When the opt-out option for email address is used, the Preferred Method for Receiving Communication cannot be set to e-mail.
- The Opt Out option should ONLY be used when the patient actually opts-out, this option is not to be used as quick way to increase the numerator or to replace the requirement for providing electronic access for each patient, remember that CMS randomly audits and the proper documentation must exist.

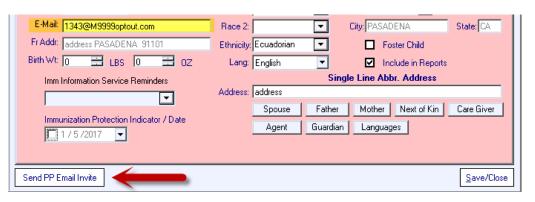


Objective: Provide Patient Access/View, Download, Transmit (VDT)

PCM Workflow

In the Registration packet, we recommend information about Patient Electronic Access/Patient Portal is included for each patient and that a copy of information is filed in the chart, for <u>audit protection</u>.

- In the Patient Data Editor, right click on the email address field and choose the optout option.
- 2. The patient's **GlobalID@practiceacctnumoptout.com** will automatically be entered as their e-mail address; this entry will serve as an indicator of the patient opting out.
- 3. Click on the "Send PP Email Invite" button, as long as the rest of the required criteria for this objective is met the patient will be added to the numerator.

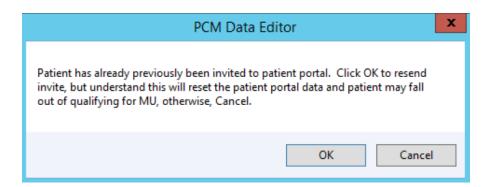




Objective: Provide Patient Access/View, Download, Transmit (VDT)

Please Note the following:

- After clicking on the "Send PP Email Invite" button, in PCM you will get "Database Updated", but an email is not actually sent anywhere; the database will just be updated as if the patient was invited.
- After sending the PP Invite, the Date Invited gets updated in the database for each patient.
- If a patient is re-invited, a warning message comes up, because the re-invite may remove the patient out of the MU eligibility (each time the patient is invited the Date Invited gets updated to today's date)





Objective: Provide Patient Access/View, Download, Transmit (VDT)

- ➤ This workflow serves as indication of the effort being made to provide the patient with the information and that an invite for Patient Electronic Access was attempted.
- ➤ To get a list of patients who have opted out and have been invited, you can create a Patient Control Report, for a List of patients with email containing "optout".



Or log on to Patient Portal as an administrator and search Sent Invitations for "optout".

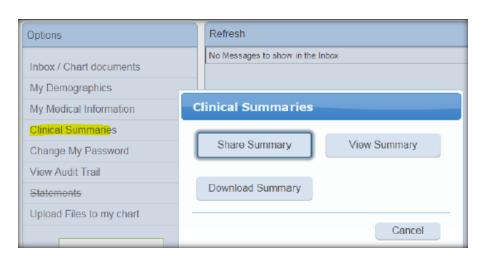




Objective: Provide Patient Access/View, Download, Transmit (VDT)

PCM Workflow/Measure 2: All patients from the denominator count who log into their patient portal account and use the Clinical Summaries options to either share, view or download their summary within the reporting period will be added to the numerator:

- When the patient uses either one of the following options, the Clinical Summary will be generated in real time.
- The Clinical Summary will show the currently available data, if data is not currently available it will have "Data not Recorded" in the Clinical Summary where the information is missing.







Objective	Description	
MU and MIPS	Measure: For an EHR reporting period in 2017, for at least 5% of all unique patients seen by the EP during the EHR	
Secure Electronic Messaging	reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a	
MU Requirement: 5% (CHANGED)	secure message sent by the patient (or the patient authorized representative) during the EHR reporting period.	
Eligible for MIPS Performance Score: Up to 10%	Exclusion: No exclusion.	

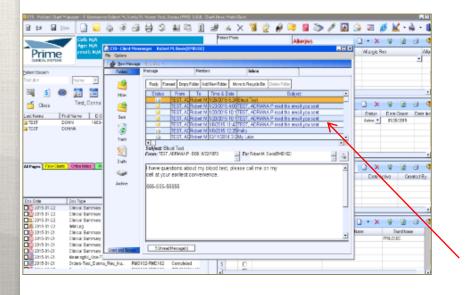
• Please refer to our online documentation found on our website, www.primeclinical.com > Meaningful Use/QPP. Tools > Meaningful Use/QPP.

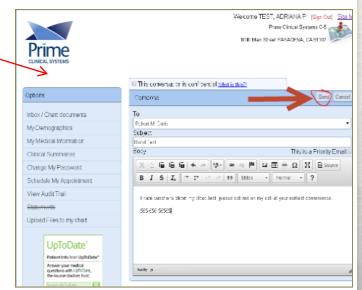




Workflow has not changed for this Objective

Patients can email out of their Portal to their provider from this window.



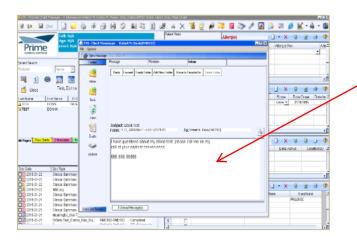


When the provider logs into PCM, they will see pending emails in their PCM Messenger.



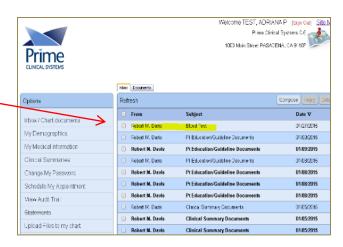


Objective: Secure Messaging



- The provider can respond to the patient and the email response will return to the patient's portal.
- The patient will receive an email notice there has been activity in their portal account.

Pending email response in patients portal account.







Objective	Description		
MU and MIPS	Measure Option 1 – Immunization Registry Reporting:		
Public Health Reporting	The EP is in active engagement with a public health agency to submit immunization data.		
MU Requirement: Two options	Measure Option 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data.		
MIPS Performance Score: o or 10% (Immunizations)	Measure Option 3 – Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized registry. Note: Specialized Registry Reporting is currently not available in PCM.		
MIPS Bonus Score: 5% (Syndromic Surveillance)			

• Please refer to our online documentation found on our website, www.primeclinical.com > Meaningful Use/QPP. Tools > Meaningful Use/QPP.





Objective: Public Health Reporting

Workflow has not changed for this Objective

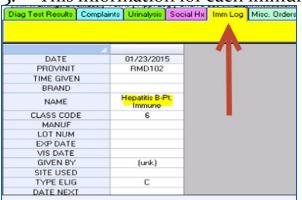
Measure Option 1: Immunization Registry Reporting

- Registration and Setup is required prior to implementing this measure in PCM.
- Please refer to our website to be directed to your county to find out what immunization registry your office needs to register with.
- All vaccines and immunizations need to be maintained and updated in PCM by your office. We have documentation on how to keep this information updated online at www.primeclinical.com > Training Tools > New Client Intellect & PCM > Additional Features > Vaccine Setup in PCM.

Workflow in PCM

- 1. All Immunization must be entered in the Imm Log in the Patient Data Tables.
- 2. After all necessary information is documented, there will be a pop up indicating the information is being exported via HL7 to the Immunization Registries.

3. This information for each immunization given is stored on your server.









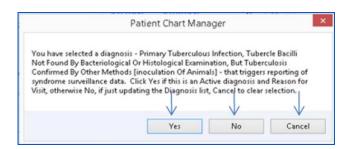
Objective: Public Health ReportingWorkflow has not changed for this Objective

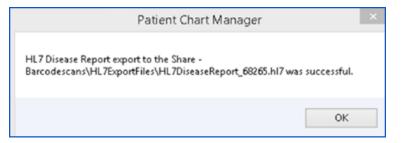
Measure Option 2: Syndromic Surveillance Reporting

Reporting of syndrome surveillance data:

After adding a quarantinable and communicable disease diagnosis to the patients' Problem List, you will get a message indicating that you have selected a diagnosis that triggers reporting of syndrome surveillance data. The message will have three options;

- 1. Yes: Indicates this is an active diagnosis and will create an HL7 Disease Report which is exported to a specific location on your server.
- 2. No: Indicates you are simply updating their diagnosis list but it is not an active problem, this will add the diagnosis to their problem list but will not create the HI7 export document.
- 3. Cancel: to clear the selection and choose a different problem





After clicking on Yes, if the export was successful, the following confirmation message comes up.



Replaces Physician Quality Reporting System (PQRS)



CQMs & MIPS Quality Measures



When the MACRA created the Quality Payment Program (QPP), the Physician Quality Reporting System (PQRS) was replaced with the MIPS performance category for Quality. For 2017:

- Performance Period: January 1 2017 December 2017
- **Submission Deadline:** Based on submission method

Submission Methods:

- **EHR Reporting:** Report Clinical Quality Measures (CQMs) through NQF Module in PCM before the submission deadline.
- ➤ Claims: (for individuals only) Submit claims-based reporting of Quality Data Codes (QDC) through Intellect.
- ➤ **Registries:** The registry collects data for the performance period from the individual or group clinicians and submits the data to CMS on behalf of the clinicians prior to the submissions deadline. There are two types of registries:
 - Qualified Clinical Data Registry (QCDR)
 - Qualified Registry
- **CMS Web Interface:** (for groups of 25+) The Web Interface is a secure Internet-based application available for pre-registered groups of more than 25 clinicians. NOTE: Determine if your clinicians will be reporting as an individual or group before selecting the reporting method, since some submission methods may not be available.

