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1 About the Meaningful Use Quick Guide

The Meaningful Use Quick Guide is intended as an easy-to-read reference guide as well as a specialized user manual. Following step-by-step procedures, a user of The Meaningful Use Quick Guide will be able to determine where the Meaningful Use requirements (both the core and menu objectives) are met within the Vālant EMR 4.00 application and how they are implemented within its respective components.

This guide is organized by the Fifteen Core and then Menu objectives that make up the Meaningful Use measures. Each measure will be described using the following format:

<table>
<thead>
<tr>
<th>Meaningful Use Objective</th>
<th>The description of the objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>The measure for the objective</td>
</tr>
<tr>
<td>Exclusion</td>
<td>The exclusion criteria, if applicable, for this objective</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>The description how the measure will be reported and calculated</td>
</tr>
<tr>
<td>Vālant EMR 4.00 Conformance</td>
<td>The Vālant component that satisfies the objective requirements</td>
</tr>
<tr>
<td>Vālant EMR 4.00 Where &amp; How</td>
<td>A step-by-step walkthrough showing Vālant component location and example of its operation within the application</td>
</tr>
</tbody>
</table>
Who Should Use It

This guide is intended for users of different degrees of knowledge and experience with the Vālant EMR 4.00 application and its integrated components, including Providers, Practitioners, and Staff Users.

This guide assumes that the user of the Vālant EMR 4.00 application and its components already has working knowledge of his-or-her operating system (e.g., Microsoft Windows 7, Apple OS 10.6), web browser (Internet Explorer, Firefox, Chrome, Safari), word processing software (e.g., Microsoft Word), and rudimentary computing terms and functionality (e.g., copying-saving-importing files, mouse and keyboard functionality, common computing terms like ‘refresh’, ‘popup box’, ‘listmenu’, and ‘sort’).

For more information, see the Vālant EMR 4.00 application Help file, Vālant Online Wiki, or other appropriate documentation.
2 Introduction

What is Meaningful Use?

Meaningful Use incentives seek to encourage the widespread adoption of EMR

The five broad goals of Meaningful Use are to:

1. Improve quality, safety, efficiency, and reduce health disparities
2. Engage patients and families
3. Improve care coordination
4. Improve population and public health
5. Ensure adequate privacy and security for personal health information

Defining Meaningful Use

Beginning in 2011, an Eligible Professional (EP) will be considered a meaningful EMR user if they meet four objectives. In order for a provider to receive Meaningful Use stimulus money, the provider must:

1. Use certified EMR technology in a meaningful way
2. Utilize electronic prescribing
3. Use a system that electronically exchanges health information to improve the quality of care
4. Submit information about clinical quality and other measures
Scope of this Guide

The purpose of this guide is to provide information and instructions of the Meaningful Use objectives and their corresponding implementation by select components and functionality explicitly found within the Vālant EMR 4.00 application. It should not be regarded as an end-to-end user manual for the Vālant EMR 4.00 application, as it contains numerous features not directly affected by Meaningful Use objectives and their compliance, nor should it be considered or consulted as “final authority” on Meaningful Use objectives and their measures.

This document is intended only to serve as a reference guide and is not to be considered a final implementation Meaningful Use. The information contained herein is based on Vālant Medical Solutions’ interpretation of Meaningful Use and the certification rules published by the Department of Human Services and are therefore subject to change. The information provided herein is “as is” and without any warranties express or implied. Using the Vālant EMR 4.00 application and any other certified health IT to prove Meaningful Use is the sole responsibility of the eligible providers and practitioners.

For More Information

For more information concerning Meaningful Use objectives and measures, the following Internet links may be found helpful:

- **Centers for Medicare and Medicaid Services (CMS) EHR Incentive Portal**
  The Official Web Site for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs

- **EHR Incentives REGISTRATION Page**
  How and where to register for the Meaningful Use (EHR) Incentive Program

- **EHR ATTESTATION Page**
  How and where to send the Meaningful Use data once it has been generated
3  The 15 Core Objectives

In order to receive federal incentive dollars, the provider or practitioner must prove "Meaningful Use," the goal of which is to improve care and outcomes for the provider or practitioner’s patients.

As defined by the Centers for Medicare & Medicaid Services (CMS), to achieve **Meaningful Use** the provider or practitioner must first meet **15 core objectives**, followed by 5 additional objectives selected from an elective menu of 10 (discussed in Section 4 below).

