Meaningful EHR Use Checklist

Overview
RevolutionEHR is an ONC-ATCB certified Complete EHR Technology that, along with RxNT, provides users with all of the necessary functionality to achieve Meaningful EHR Use. While EHR users must have a full understanding of all of the Meaningful Use (MU) Objectives in order to attest to MU, the users must be ready to transfer their understanding into daily actions. This checklist will allow a RevolutionEHR user to define the processes that they need to consider to successfully achieve MU.

Preparation Steps – 30 days prior to beginning MU demonstration
The steps that must be taken prior to beginning MU demonstration are:

☐ Review the RevolutionEHR Security capabilities, including these examples:
  • User Name and Password controls for every employee
  • Assuring “https” login
  • Understand Access Log and Audit Log capabilities, and review the logs as needed

☐ Schedule three staff meetings, to discuss these topics:
  • Initial discussion of the need for a team commitment to MU standards, preparing everyone for their mutual commitment to consistent software use and data entry, while explaining the key history, exam, and post-exam processes that will be expected (see checklist below)
  • Discussion of sensitive actions and plans – capturing race and ethnicity, taking vital signs like weight measurement; assign key employees to work as facilitators for other staff to periodically report to entire staff on progress toward goal of successful data documentation
  • Preparing for go-live by discussing the overall intent of the practice to improve patient care, in order to gain government funds to improve IT infrastructure and to offset software cost, and clearly outlining the intended 90 day date range for planned MU review

☐ Develop strategies and implement actions to accomplish these patient processes:
  • Documenting email addresses for all patients, especially for patient communications of those over 65 or under 5 years old; then use the email confirmation button for any upcoming appointments for patients in those age ranges
  • Educating new patients referred to the clinic to bring a current medication list or clinical summaries from the referring doctor

☐ Purchase equipment:
  • Commercial grade scale for weight measurement
  • Height measuring device (optional)
  • Blood pressure measuring device (auto-sphygmomanometer; manual sphygmomanometer and stethoscope; child and large adult options to be considered)

☐ Software set-up process
  • Assure proper lists for Preferred Language, Race, and Ethnicity
  • Develop System Rules for Patient Education and Clinical Decision Support
  • Add screens for Education and CDS to Assessment & Plan step

☐ Develop e-Rx plan, preferably establishing an account with RxNT
  • Must have interaction checks available for entire reporting period
Interview/Case History Action Plan
- Document demographic details for every patient: preferred language, race, ethnicity
- for any patient referred in to the practice/provider, document Referring doctor information and Transition of Care on Patient RFV screen, as applicable
- Review and document patient self-reported medications
- Perform medication reconciliation for any patient referred to the provider by clicking checkbox as applicable
- Review and document all patient self-reported medication and non-medication allergies
- Review and document the Master Diagnosis History list
- Review and document Social History components: patient tobacco use and smoking status

Examination Action Plan
- Capture Vital Signs as indicated by patient case presentation (periodically, based upon risk factors)
- Review all master lists with patient for accuracy (medications, med allergies)
- Diagnosis coding for any condition should be added to Today’s Diagnoses list, especially ICD-9 codes for accurate representation of diabetic retinopathy
- Medication prescriptions should be done by CPOE into RxNT (and any meds ordered by a provider-user should be entered into RevolutionEHR’s Medication screen
- Understand and utilize RxNT’s special capabilities, including drug-drug, drug-allergy, and drug-formulary checks
- Analyze and act upon any Clinical Decision Support alerts
- Analyze and act upon any Patient Education alerts

Post-Examination Action Plan
- Generate and deliver Clinical Summary documentation for every Comprehensive examination or any encounter where a new medication is prescribed
- Generate “Diabetes Encounter Summary for PCP” for any patient with a diabetic retinopathy code
- Create a new Referral for any patient who is being transferred outbound to an external provider, and generate a Record Summary that should be delivered to the doctor to whom the referral is being made
- Create patient Login Access to the online patient portal under Login Information in Demographics (this feature will be available in Fall 2011)

General Action Plan
- For any clinical laboratory tests ordered by a RevolutionEHR provider, document results in the Lab/Imaging Orders component
- Generate a Patient List specific to a particular medical diagnosis code or code set, to be used to improve the health status of your patients
- Be prepared to provide an electronic copy of a Record Summary to any patient who requests it, delivered as a PDF via secure email or copied onto a flash drive, or sent to another EHR system as a CCR document
Special Actions for Attestation

☐ Prepare for and perform a test of RevolutionEHR’s ability to electronically exchange information (instructions to come in future updates)
☐ Generate a Clinical Quality Measures report in XML format and save to your computer, for eventual transmission to CMS during the attestation period

Conclusion

When all of these actions are taken, a RevolutionEHR user will be a successful meaningful EHR user who will have the ability to meet all 15 Core and any of the 10 Menu Objectives for MU.