IMPORTANT: Per CMS, 'states will continue to determine the form and manner of reporting CQMs for their respective state Medicaid EHR Incentive Programs subject to CMS approval.'





If you choose to report your 2017 MIPS Quality Measures through Patient Chart Manager, you need to know the following:

- The Quality category will be 60% of the Final Score for MIPS.
- Most participants must report up to 6 measures, including one outcome measure or one high priority measure.
- ➤ Patient Chart Manager was Certified in 2015 for 9 CQMs
- There are 53 Quality Measures approved for EHR reporting.
- ➤ If a clinician wishes to report on a CQM not on the list of Certified CQMs in PCM, they have the option of reporting with a registry or submiting claims-based quality data codes to meet the 2017 MIPS Quality performance category requirements.
- All Quality Measures must be reported through a single submission method.



NQF Measures Available in PCM



Quality ID	CMS ID	NQF	Measure Title	Description
066	146	0002	Appropriate Testing for Children with Pharyngitis	Percentage of children 3- 18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.
236	165	0018	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.
238	156	0022	Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications



NQF Measures Available in PCM



Quality ID	CMS ID	NQF	Measure Title	Description
N/A	126	0036	Use of Appropriate Medications for Asthma	Percentage of patients 5- 64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.
312	166	0052	Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain Xray, MRI, CT scan) within 28 days of the diagnosis.
001	122	0059	Diabetes: Hemoglobin Aıc Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
119	134	0062	Diabetes: Medical Attention for Nephropathy	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.



NQF Measures Available in PCM



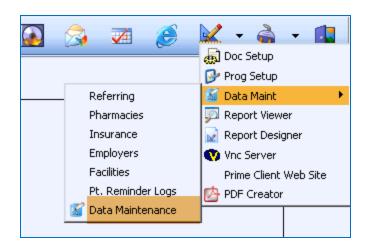
Quality ID	CMS ID	NQF	Measure Title	Description
N/A	163	0064	Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dL)	Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled.
128	69	0421	Preventive Care and Screening: Body Mass Index (BMI) Screening & Follow Up Plan	Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.

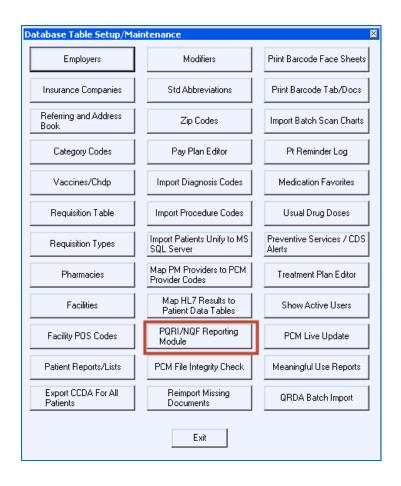
- Please note that running reports using the NQF Reporting Module will not generate instant reports, the time it will take to show results will vary depending on the amount of data in the database.
- You can submit a request for a report, close the screen and perform other PCM tasks, the report will continue to run, it may take hours, or days to complete.





Accessing NQF Module

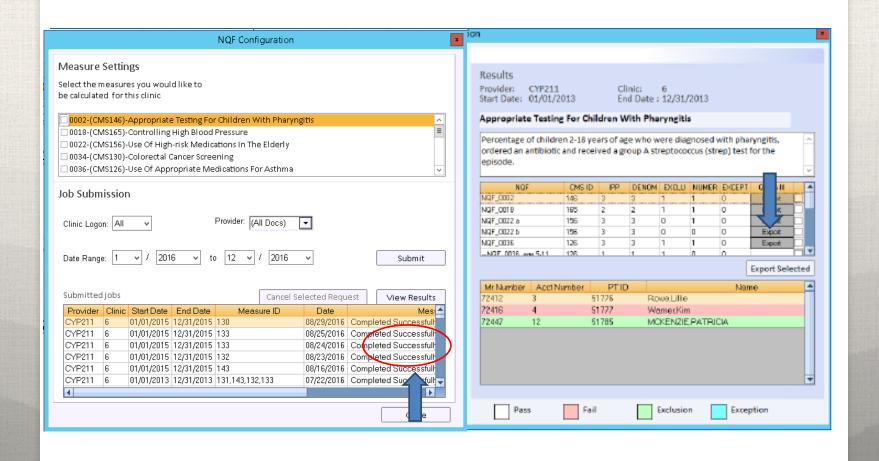








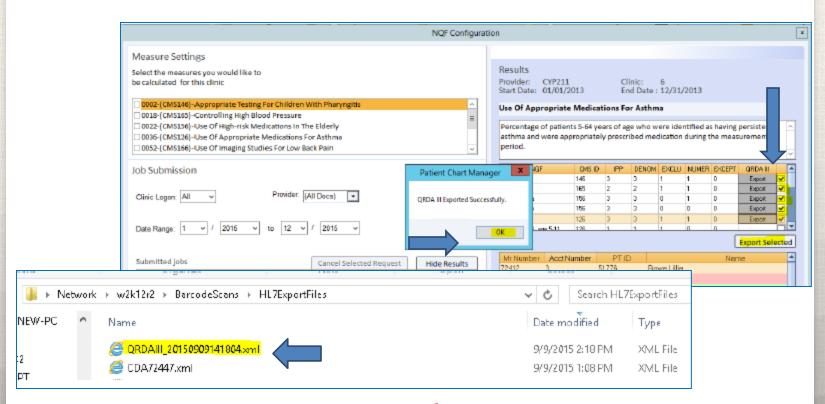
Viewing Results







Exporting Results



For Registry Submissions:

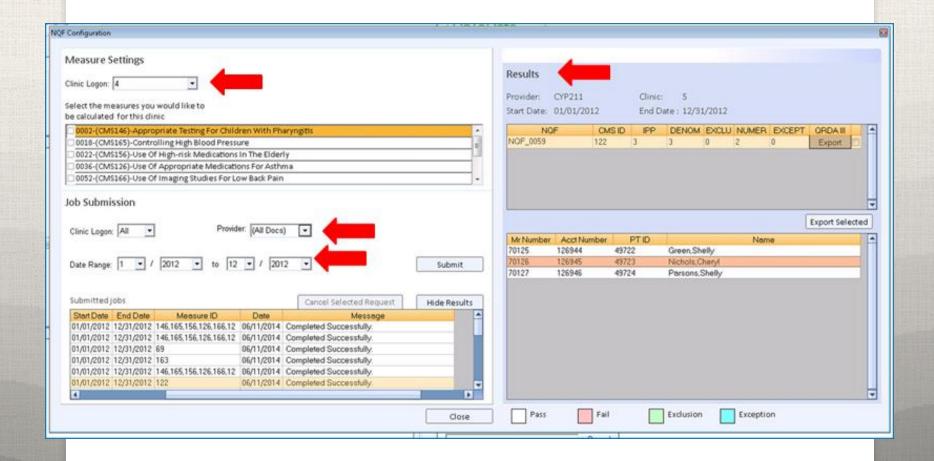
CMS has not yet published the approved list of Qualified Registries and QCDRs for MIPS under the Quality Payment Program.

For more information: https://qpp.cms.gov/resources/education





Below is an example of the NQF module in PCM. You will be able to select all your NQF measures and export them as well from one location.









EHR Incentive Programs Audits

An EP attesting to receive an incentive payment for either the Medicare or Medicaid EHR Incentive Program may be subject to an audit.

- > Types of Audits:
 - Pre-Payment Audit
 - Post-Payment Audit
- Audit Process:
 - All Documentation to support attestation data for meaningful use objective and clinical quality measures should be retained for six years post-attestation per CMS.
- Medicaid providers can contact their State Medicaid Agency for more information about audits for Medicaid EHR Incentive Program payments.
 - Information is currently not available on their website.





EHR Incentive Programs Audits

Audit Appeals

- CMS does have an appeals process for EPs that participate in the Medicare EHR Incentive Program.
- Providers may contact the EHR Information Center at 888-734-6433
 between 9am 5pm EST Monday through Friday.
- Providers that participate in the Medicaid EHR Incentive Program, you will need to contact your State Medicaid Agency for more information about the appeals process.





EHR Incentive Programs Audits

Prime Clinical MU Audit Assistance

- PCS does provide assistance for Meaningful Audits.
- For additional information, please contact Marty at <u>Marty@primeclinical.com</u>.
- Include all of your contact information.

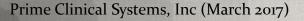






15 minutes!!