1. §170.304(A): COMPUTERIZED PROVIDER ORDER ENTRY
2. §170.302(A): DRUG-DRUG, DRUG-ALLERGY INTERACTION CHECKS
3. §170.302(C): MAINTAIN UP-TO-DATE PROBLEM LIST
4. §170.304(B): ELECTRONIC PRESCRIBING (ERX)
5. §170.302(D): MAINTAIN ACTIVE MEDICATION LIST
6. §170.302(E): MAINTAIN ACTIVE MEDICATION ALLERGY LIST
7. §170.304(C): RECORD DEMOGRAPHICS
8. §170.302(F): RECORD AND CHART VITAL SIGNS
9. §170.302(G): SMOKING STATUS
10. §170.304(J): CALCULATE AND SUBMIT CLINICAL QUALITY MEASURES
11. §170.304(E): CLINICAL DECISION SUPPORT
12. §170.304(F): ELECTRONIC COPY OF HEALTH INFORMATION
13. §170.304(H): CLINICAL SUMMARIES
14. §170.304(I): EXCHANGE CLINICAL INFORMATION AND PATIENT SUMMARY RECORD
15. §170.302(O-V): PROTECT ELECTRONIC HEALTH INFORMATION
   a. §170.302(o): Access Control
   b. §170.302(p): Emergency Access
   c. §170.302(q): Automatic Log-Off
   d. §170.302(r): Audit Log
   e. §170.302(s): Integrity
   f. §170.302(t): Authentication
   g. §170.302(u): General Encryption
   h. §170.302(v): Encryption When Exchanging Electronic Health Information
§170.304(a): Computerized Provider Order Entry

Use computer provider order entry (CPOE) for medication orders.

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 30% of unique patients with at least one medication in their medication list seen by the eligible provider have at least one medication order entered using CPOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>Any eligible professional who writes fewer than one hundred prescriptions during the reporting period</td>
</tr>
</tbody>
</table>
| Reporting Capabilities | – Numerator: The total number of patients in the denominator that have at least one medication order entered. Patients “on no meds” will not be counted.  
– Denominator: The total number of unique patients with at least one medication in their medication list seen by the eligible professional (EP) during the reporting period.  
The resulting percentage (Numerator ÷ Denominator) must be more than 30% in order for an EP to meet this measure. |

Vālant EMR 4.00 Conformance

Vālant conforms with this measure through the DrFirst component

Path: Patient Chart [Patient] ➤ Medications ➤ New Medications ➤ DrFirst

Vālant EMR 4.00 Where and How

1. From the left-hand menu column, select Open Patient Chart, then select Patient from the drop-down menu on the popup
2. From the **Patient Chart**, select the **Medications** tab, then the **New Medication** button to access the **DrFirst** component.

3. From **DrFirst**, the elements necessary for ordering medications are easily accessible (e.g., **Pharmacy**, **Medication for Prescription**, **Medication History**, **Pending Medications**, **Allergies**, and **Adverse Reactions**).
§170.302(a): Drug-Drug, Drug-Allergy Interaction Checks

<table>
<thead>
<tr>
<th>Measure</th>
<th>The eligible provider has enabled this functionality for the entire EHR reporting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>N/A</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>Provider/practitioner must attest this functionality is turned on.</td>
</tr>
</tbody>
</table>

Vālant EMR 4.00 Conformance

Vālant conforms with this measure through the *DrFirst* component

Path: Patient Chart [Patient] ➤ Medications ➤ New Medications ➤ DrFirst

Vālant EMR 4.00 Where and How

1. From the *left-hand menu column*, select **Open Patient Chart**, then select a **Patient** from the *drop-down menu on the popup*

2. From the **Patient Chart**, select the **Medications** tab, then the **New Medication** button to access the **DrFirst** component

3. From **DrFirst**, drug-drug and drug-allergy interaction checks will occur if (a) patient’s allergies are entered and up-to-date, and if (b) contraindications are detected between medications.
§170.302(c): Maintain Up-to-Date Problem List

Maintain an up-to-date problem list of current and active diagnoses.

| Measure | More than 80% of all unique patients seen by the eligible provider have at least one entry or an indication that no problems are known for the patient recorded as structured data. |
| Exclusion | Any EP who writes fewer than one hundred prescriptions during the reporting period |
| Reporting Capabilities | – Numerator: The total number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.  
– Denominator: The total number of unique patients seen by the EP during the reporting period. |

Vālant EMR 4.00 Conformance

Vālant conforms with this measure through Diagnoses on the Patient Chart.

Path: Patient Chart [Patient] ▶ Diagnoses

Vālant EMR 4.00 Where and How

1. From the left-hand menu column, select Open Patient Chart, then select a Patient from the drop-down menu on the popup
2. From the Patient Chart, select the Diagnoses tab, then New Diagnosis button (from Axis I, Axis II, or Axis III, as relevant), enter a Diagnosis. Save
§170.304(b): Electronic Prescribing (eRx)

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 40% of all permissible prescriptions written by the eligible provider are transmitted electronically using certified EHR technology.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>Any EP who writes fewer than one hundred prescriptions during the reporting period</td>
</tr>
</tbody>
</table>
| Reporting Capabilities | – Numerator: The total number of prescriptions written by the eligible provider and transmitted electronically for drugs requiring a prescription in order to be dispensed other than controlled substances during the reporting period.  
– Denominator: The total number of prescriptions in the denominator generated and transmitted electronically. |

Vālant EMR 4.00 Conformance
Vālant conforms with this measure through the DrFirst component

Path: Patient Chart [Patient] ► Medications ► New Medications ► DrFirst

Vālant EMR 4.00 Where and How
1. From the left-hand menu column, select Open Patient Chart, then select a Patient from the drop-down menu on the popup
2. From the Patient Chart, select the Medications tab, then the New Medication button to access the DrFirst component
3. From DrFirst, the elements necessary for electronic prescriptions (eRx) are accessible (e.g., Manage Medications, Renew, Prescribe, Stop)
§170.302(d): Maintain Active Medication List

| Measure | More than 80% of all unique patients seen by the eligible provider have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. |
| Exclusion | N/A |
| Reporting Capabilities | – Numerator: The total number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.  
  – Denominator: The total number of unique patients seen by the EP during reporting period. |