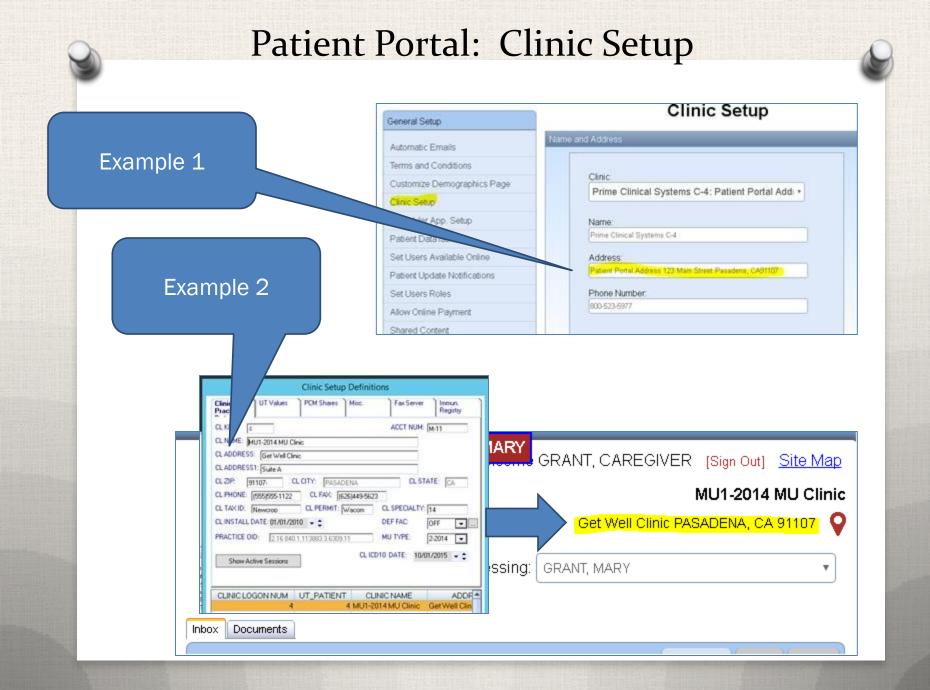


Patient Portal: Clinic Setup



Clinic Address Setup

- General Setup:
 - If the Clinic Setup address is left blank, the default address the patients will see is from Clinic Setup (which is added in Intellect) See Example 1.
 - If you want patients to see a separate address when they log into Patient Portal, you can add a separate address in the *Patient Portal Clinic Setup*. See Example 2.
 - Patients will see that address instead because some clients want a separate address to display other than the Clinic address.

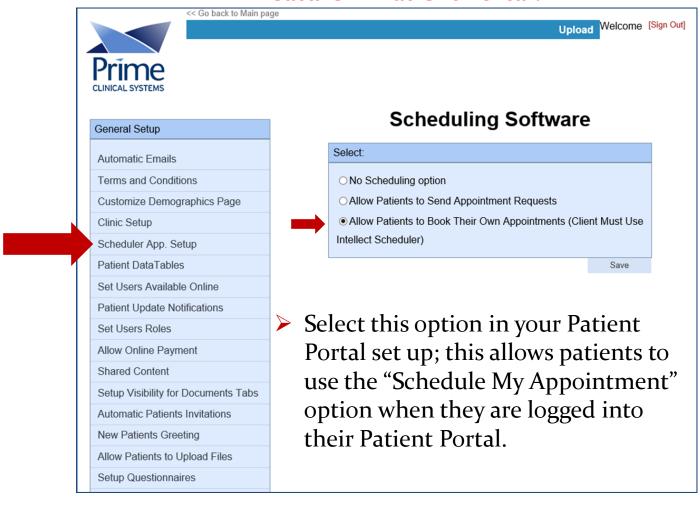




Patient Portal: Scheduler Appointment Setup



Set up is required in Intellect prior to use of this feature in Patient Portal.





New Features in Patient Portal



➤ After clicking on "Schedule My Appointment", the patient makes the appropriate selections for their requested appointment in this screen:





New Features in Patient Portal



<< Go back to Main page

Site Map[Sign Out]



Request an Appointment

Mon 01-18-2016	Tue 01-19-2016	Wed 01-20-2016	Thr 01-21-2016	Fri 01-22-2016
MD. DAVIS				
7:00 AM	07:00 AM	07:00 AM	07:00 AM	07:00 AM
7:15 AM	07:15 AM	07:15 AM	07:15 AM	07:15 AM
07:30 AM				
07:45 AM				
08:00 AM				
08:15 AM				
08:30 AM	08:30.AM	08:30 AM	08:30 AM	08:30 AM
08:45 AM				
09:00 AM				
09:15 AM				
09:30 AM				
09-45 AM	09-45 AM	109:45 AM	09:45 AM	09:45 AM



New Features in Patient Portal



- The patient will receive a confirmation in Patient Portal of their appointment.
- Any changes to their appointment will have to be made by calling your office.

<< Go back to Main page

Site Map[Sign Out]



Request an Appointment

Thank you for using our online scheduling system.

Your appointment is scheduled as shown below.

Please call our office to make any changes to this appointment.

Date: 01-18-2016 09:00 AM Doctor: MD. ROBERT M DAVIS, MD

Facility: facility name





HL7 Interfaces



An HL7 interface allows lab reports, hospital reports, transcription, etc. to automatically file into PCM.

HL7 Interfaces





An HL7 interface...

- ➤ Is a method to electronically receive data from labs, hospitals, transcription companies, etc.
- ➤ Allows the reports to automatically file into PCM (abnormal results go to the Abnormal Inbox as well).
- Provides a way to import lab results directly into text notes, as well as graph results.

HL7 Interfaces

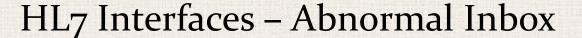




If you have existing HL7 interfaces...

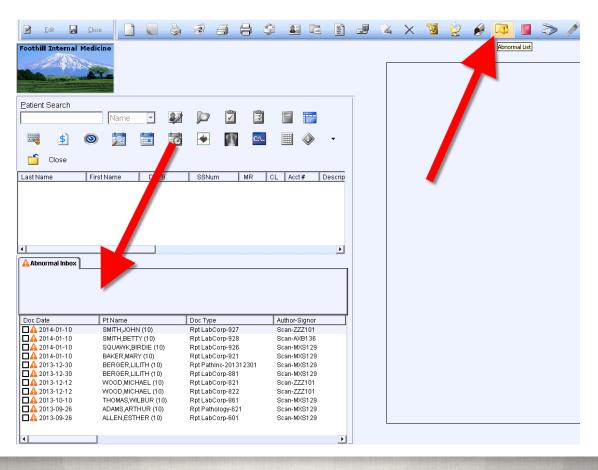
➤ Please have your staff contact our Support Dept if reports rarely auto-file to charts or if you stop receiving reports.

- If you'd like to setup an interface with a lab, hospital, etc...
 - o Please have your Rep from the lab, hospital, etc reach out to our Sales Department: Marty Beteta at marty@primeclinical.com or 626-449-1705 Ext 222.





When results come in via an HL7 interface, they will automatically go to the Abnormal Inbox if the facility they came from flagged them as abnormal. The Abnormal Inbox is a central location your staff can check for abnormal results.

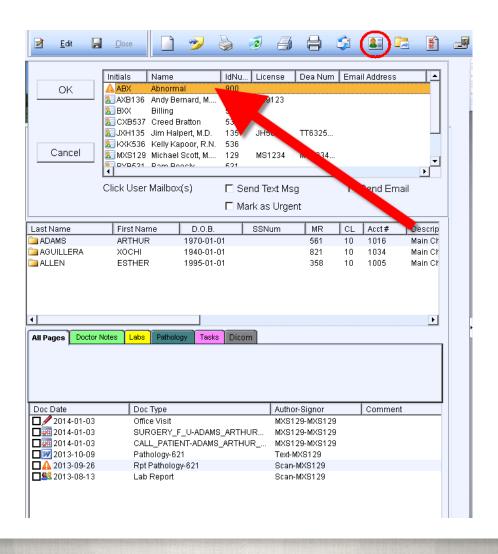


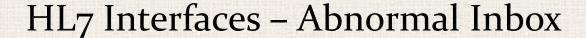


HL7 Interfaces – Abnormal Inbox



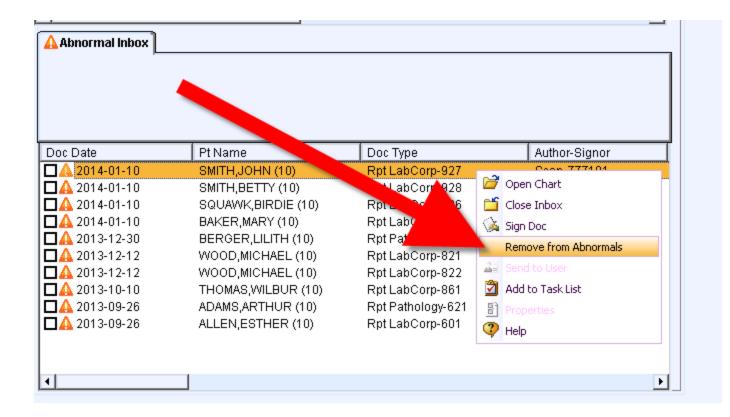
You can also manually send documents to the Abnormal Inbox.

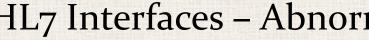


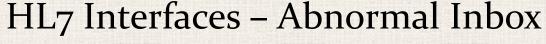




With appropriate user permissions, the results can be manually removed from the Abnormal Inbox.