Välan EMR 4.00 Conformance

Välan conforms with this measure through the DrFirst and Välan components

Path: Patient Chart [Patient] ➤ Medications ➤ New Medications ➤ DrFirst

Välan EMR 4.00 Where and How

1. From the left-hand menu column, select Open Patient Chart, then select a Patient from the drop-down menu on the popup
2. From the Patient Chart, select the Medications tab. Select the New Medication button to access the DrFirst component
3. From DrFirst, the elements necessary for maintaining an active medications list are accessible (e.g., Manage Medications, Renew, Prescribe, Stop)
§170.302(e): Maintain Active Medication Allergy List

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 80% of all unique patients seen by the eligible provider have at least one entry (or an indication patient has no known medication allergies) recorded as structured data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Reporting Capabilities                                                 | Numerator: The total number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.  
Denominator: The total number of unique patients seen by the EP during reporting period. |

Vālant EMR 4.00 Conformance

Vālant conforms with this measure through the DrFirst and Vālant components

Path: Patient Chart [Patient] ➤ Medications ➤ New Medications ➤ DrFirst

Path: Patient Chart [Patient] ➤ Allergies

Vālant EMR 4.00 Where and How

1. From the left-hand menu column, select Open Patient Chart, then select a Patient from the drop-down menu on the popup

2. From the Patient Chart, select the Medications tab. Select the New Medication button to access the DrFirst component

3. From DrFirst, the elements necessary for maintaining an active medication allergy list are accessible (e.g., Current Allergies/Adverse Reactions, Add/View Allergies, Allergies Reviewed)

4. Once allergies have been entered into the DrFirst component, they can also be viewed in the Patient Chart under the Allergies tab
§170.304(c): Record Demographics

Record demographics: preferred language; gender; race; ethnicity; date of birth

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 50% of all unique patients seen by the eligible provider have demographics recorded as structured data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>N/A</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Vālant EMR 4.00 Conformance

Vālant conforms with this measure through Persons & Institutions ▶ Patients ▶ Demographics and Misc. tabs

Path: Persons and Institutions ▶ Patients ▶ New Patient ▶ Demographics | Misc

Vālant EMR 4.00 Where and How

1. From the left-hand menu column, select Persons and Institutions, then select Patient and New Patient

2. Under Demographics tab, Gender and Date of Birth are entered

3. Under Misc. tab, Race, Ethnicity, and Preferred Language are entered.
§170.302(f): Record and Chart Vital Signs

- Height; weight; blood pressure
- Calculate and display BMI for ages 2 and over
- Plot and display growth charts for children 2-20 years, including BMI

| Measure | For more than 50% of all unique patients age 2 and over seen by the eligible provider — height, weight and blood pressure are recorded as structured data |
| Exclusion | – EPs who do not see patients 2 years or older  
– Any EP who believes all 3 vital signs of height, weight and blood pressure of their patients has no relevance to their scope of practice. |
| Reporting Capabilities | Numerator: total number of patients in the denominator who have at least one entry of their height, weight, and blood pressure recorded as structured data.  
– Denominator: total number of unique patients 2 and over seen during the reporting period.  
Note: You do not need to report on BMI, you just need to be able to calculate and display it. |

Vālant EMR 4.00 Conformance

Vālant conforms with this measure through Patient Chart and Measurements components

**Path:** Patient Chart [Patient] ➤ Measurements

Vālant EMR 4.00 Where and How

1. From the left-hand menu column, select Persons and Institutions, then select Patient
2. Select the Measurements tab, select New Measurement button
3. In the Add Measurement popup, under Measurement Type select Height, Weight, or Blood Pressure and enter corresponding measurement values (height in inches, weight in pounds, blood pressure in systolic/diastolic numbers.

4. BMI is calculated automatically whenever Height and Weight are entered on the same Date-Time.
<table>
<thead>
<tr>
<th>Measurement</th>
<th>Date</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>4/29/2011</td>
<td>120/80 mm[Hg]</td>
</tr>
<tr>
<td>BMI</td>
<td>4/29/2011</td>
<td>5.7 kg/m2</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>4/29/2011</td>
<td>155 /min</td>
</tr>
<tr>
<td>Height</td>
<td>4/29/2011</td>
<td>72 in</td>
</tr>
<tr>
<td>Weight</td>
<td>5/6/2011</td>
<td>45 lb</td>
</tr>
<tr>
<td>Weight tracking</td>
<td>5/6/2011</td>
<td>55 lb</td>
</tr>
</tbody>
</table>

**New Blood Pressure Measurement**

<table>
<thead>
<tr>
<th>Date</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/29/2011</td>
<td>120/80 mm[Hg]</td>
<td>George Michael Hall</td>
</tr>
</tbody>
</table>
§170.302(g): Smoking Status

Record smoking status for patients 13 years old or older.