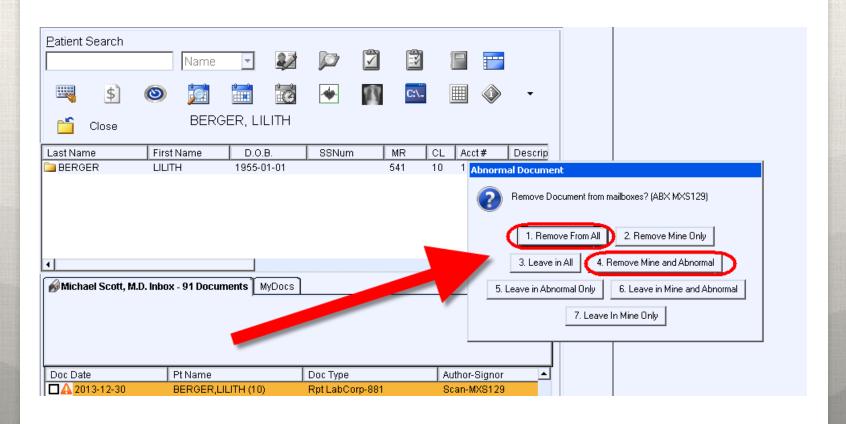


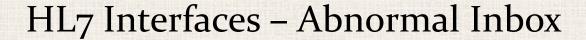






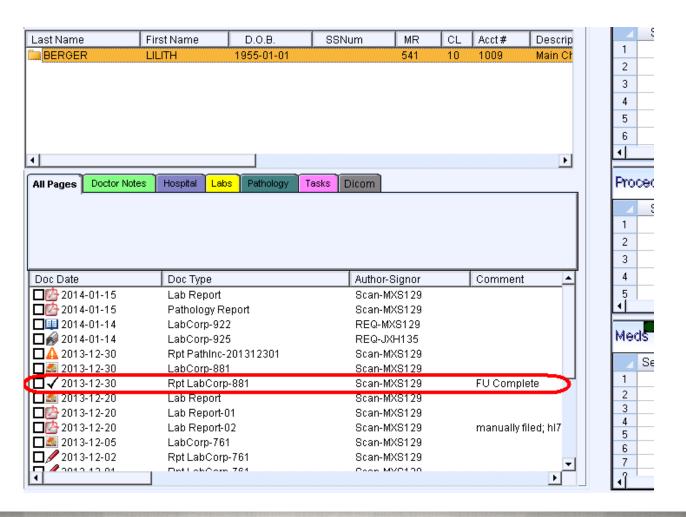
Results can be automatically removed from the Abnormal Inbox when signing.







Once removed from the Abnormal Inbox, the document in the chart displays 'FU Complete' in the Comment.

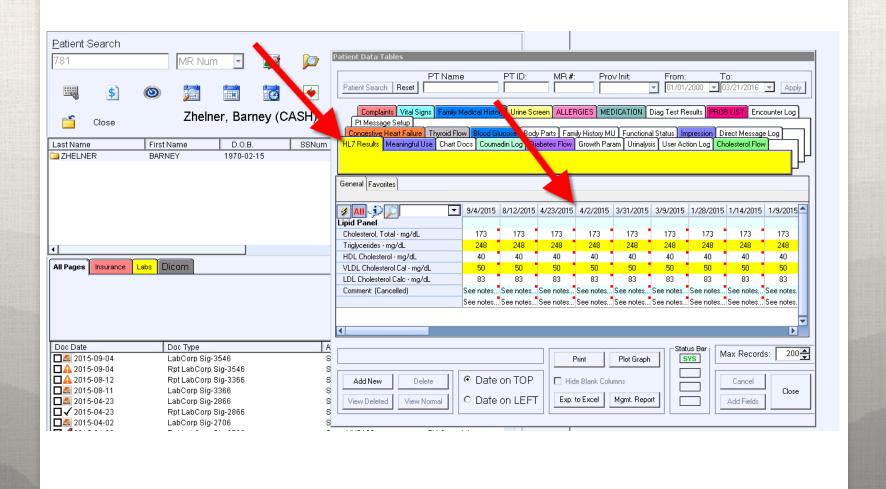




HL7 Interfaces – Data Tables



Results automatically display in the HL7 Results data table.

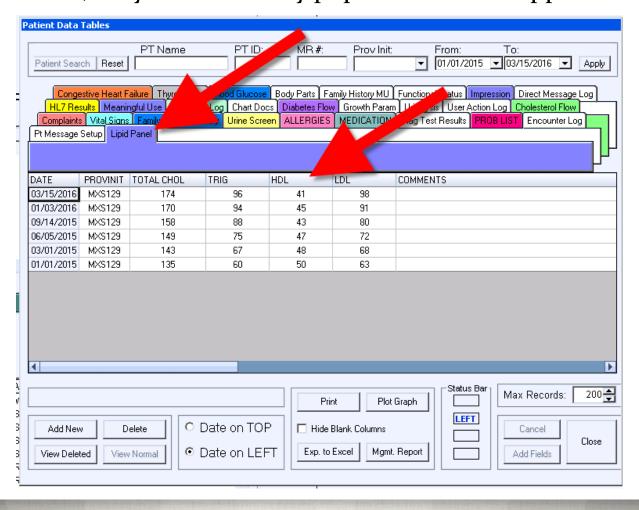




HL7 Interfaces – Data Tables



Results can also be mapped to custom data tables. When results are received, they automatically populate in the mapped table.





HL7 Interfaces – Data Tables



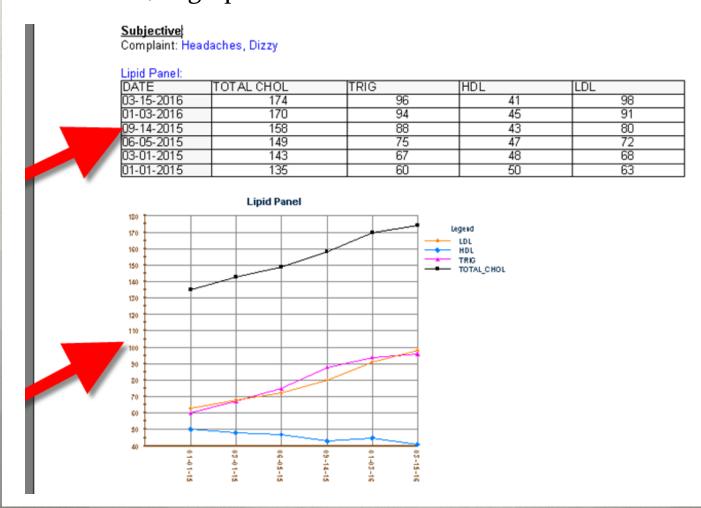
Results can be graphed from the HL7 Results data table as well as the custom data table.

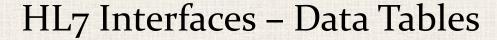






Results can also be automatically imported into text notes as data tables and/or graphs...









Mapping results to custom data tables is done through the Data Maintenance Menu in PCM.

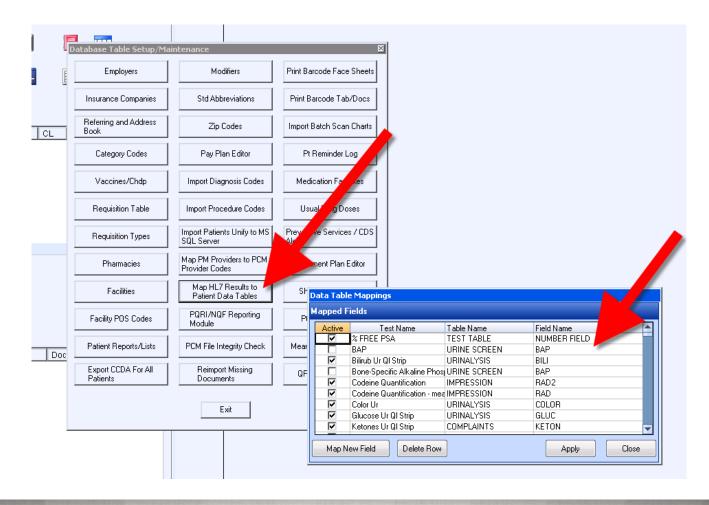






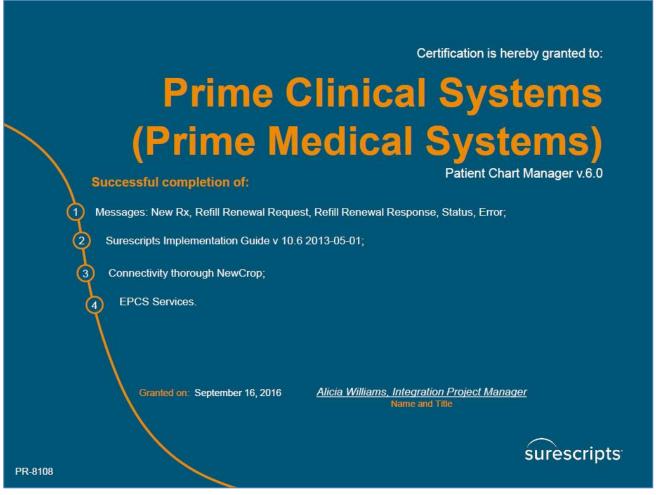


Table of Contents

- ➤ EPCS: Electronic Prescription of Controlled Substances
- Task Manager Updates
 - ✓ Column Sort Order
 - ✓ Patient Search Option
 - ✓ Create New Accounts
 - ✓ Create New Charts
- Patient Signature Capture
- ➤ Automatically Create Charts in PCM when a new account is created in Intellect
- Show Updated Patient Eligibility Information in Daily Appointment List & Eligibility Patient Data Table
- HIE Submission via PCM













On September 16, 2016, EPCS Certification through SureScripts was granted to Prime Clinical Systems Patient Chart Manager v.6.0 for connectivity through NewCrop.