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 50% of all unique patients 13 years old or older seen by the eligible provider have smoking status recorded as structured data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>An EP who sees no patients 13 years or older would be excluded from this requirement.</td>
</tr>
</tbody>
</table>
| Reporting Capabilities | – Numerator: The total number of unique patients in the denominator with smoking status recorded as structured data.  
– Denominator: The total number of unique patients 13 years or older seen during reporting period. |

Vālant EMR 4.00 Conformance

Vālant conforms with this measure through Patient Chart and Measurements components

Path: Patient Chart [Patient] ➤ Measurements

Vālant EMR 4.00 Where and How

1. From the left-hand menu column, select Persons and Institutions, then select Patient
2. Select the Measurements tab, select New Measurement button
3. In the Add Measurement popup, under Measurement Type select Smoking Status then enter the corresponding condition under Value:
   [1] Current every day smoker
   [2] Current some day smoker
   [3] Former smoker
   [4] Never smoker
   [5] Smoker, current status unknown
   [9] Unknown if ever smoked
# §170.304(j): Calculate and Submit Clinical Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Report ambulatory clinical quality measures to Centers for Medicare &amp; Medicaid Services (CMS) or, in the case of Medicaid eligible providers, the States. In total, eligible providers must report on 6 total measures: 3 core measures (substitute the alternate core measures if necessary) and 3 additional measures. A maximum of 9 measures would be reported if the eligible provider needed to attest to the 3 required core, the three alternate core, and the 3 additional measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>N/A</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>Successfully report to Centers for Medicare &amp; Medicaid Services (CMS) ambulatory clinical quality measures selected by CMS in the manner specified by CMS.</td>
</tr>
</tbody>
</table>

## Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing several components used in the manual insertion of Quality Measures data, including Transaction Codes ► Non-Billing Codes, Reference Data ► Other Codes, Reference Data ► Immunization Types, Patient Chart ► [Patient] ► Codes, Patient Chart ► [Patient] ► Immunizations, and Patient Chart ► Measurement.

**Path:** Transaction Codes ► Non-Billing Codes  
**Path:** Reference Data ► Other Codes  
**Path:** Reference Data ► Immunization Types  
**Path:** Patient Chart [Patient] ► Codes  
**Path:** Patient Chart [Patient] ► Immunizations  
**Path:** Patient Chart [Patient] ► Measurements

Although the calculations that make up the Valant EMR 4.0 Quality Measures section are produced automatically ‘behind-the-scenes’ (Numerator and Denominator cannot be manually entered, updated, or changed as they can in the Meaningful Use section), it is the provider’s responsibility to manually enter the applicable codes (procedural, lab, and patient), diagnoses, measurements, and measurement period date ranges in order to functionally populate the Numerators, Denominators, and Reporting Percentage fields on the Quality Measures page (Tools ► Quality Measures ► Date Ranges FROM/TO ► Calculate Quality Measures).

For information regarding the nine (9) ambulatory Quality Measures supported by Vālant and their necessary codes and measurement periods, please refer to the NQF Human Readable (PDF) and NQF Retooled Measure (XLSX) document links available immediately below.
There are nine (9) Quality Measures supported by the Valant EMR 4.00 applications, six (6) of which are Core, and three (3) which are Elective:

**CORE**

1. (NQF 0013) Hypertension: Blood Pressure Measurement
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)
2. (NQF 0024) Weight Assessment and Counseling for Children and Adolescents
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)
3. (NQF 0028a) Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)
4. (NQF 0028b) Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)
5. (NQF 0038) Childhood Immunization Status
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)
6. (NQF 0041) Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)
7. (NQF 0421) Adult Weight Screening and Follow-Up
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)

**ELECTIVE**

1. (NQF 0018) Controlling High Blood Pressure
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)
2. (NQF 0043) Pneumonia Vaccination Status for Older Adults
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)
3. (NQF 0086) Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
   a. NQF_HQMF_HumanReadable (PDF)
   b. NQF_Retooled_Measure (XLSX)

Each of these Quality Measures have specific codes, measurements, diagnoses, and date ranges that must be entered manually in conjunction with the individual Patient's age group and numbers of office visits ("Encounters" before the Numerators, Denominators, Reporting Percentages and Performance Percentages will display on the Quality Measures page.

Vālant EMR 4.00 Where and How

1. From the left-hand menu column, select Tools, then select Quality Measures
2. Enter the measurement period date ranges (from/to), then click the Calculate Quality Measures button

NOTE: The Quality Measures page will not populate correctly until all relevant codes, diagnoses, and measurement types have first been manually added into the following EMR components: Transaction Codes ► Non-Billing Codes, Reference Data ► Other Codes, Reference Data ► Immunization Types, Patient Chart ► [Patient] ► Codes, Patient Chart ► [Patient] ► Immunizations, and Patient Chart ► [Patient] ► Measurements

The Vālant Quality Measures Page
§170.304(e): Clinical Decision Support

<table>
<thead>
<tr>
<th>Measure</th>
<th>Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>N/A</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>Eligible professionals (EPs) must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet the measure.</td>
</tr>
</tbody>
</table>

Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing clinical decision support rules for the following 2 (2) areas:

- Second-Generation Anti-Psychotic Medication Prescribed
- Height/Weight Measurements for Minors

These will be displayed in the form up ‘popup’ windows when the critical decision support criteria is encountered (e.g., patient age is less than 21 years old).

Vālant EMR 4.00 Where and How

As a ‘popup’ window.
§170.304(f): Electronic Copy of Health Information

Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.</td>
</tr>
</tbody>
</table>
| Reporting Capabilities | - DENOMINATOR: Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.  
- NUMERATOR: Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.  
The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure. |

Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing the functionality to make by request an electronic copy of a patient’s health information via the generation and exportation of a Continuity of Care Document (CCD file).

Vālant EMR 4.00 Where and How

1. From the left-hand menu column, select Open Patient Chart, then select a Patient from the drop-down menu on the popup.
2. From any tab on the Patient Chart, select the Options button in the lower right-hand corner, then select the Export to CCD option. In the Export to CCD popup window, select the Provider, Start Date, and End Date of the measurement period to be displayed in the CCD file.
3. This file (XML format) can now be digitally copied to a USB flash drive, burned to a CD or DVD, or electronically transferred to an online health repository (like Microsoft Health Vault, Google Health, or some other third-party solution).
4. It can also be displayed for viewing or printing through File Actions ➤ Display CCD/CCR.
Better Behavioral Health Clinical Summary

Created On: May 12, 2011

Patient: George George
55 Woodland St
Osh Kosh, WI, 98002
tel:+1-(206)555-4433

MRN: GEOGEO

Birthdate: February 23, 1955
Gender: Male

Table of Contents
- Summary Purpose
- Problems
- Allergies and Adverse Reactions
- Medications
- Vital Signs

Summary Purpose

Note - Mental Health

Problems

<table>
<thead>
<tr>
<th>Axis</th>
<th>ICD Code</th>
<th>Diagnosis</th>
<th>Diagnosis Date</th>
<th>Last Changed Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>000.00</td>
<td>Undetermined Diagnosis</td>
<td>May 4, 2011</td>
<td></td>
<td>Active</td>
</tr>
<tr>
<td>III</td>
<td>346.10</td>
<td>Migraine, common</td>
<td>Apr 18, 2011</td>
<td></td>
<td>Active</td>
</tr>
<tr>
<td>III</td>
<td>45</td>
<td>meningitis</td>
<td>Apr 18, 2011</td>
<td></td>
<td>Active</td>
</tr>
</tbody>
</table>

Allergies and Adverse Reactions

CCD (XML) file, Generated and Displayed as HTML file in browser
§170.304(h): Clinical Summaries

Provide clinical summaries for patients for each office visit.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>Any EP who has no office visits during the EHR reporting period.</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>- DENOMINATOR: Number of office visits by the EP during the EHR reporting period</td>
</tr>
<tr>
<td></td>
<td>- NUMERATOR: Number of office visits in the denominator</td>
</tr>
<tr>
<td></td>
<td>The resulting percentage (Numerator ÷ Denominator) must be more than 550% in order for an EP to meet this measure.</td>
</tr>
</tbody>
</table>

Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing the functionality to produce electronic copy of a patient’s health information via the generation and exportation of a Continuity of Care Document (CCD file), or to manually print just such a document.

- Problem List
- Diagnostic Test Results
- Medication List
- Medication Allergy List

Vālant EMR 4.00 Where and How

1. From the left-hand menu column, select Open Patient Chart, then select a Patient from the drop-down menu on the popup
2. From any tab on the Patient Chart, select the Options button in the lower right-hand corner, then select the Export to CCD option. In the Export to CCD popup window, select the Provider, Start Date, and End Date of the measurement period to be displayed in the CCD file.
3. This file (XML format) can now be digitally copied to a USB flash drive, burned to a CD or DVD, or electronically transferred to an online health repository (like Microsoft Health Vault, Google Health, or some other third-party solution).
4. It can also be displayed for viewing or printing through File Actions ➤ Display CCD/CCR.
Options > Export to CCD

Better Behavioral Health Clinical Summary

Created On: May 12, 2011

Patient: George George
55 Woodland St
Osh Kosh, WI, 98002
tel:+1-(206)555-4433

Birthdate: February 23, 1955
Sex: Male
Guardsian: Next of Kin:

Table of Contents

- Summary Purpose
- Problems
- Allergies and Adverse Reactions
- Medications
- Vital Signs

Summary Purpose

Note - Mental Health

Problems

<table>
<thead>
<tr>
<th>Axis</th>
<th>ICD Code</th>
<th>Diagnosis</th>
<th>Diagnosis Date</th>
<th>Last Changed Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>000.00</td>
<td>Undetermined Diagnosis</td>
<td>May 4, 2011</td>
<td></td>
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<tr>
<td>III</td>
<td>346.10</td>
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<td></td>
<td>Active</td>
</tr>
<tr>
<td>III</td>
<td>45</td>
<td>meningitis</td>
<td>Apr 18, 2011</td>
<td></td>
<td>Active</td>
</tr>
</tbody>
</table>

Allergies and Adverse Reactions

CCD (XML) file, Generated and Displayed as HTML file in browser
§170.304(i): Exchange Clinical Information and Patient Summary

Record

Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| Reporting Capabilities | Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information during the EHR reporting period to meet this measure. |

Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing the functionality to produce electronic copy of a patient’s health information via the generation and exportation of a Continuity of Care Document (CCD file), or import and display a Continuity of Care Document (CCD) file or Continuity of Care Record (CCR), or encrypt/decrypt files for electronic transfer, or by using Message Digest.