EPCS provides practitioners with the option of sending prescriptions for controlled substances electronically.

Identity Proofing (IDP) must be completed by all existing providers before being able to send EPCS. Credentialing is not required for existing providers.

➤ IDP (Identity proofing): This is done by UIS, Verizon's Universal Identity Service; this process verifies your identity and confirms that you are who you say you are, be sure and enter your personal information and address, not your practice information at the time of registration.





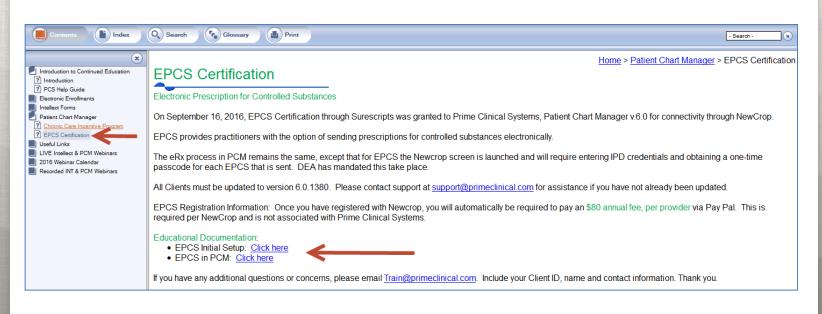
- ➤ Credentialing: This is done by NewCrop after the IDP is done. This process involves sending an email to NewCrop (providerverification@NewCroprx.com) with specific information that was used during the UIS process, along with copies of your Medical license, DEA, NPI, and State ID such as driver's license, for NewCrop to verify your credentials. Upon completion, you will receive a confirming text message. NewCrop will inform PCS that you may now transmit prescriptions electronically.
- ➤ The DEA has mandated this process.
- ➤ Fee: \$80 annual licensing fee per provider, paid to Newcrop via PayPal when you register. Note: Fee is not associated with Prime Clinical Systems.





To Get Started....

- 1. PCM must be updated to version .1381. Contact PCM support at support@primeclinical.com and request an update if needed.
- 2. Read and register for EPCS. Please refer to *EPCS Initial Setup*.
- 3. Once setup is completed, refer to *EPCS in PCM* for Workflow on step by step process of completing EPCS in PCM.
- 4. Written documentation from line item 2 & 3 is found on our website www.primeclinical.com > Training Tools > Continuing Education > Patient Chart Manager > EPCS Certification.

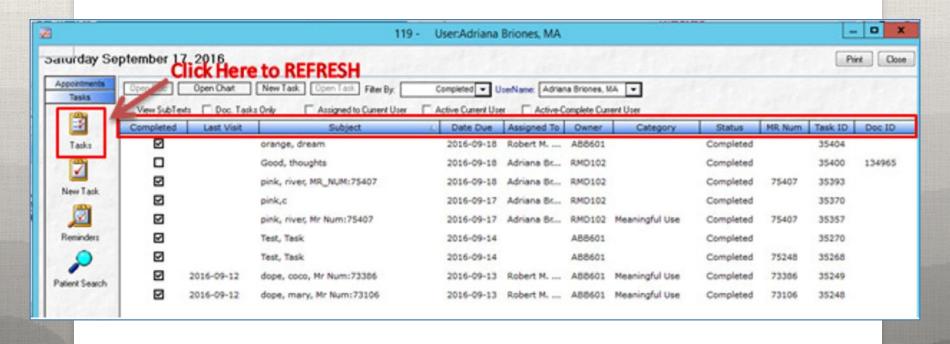






A. Column Sort Order:

- 1. When sorting the task manager columns, the order will no longer be refreshed on closing the Task Manager.
- 2. Refreshing of the list is required after making certain changes to the task list, such as adding a new task, or updating an existing task, but the refresh is intended to only update those changes and not to refresh the column sort order.







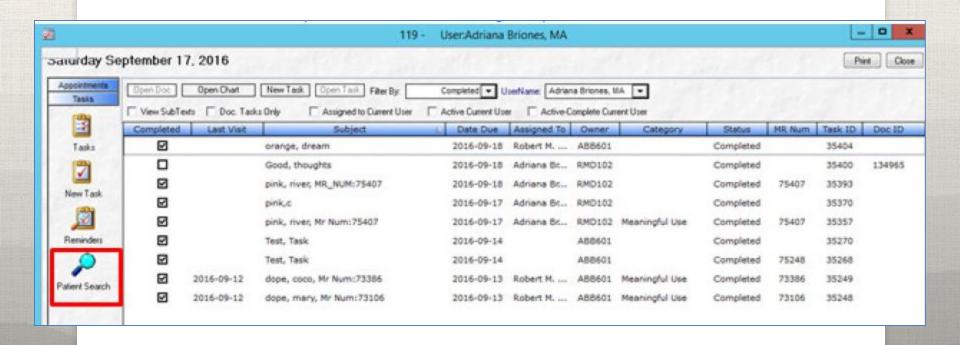
- 3. If you notice a change of the task is not being refreshed correctly, you can manually refresh the Task list by clicking on the Tasks button, but please be sure to notify support as well, so that we may address and fix the issue.
 - a) The Default sort order is by Task ID
 - b) All columns are sortable
 - To refresh the order after sorting any of the columns, click on the "Tasks" icon on the left
 - d) The column sort order will also refresh after logging off/logging back on to PCM





B. Patient Search Option:

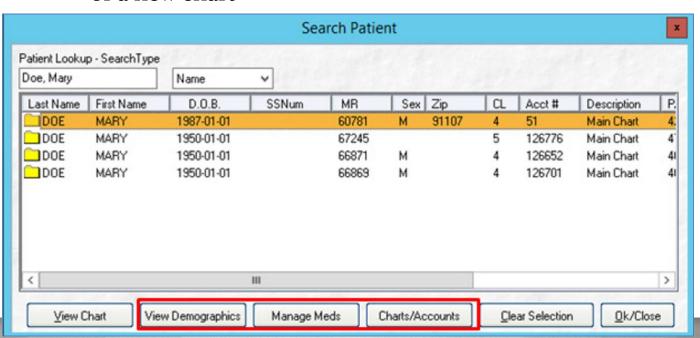
- 1. There is a new **Patient Search** option.
- 2. This button brings up the Search Patient Screen.







- 3. In the Search patient, search for and select a patient, then use the options;
 - **a) View Demographics**: allows for viewing or updating demographics for the selected patient
 - **b) Manage Meds**: option brings up the selected patient's Medication Pane, this allows for writing new prescriptions or refills directly from the patient's Medication Pane.
 - c) Charts/Accounts: option allows you to create a new account or a new chart







C. Create New Charts or Accounts from Task Manager

There is a new option that allows you to create a new chart or a new account from the Task Manager if one is not found.

Create a New Account

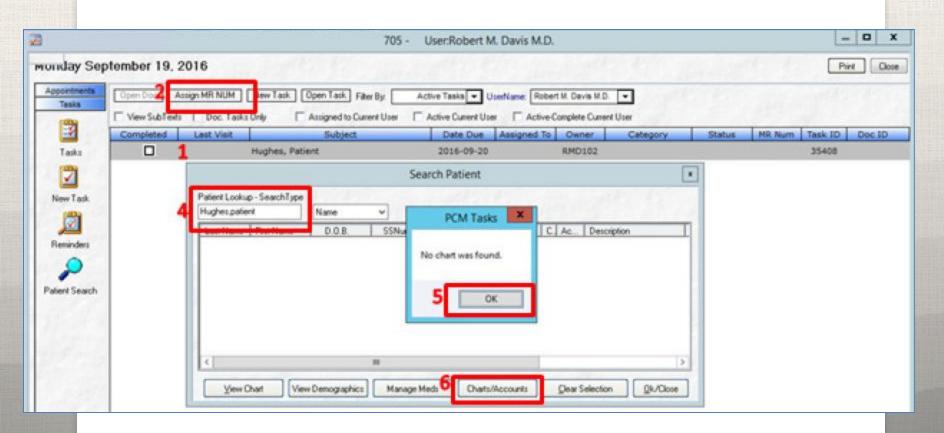
Workflow: when an account does not yet exist.

- 1. Select the Task
- 2. Click on the Assign MR NUM button
 - Note: you can also edit the task and click on the MR NUM filed while in Task edit mode
- 3. The Search Patient Screen comes up
- 4. In Patient Lookup, type the patient's name and hit <enter>Search; this will search for an existing patient chart.
 - ➤ Note: When selecting a Pharmacy Refill Request task, the patient's name will automatically populate in the Patient Lookup field





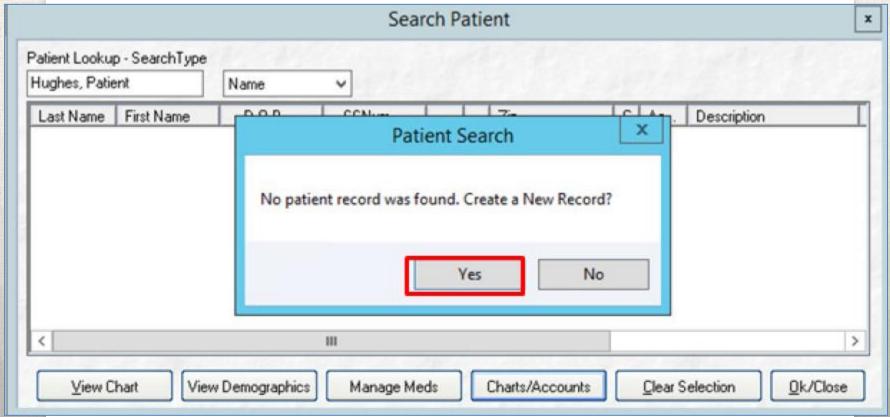
- 5. Click on Ok to the "No Chart was found" pop up
- 6. Click on the Charts/Accounts button, the Search Patient screen that comes up will search for the patient account







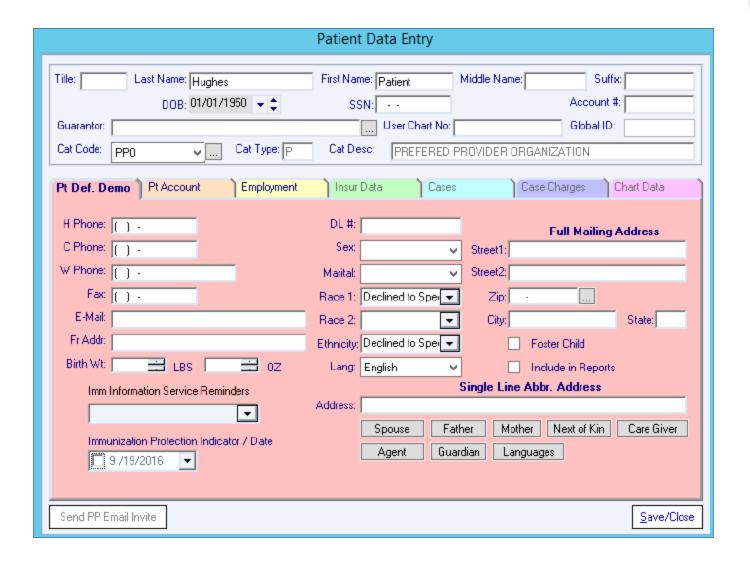
7. Click on Yes to the following option:



- 8. The Patient Data Entry screen comes up, complete the info
- 9. Click on Save/Close and proceed with new account creation



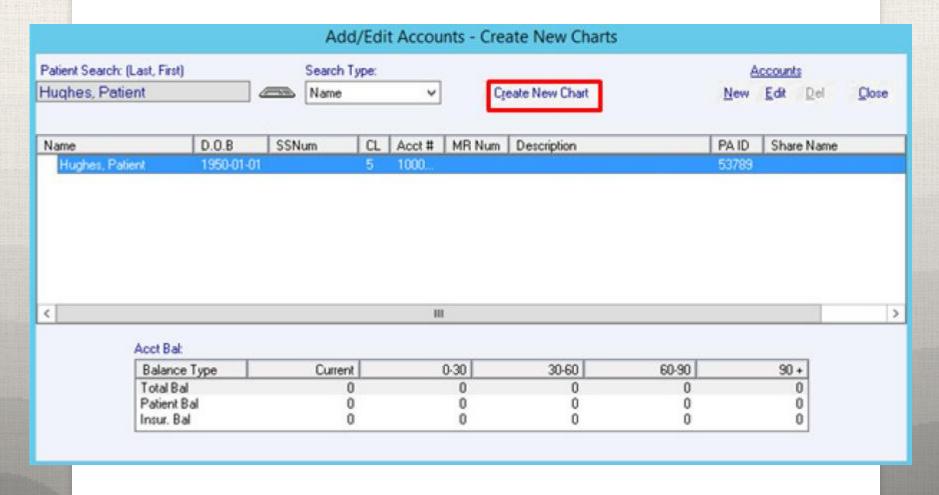








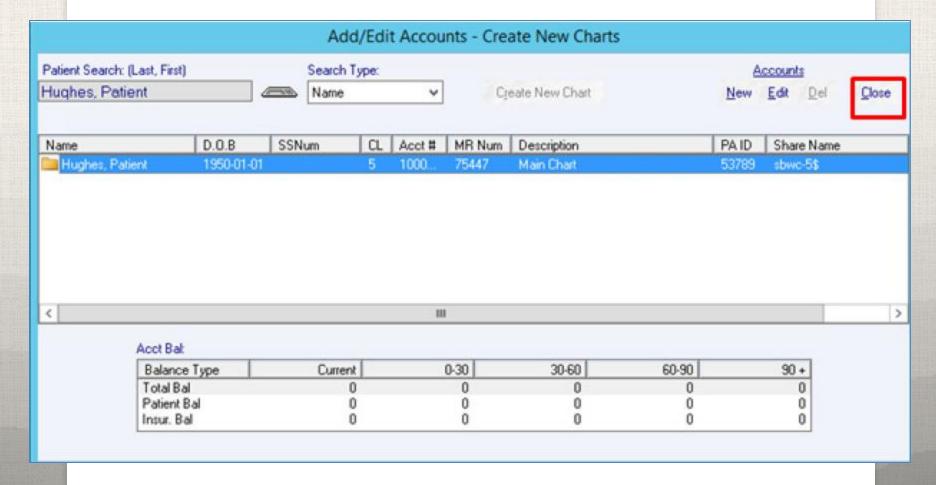
10. In the following screen, Click on the "Create New Chart" option, proceed with the Chart Creation







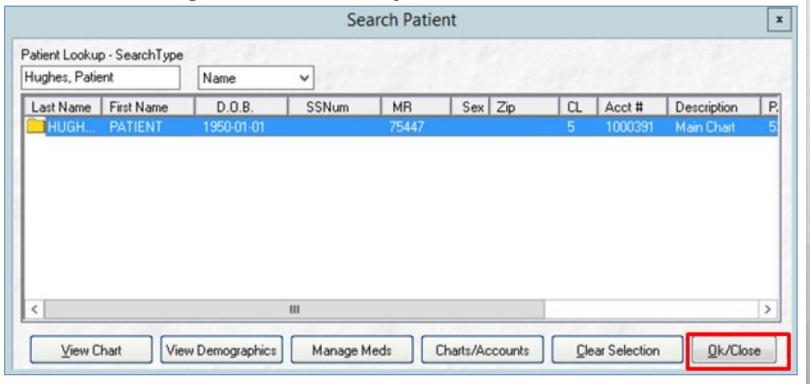
11. Once the chart is created, Click on Close



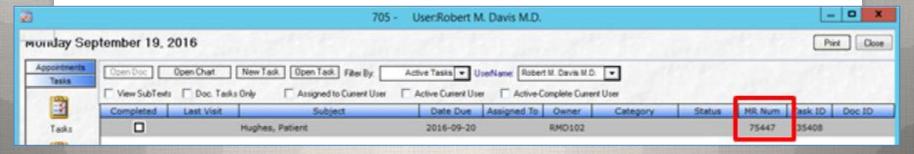




12. Select the patient if not already selected, then click on OK/Close.



13. The MR NUM is assigned to the task.







Create a New Chart

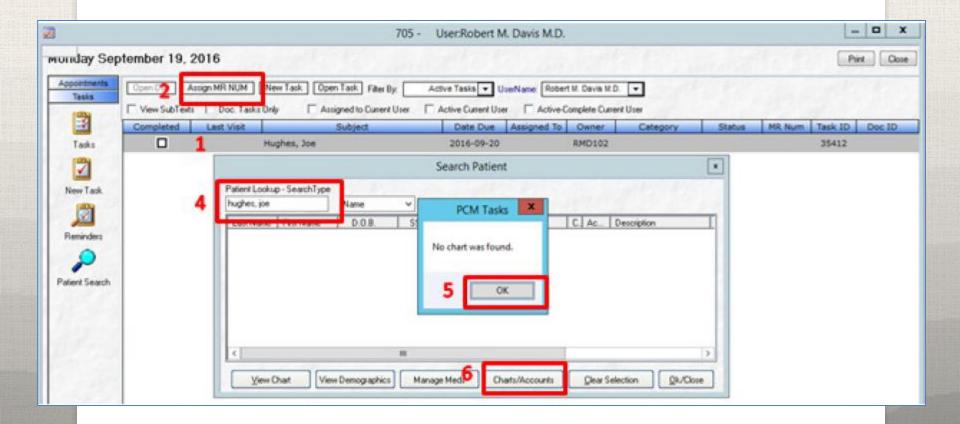
Workflow: when an account exists, but not a chart