Vālant EMR 4.00 Where and How

Create CCD file

1. From the left-hand menu column, select Open Patient Chart, then select a Patient from the drop-down menu on the popup
2. From any tab on the Patient Chart, select the Options button in the lower right-hand corner, then select the Export to CCD option. In the Export to CCD popup window, select the Provider, Start Date, and End Date of the measurement period to be displayed in the CCD file.
3. This file (XML format) can now be digitally copied to a USB flash drive, burned to a CD or DVD, or electronically transferred to an online health repository (like Microsoft Health Vault, Google Health, or some other third-party solution).
4. It can also be displayed for viewing or printing through File Actions » Display CCD/CCR.
Message Digest

When a file is passed through the Message Digest function, an algorithm creates a unique sequence of characters that act as kind of digital “fingerprint.” Any change to the text of the file, no matter how trivial, will produce a significantly different “fingerprint.” By comparing a file with its digital fingerprint, a provider can determine whether the file is original or if it has been tampered with in some fashion. There isn’t any way to obtain the same fingerprint for a file that has been doctored and it is statistically impossible to find two files yielding identical digital fingerprints (like trying to find two people sharing the same set of fingerprints).

Using Message Digest is a quick way to determine whether a file has been altered. By comparing the digest “key” of the original file with the digest “key” of the file just received or recovered, a provider can know the file to be bona fide and unaltered.

From the left-hand menu, select File Actions ► MessageDigest
From the Message Digest popup box, browse to the location of the file to be given the digital “fingerprint” or key, and make sure to copy-and-paste that key to a file in a safe location for future use and comparison.
Import/Display CCD/CCR File

Continuity of Care Documents (CCD) and Continuity of Care Records (CCR) are different health standards used to create flexible patient documents. Both CCD and CCR files contain relevant health summaries and other timely patient information which can be sent electronically from one provider to another. While the Valant EMR 4.00 application supports the importation and display of files of both the CCD and CCR standards, it creates exportable files using only the CCD file format.

1. From the left-hand menu, select File Actions ▶ Display CCD/CCR
2. From the Open popup box, navigate to the location of the CCD or CCR (XML-formatted) file you want to view, then select the Open button (depending on your browser or browser settings you may have to click a second Open button in another popup box).

Example of an Imported CCR (XML) file, generated and displayed as HTML in browser
§170.302(o-v): Protect Electronic Health Information

Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>N/A</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>Eligible professionals (EPs) must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.</td>
</tr>
</tbody>
</table>

Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing safe and secure access to and storage of EHR files through the EMR and its components. These components, including the management of storage servers and database servers, undergo daily risk analysis and safeguard management. Implementation of the Vālant EMR application complies with strict administration procedure in regards to access control (user permissions, log-ins, passwords, and restrictions to select components as electively administrated), emergency access, automatic log-off, audit logs, integrity, authentication, general encryption, and encryption when exchanging electronic health information.

- §170.302(o): Access Control
- §170.302(p): Emergency Access
- §170.302(q): Automatic Log-Off
- §170.302(r): Audit Log
- §170.302(s): Integrity
- §170.302(t): Authentication
- §170.302(u): General Encryption
- §170.302(v): Encryption When Exchanging Electronic Health Information

NOTE: This array of “sub”-measures as mentioned will be examined immediately below.
§170.302(o): Access Control

Assign unique login IDs and passwords with the ability to deactivate a no longer active user account

Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing administrative management and safeguards to:

1) Assign a new user name.
2) Ensure that the name is unique.
3) Assign permissions to the name for accessing electronic health information.

Vālant EMR 4.00 Where and How

Administrator Account

1. Log-in as Administrator to an administrator account.
2. Under Persons and Institutions, set up a new user (either Provider or Office Staff) and administer which EMR components this user can access:
   a. Appointments
   b. Biller’s tools
   c. Delete Documents
   d. Easy Billing
   e. Edit Documents
   f. Edit Other Schedules
   g. Edit Patient Charts
   h. Emergency Access
   i. Patient Clinical charts
   j. Record Appointments
   k. Reports
   l. Upload Documents
   m. View Other Schedules
§170.302(p): Emergency Access

Permit authorized users access to all electronic health information in case of an emergency. Users who have been assigned the emergency access role will be able to invoke emergency access, which will activate a Top-Level role.

Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing a means for authorized users access to electronic health information in case of an emergency, and to:

1) Assign emergency access authorizations to user accounts.
2) Activate/deactivate emergency access scenarios

Vālant EMR 4.00 Where and How

Administrator Account

1. Log-in as Administrator to an administrator account.
2. Under Persons and Institutions, select a user (either Provider or Office Staff) to be granted Emergency Access (single instance, does not carry over through logging-out and logging in again).
§170.302(q): Automatic Log-Off

Per user preferences, system can be set to automatically log idle users off the system after a specified period of time. Users have the preference to use this feature or the automatic system lock.

Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing a means for automatically logging-out users if the systems is idle for a specific period of time.

Vālant EMR 4.00 Where and How

1. **System ▶ Preferences ▶ Time Out ▶ Timeout in Minutes**
2. Time can be changed to timeout after 10 minutes to 360 minutes

![Timeout in Minutes settings](image)
§170.302(r): Audit Log

Record all actions (view, create, edit, delete) to the audit trail and allow users to search and sort by action, user, patient, date, or time.

Vālant EMR 4.00 Conformance

Vālant conforms with this measure by providing a means to:

- Create, modify, access, and delete electronic health information.
- Record actions related to electronic health information (automatic functions used to create log entries)
- Enable a user to generate an audit log for a specific time period and to sort the audit log entries according to standard elements.

Vālant EMR 4.00 Where and How

Creating, Modifying, Accessing and Deleting Electronic Health Information

1. Open Patient Chart ▶ Patient [select Patient]
   AND/OR
2. Persons & Institutions ▶ Patients [select Patient]

Generating an Audit Log

1. Tools ▶ Reports ▶ Clinical ▶ Audit Log – Patient [select Patient]
§170.302(s): Integrity

Ability to create a hash value when saving data outside of the database in a report or file. The same hash value will be generated each time if the data has not been changed. If the data has been changed, the user will receive a new hash value, allowing them to see that the data has been altered.

Vēlant EMR 4.00 Conformance

Vēlant has implemented Secure Hashing Algorithm 1 (SHA-1).

Vēlant EMR 4.00 Where and How

When a file is passed through the Message Digest function, an algorithm creates a unique sequence of characters that act as kind of digital “fingerprint.” Any change to the text of the file, no matter how trivial, will produce a significantly different “fingerprint.” By comparing a file with its digital fingerprint, a provider can determine whether the file is original or if it has been tampered with in some fashion. There isn’t any way to obtain the same fingerprint for a file that has been doctored and it is statistically impossible to find two files yielding identical digital fingerprints (like trying to find two people sharing the same set of fingerprints).

Using Message Digest is a quick way to determine whether a file has been altered. By comparing the digest “key” of the original file with the digest “key” of the file just received or recovered, a provider can know the file to be bona fide and unaltered.

1. From the left-hand menu, select File Actions ➤ MessageDigest
2. From the Message Digest popup box, browse to the location of the file to be given the digital “fingerprint” or key, and make sure to copy-and-paste that key to a file in a safe location for future use and comparison.
§170.302(t): Authentication

Through the use of User IDs, passwords, and roles, verify that the user seeking access to information has permissions to do so.

**Välant EMR 4.00 Conformance**

Välant conforms with this measure by providing a means to administrate user accounts, log-ins, permissions, and privileges.

**Välant EMR 4.00 Where and How**

**Administrator Account**

1. Log-in as Administrator to an administrator account.
2. Under Persons and Institutions, select a current user or set up a new user (either Provider or Office Staff) and administer which EMR components the user can access:
   a. Appointments
   b. Biller's tools
   c. Delete Documents
   d. Easy Billing
   e. Edit Documents
   f. Edit Other Schedules
   g. Edit Patient Charts
   h. Emergency Access
   i. Patient Clinical charts
   j. Record Appointments
   k. Reports
   l. Upload Documents
   m. View Other Schedules
§170.302(u): General Encryption

Encrypt health information saved outside of the database and allow the ability to decrypt the information.

**Vālant EMR 4.00 Conformance**

Vālant has implemented 128-bit Advanced Encryption Standard (AES-128) encryption algorithm.

**Vālant EMR 4.00 Where and How**

*Encryption*

The *Encrypt* tool can transform a readable text file into "cipher" text. Cipher text looks like a random sequence of characters and is completely meaningless to anyone who opens the file. To make the file readable again it needs to be passed through the *Decrypt* tool which converts cipher text back into the original text file allowing it to meaningful again.

1. From the left-hand menu, select *File Actions ➤ Encrypt*
2. From the *Encrypt File* popup box, browse to the location of the text file (TXT-formatted) you want to encrypt, then select the *Open* button. When returned to the *Encrypt File* popup box, you can either *Cancel* the process (no harm, no foul) or continue by selecting Encrypt. This will open a Save popup box prompting you for a file name and save location (it is recommended that you give the encrypted file a name that is different from the original if you are saving to the same location). Once the *Encrypt* file is saved, you can open it to confirm that the once meaningful text has been transformed into cipher text.

   ![Encrypt File Popup Box](image)

   **Encrypt File Popup Box**

   *Call me Ishmael. Some years ago - never mind how long precisely - having little or no money in my purse, and nothing particular to interest me on shore, I thought I would sail about a little and see the watery part of the world.*

   **Original File**
The Decrypt tool reverses the transformation made by the Encrypt tool. It can convert “cipher” text—a random sequence of meaningless characters in a text file—back into meaningful text.

1. From the left-hand menu, select **File Actions ▶ Decrypt**.
2. From the **Decrypt File** popup box, browse to the location of the text file (TXT-formatted) you want to decrypt, then select the **Open** button. When returned to the **Decrypt File** popup box, you can either **Cancel** the process continue by selecting **Decrypt**. This will open a Save popup box prompting you for a file name and save location. Once the **Decrypt** file is saved, you can open it to confirm that the once meaningless text has been transformed back into a readable format.