- 1. Select the Task
- 2. Click on the Assign MR NUM button
 - ➤ Note: you can also edit the task and click on the MR NUM filed while in Task edit mode
- 3. The Search Patient Screen comes up
- 4. In Patient Lookup, type the patient's name and hit <enter> Search; this will search for an existing patient chart.
 - ➤ Note: When selecting a Pharmacy Refill Request task, the patient's name will automatically populate in the Patient Lookup field
- 5. Click on Ok to the "No Chart was found" pop up





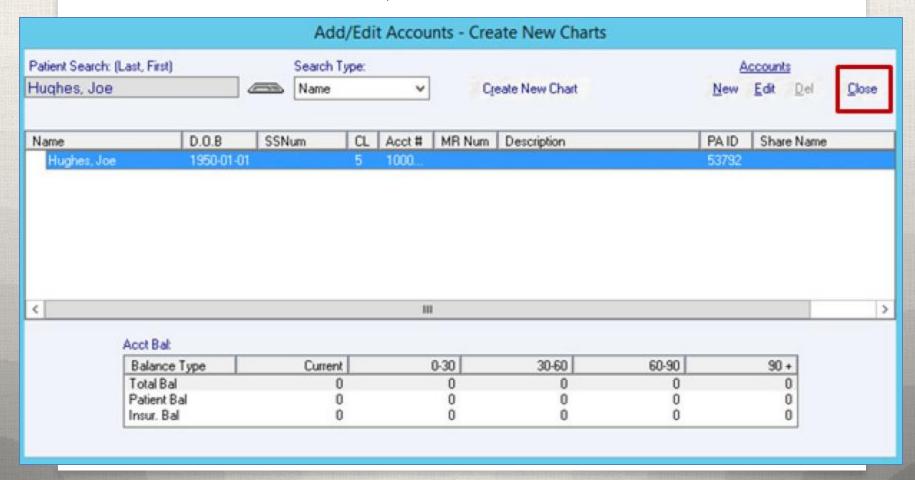
6. Click on the Charts/Accounts button, the Search Patient screen that comes up will search for the patient account



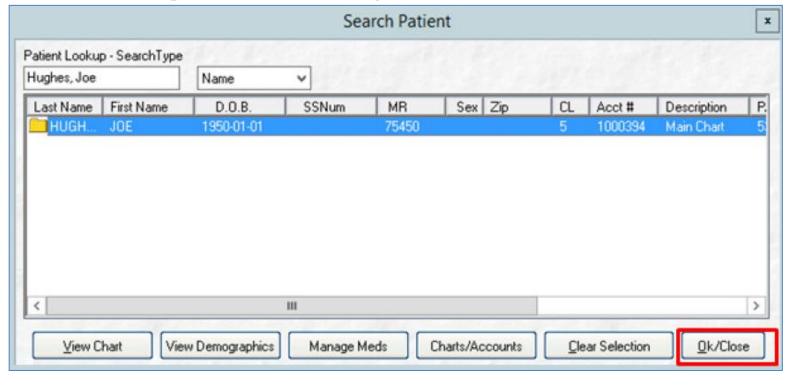




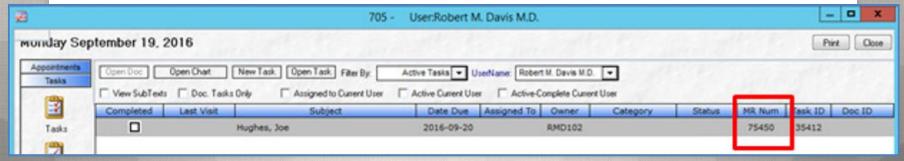
- 7. In the following screen, select the patient (if not already selected) then Click on the "Create New Chart" option, proceed with the Chart Creation
- 8. Once the chart is created, Click on Close



9. Select the patient if not already selected, then click on OK/Close



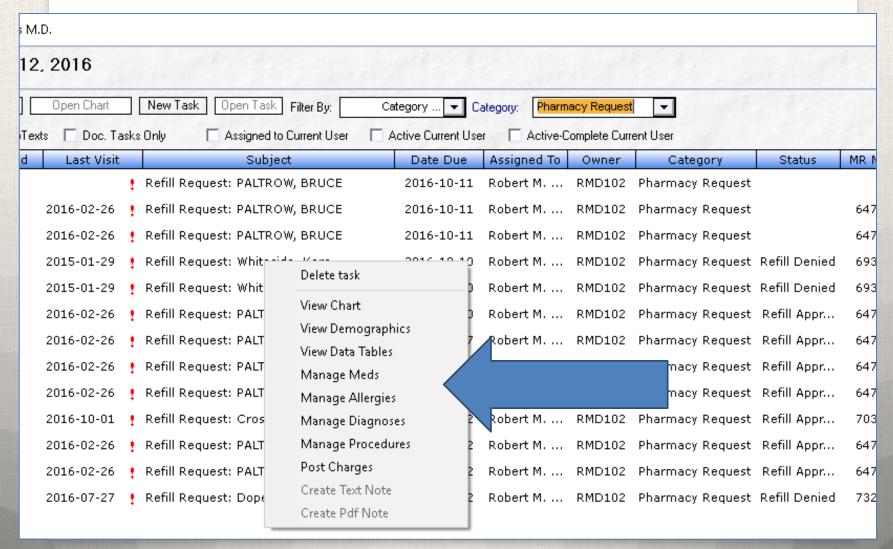
10. The MR NUM is assigned to the task







New Right Click Menu has been added.



Patient Signature Capture





- This new feature can be used with PDF, PEN, and TEXT type documents that are Univ, AllUser, NOSIG, or REQ type.
- Signatures can be captured using Topaz Signature Pad or tablet/touchscreen computer.
- You can capture more than one patient signature on a document.
- > The patient's guarantor name and the date/time will show below the patient signature.
- > Patient's name will show if guarantor for the patient does not exist.
- Once the patient signs and the document is saved, their signature cannot be manipulated or deleted.

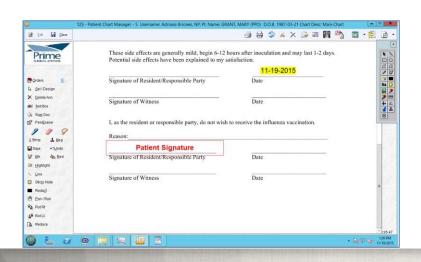






Chart Creation



Automatically Create Charts in PCM when a new account is created in Intellect

- ➤ There is a new Parameter option "Create PCM Chart" in Intellect with this option enabled; a chart is automatically created in PCM anytime a new account is created in Intellect.
 - The option is clinic specific and is disabled by default.
 - To enable the option, log into Intellect, from the main toolbar, go to *Utility* → *Set Up* → *Parameter* → *Modify*, the option is located on the bottom left, it is called "Create PCM Chart", simply select the Yes option and click on Modify to save the changes.
 - When the option is enabled, only charts for new accounts will be created, not for any of the accounts that were already existing prior to the option being turned on.
 - An Intellect update is required for this option.



Chart Creation



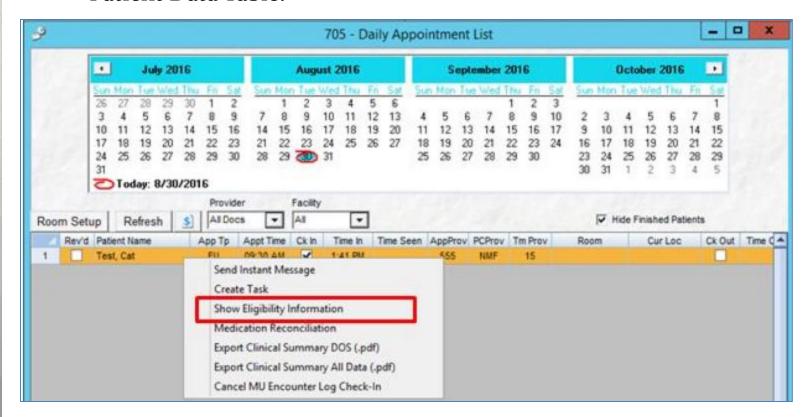
Modify PARAMETER					
Clinic No.	1	Default Zip Code		Default Phone Area	
Follow Up Letters	E 🔻	Ledger (A/N)	N -	Itemization	E 🔻
WebStaff Assistant Surg	N 🔻	Cycle	Y	Minimum Statement	2.99
Number of Cycles	28	Stop Statement Age	0	Statement Selection	21 🔻
Statement Sorting	N 🔻	Check Pt Duplicate	Y	Ignore Statement Date	N 🔻
Include Zero Charges	N 🔻	Auto Patient No	Y	Delete Entry	A 🔻
Starting Account Number	1144	Debug On	0	Super Bill Sort	N -
Message (Y/N)	Y	Separate Bill by Entry/Facility	Z	Billing Method	D 🔻
Billing Sorting	▼	Update ICD10 Equivalent	YES 🔻	Credit Display	- 🔻
Upper/Lower	A 🔻	Temporary Directory	/tmp ▼	Default Category	NP
Default Facility		Default Provider		Default Encounter	0
Referring	C 🔻	Guarantor	A 🔻	Payment Remark	Y
Default Pay Plan	DEF	Prep Notes	N 🔻	Reminder Setup	Y -
Appointment lookup days	90	Appointment Notification	Y	Path File	/home/staff
Patient ID Card	N 🔻	Payment Comment on Stmt?	Y	Appointment Refresh Delay	10 🔻
Print Statement Check#	D 🔻	Patient Reminder	N 🕶	FollowUpLetters/Balance	N 🔻
Appointment Color	2 🔻	Waiting List Lookup Days		Default Eligibility	ELIGR
Automatic HL7 Export	ВОТН ▼	Attach Encounter	Y	Age Ledger account	NO 🔻
Batch Sorting	Zip Code ▼	ICD10 Effective Date	10/01/2015	Hold Imported Charges	Y
Pass Procedure	NO ▼	Auto post PCM	YES 🔻	PCM Delay Import	1 🔻
PCM Doc Lookup Days		Delete Duplicate Imported Charges	YES 🔻	Idle Time in Minutes	30
HL7 Path		Modify on Self Checkin	No 🔻	ICD10 Lookup	YES ▼
PCM Charge Lookup in Days	5	Create PCM Chart	NO 🔻		
		< BACK NEXT >> Modify	NO Exit		



Show Eligibility Information



➤ The option to show patient's eligibility from the Daily Appointment List has been updated to open the Eligibility Patient Data Table.



NOTE: Must be using the insurance Eligibility feature in Intellect.



Show Eligibility Information



➤ The Eligibility Patient Data table has been updated as well to show additional fields.

	Eligi
DATE	
PROVINIT	
INSURANCE NAME	
COVERAGE FROM	
COVERAGE TO	
RECORD COVERAGE FROM	
RECORD COVERAGE TO	
MESSAGE	
SUBSCRIBER NAME	
SUBSCRIBER NO	
VERIFIED DOS	
USER NO	
DESCRIPTION	
ADITIONAL DESCRIPTION	
AMOUNT	
COVERAGE PERCENT	
EB06 DESCRIPTION	
DTP DESCRIPTION	
ELIGIBILITY TYPE	
PLAN TYPE	
DATE CREATED	
CREATED BY	
DATE MODIFIED	
MODIFIED BY	
DATE DELETED	
DELETED BY	



HIE Data Submission via PCM



What is HIE?

- ➤ Electronic health information exchange (HIE) allows health care providers to appropriately access and securely share a patient's vital medical information electronically with a hospital associated with your provider; improving the speed, quality, safety and cost of patient care.
 - Automatically takes place in the background once setup.
 - Is not required for Meaningful Use.



HIE Data Submission via PCM



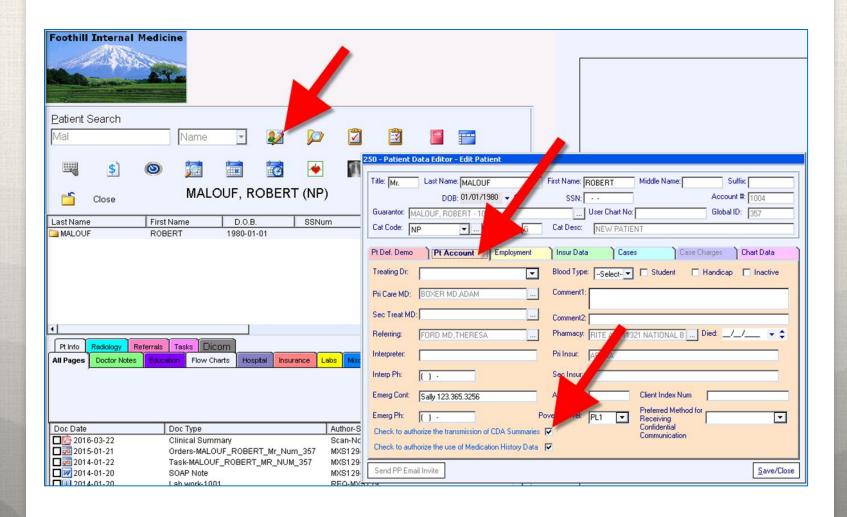
- By default, all patients are 'opted in' to sharing data with the HIE.
- ➤ It is your responsibility to inform all patients that their health information will be shared with the HIE and to obtain written, signed consent from all patients (new and existing).
- ➤ If a patient doesn't consent to sharing their data with the HIE, you must opt the patient out of sharing.
- ➤ Once HIE connection is established, patient data will be automatically submitted to the HIE when ANY PCM user:
 - a) Generates a clinical summary at check out
 - b) Manually generates a clinical summary (DOS or All Data)
 - c) Generates a summary of care record via a treatment plan



HIE Data Submission via PCM



Opt a patient out of sharing via the Patient Data Editor in PCM...





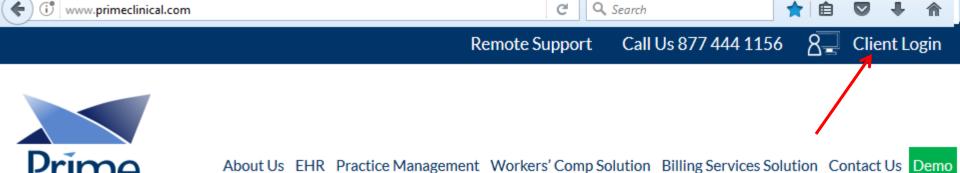
Accessing our Website and Utilizing our Tools!

Accessing Our Website





1. Log onto Prime Clinical Systems' website ⇒ <u>www.primeclinical.com</u>



2. Enter **User name** (M-####) & **Password.**







Continuing Education





Important Training Tools:

- New Client Intellect & PCM: Online Training Plan for New clients.
- Work Comp Intellect & PCM: Online Training Plan with Work Comp features.
- MIPS & APMS: Information about MACRA & the Quality Payment Program.
- Continuing Education:
 - Introduction to Continued Education → PCS Help Guide
 - LIVE Webinar registration
 - Webinar Calendar
 - Recorded Webinar





Meaningful Use & Quality Payment Program Tools:

All information on our website is available to you 7 days a week, 24 hours a day. It is very important that you become familiar with the tools listed and use them to gain a full understanding of Meaningful Use for the Medicaid EHR Incentive Program and/or MIPS & APMs tracks under the Quality Payment Program. You may also visit CMS at www.cms.gov or the Quality Payment Program at www.qpp.cms.gov





New tools and resources will be added as more information becomes available about the Quality Payment Program. Check often!

Meaningful Use & QPP

Newly expanded reviews of Meaningful Use Modified Stage 2 Objectives and the MIPS performance categories and measures under the Quality Payment Program.

Your Report Card!

Reviews how to run your MU Report Card in PCM.

Meaningful Use/QPP Tools

Your Report Card!

Meaningful Use/QPP

How to Attest

MU Resources

How to Attest

Reviews how to Attest for EHR Incentive Program.

MU Resources

Reviews MU resources within CMS, MU Audit Information, Payment Adjustment Information & EPs Hardship Exception Information.





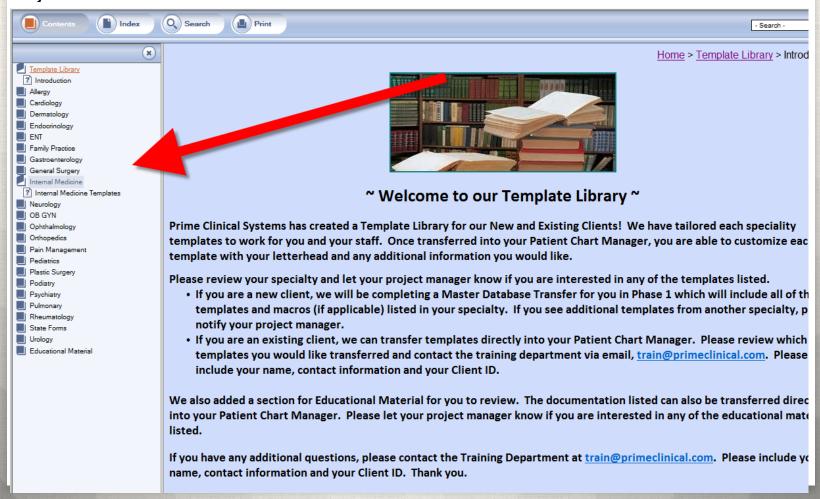
Important PCM items....

- *PCM Documents & Videos*: PCM online documentation and videos.
- *Template Library*: Templates & Educational documentation by Specialty.
- *PCM & Dragon Video*: Video tutorial of Dragon Voice Dictation in PCM.
- *PCM Update Memos*: Release of all PCM Update Memos and Software Updates.
- *PCM FAQs*: Random facts and questions about PCM.





The PCM Template Library contains specialty specific text templates, pen templates, requisition templates, and macros that can be transferred to your system...







Find us on

https://www.facebook.com/primeclinicalsystems/



Q&ATime for Questions!





Thank you for attending our 2017 PCM User Meeting Presentation!



Your feedback is important to making our User Meeting successful, please take a few minutes to complete the survey.