Decryption

Call me Ishmael. Some years ago – never mind how long precisely – having little or no money in my purse, and nothing particular to interest me on shore, I thought I would sail about a little and see the watery part of the world.
§170.302(v): Encryption When Exchanging Electronic Health Information

Allow users to encrypt and save encrypted information over a secure link.

**Note:** “Certified EHR Technology must include the capability to encrypt and decrypt information regardless of the transmission method used. This certification criterion and related standard do not specify the circumstances under which encryption and decryption must be performed; they simply require the capability.”

**Vālant EMR 4.00 Conformance**

Vālant has implemented 128-bit Advanced Encryption Standard (AES-128) encryption algorithm.

**Vālant EMR 4.00 Where and How**

As above in §170.302(u): General Encryption

**Encryption**

1. From the left-hand menu, select `File Actions` ➤ `Encrypt`.
2. From the `Encrypt File` popup box, browse to the location of the text file (TXT-formatted) you want to encrypt, then select the `Open` button. When returned to the `Encrypt File` popup box, you can either `Cancel` the process (no harm, no foul) or continue by selecting `Encrypt`. This will open a Save popup box prompting you for a file name and save location (it is recommended that you give the encrypted file a name that is different from the original if you are saving to the same location). Once the `Encrypt` file is saved, you can open it to confirm that the once meaningful text has been transformed into cipher text.

**Decryption**

1. From the left-hand menu, select `File Actions` ➤ `Decrypt`.
2. From the `Decrypt File` popup box, browse to the location of the text file (TXT-formatted) you want to decrypt, then select the `Open` button. When returned to the `Decrypt File` popup box, you can either `Cancel` the process continue by selecting `Decrypt`. This will open a Save popup box prompting you for a file name and save location. Once the `Decrypt` file is saved, you can open it to confirm that the once meaningless text has been transformed back into a readable format.
4 10 Menu Objectives (Must Support 5)

Providers/practitioners must also meet at least five (5) criteria of the following “menu” of 10

1. 170.302(b): Implement drug formulary checks
2. 170.302(h): Incorporate lab test results as structured data
3. 170.302(i): List all patients who have a particular medical condition, for at least one condition
4. 170.302(m): Identify and provide patient-specific educational materials
5. 170.302(j): Reconcile medications
6. 170.304(i): Provide summary records during encounters and transitions of care
7. 170.302(l): Show ability to provide data to public health agencies
8. 170.302(k): Immunization registries
9. 170.304(d): Send patients preventive and follow-up care reminders
10. 170.304(g): Provide patients with timely electronic access to their health information

The Vālant EMR application supports all ten of these menu objectives, although the provider/practitioners may choose only five out of the ten to support in order to qualify for the Meaningful Use incentive.
170.302(B): Implement Drug-Formulary Checks

<table>
<thead>
<tr>
<th>Measure</th>
<th>The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>Any EP who writes fewer than 100 prescriptions during the EHR reporting period.</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>Eligible professionals (EPs) must attest YES to having enabled this functionality and having had access to at least one internal or external formulary for the entire EHR reporting period to meet this measure.</td>
</tr>
</tbody>
</table>

Valant EMR 4.00 Conformance

Valant EMR 4.00 is a partner with DrFirst, certified for submitting all transaction types available for fully informed e-prescribing, including the ability to obtain eligibility, benefits, and formulary information; access to aggregated medication history data available for the patient; submitting e-prescriptions and electronic refills to retail and mail-order pharmacies.

Valant EMR 4.00 Where and How

1. From the left-hand menu column, select Open Patient Chart, then select Patient from the drop-down menu on the popup
2. From the Dashboard, select New Medications or select the Medications tab and select New Medications
3. In the DrFirst, the formulary functionality will be displayed, provided the Patient is using insurance with formularies (otherwise None will be displayed for formularies).
### Formulary Information Displayed in Red and Green

<table>
<thead>
<tr>
<th><strong>Favorites:</strong></th>
<th><strong>Use free text 'Diabeta'</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabeta (glyburide)</strong> (Brand: NF Generic: P1)</td>
<td>Tablet 1.25 mg</td>
</tr>
<tr>
<td></td>
<td>Tablet 2.5 mg</td>
</tr>
<tr>
<td></td>
<td>Tablet 5 mg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Favorites:</strong></th>
<th><strong>Use free text 'Erythromycin'</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>erythromycin (P1)</strong></td>
<td>Capsule, Delayed Release(E.C.) 250 mg</td>
</tr>
<tr>
<td></td>
<td>Tablet 250 mg</td>
</tr>
<tr>
<td></td>
<td>Tablet 500 mg</td>
</tr>
<tr>
<td><strong>erythromycin (Abne-Mycin) (NF, TM)</strong></td>
<td>Ointment 2%</td>
</tr>
<tr>
<td><strong>erythromycin (bulk) (NF)</strong></td>
<td>Powder</td>
</tr>
<tr>
<td><strong>erythromycin (Ery-Tab) (F)</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Favorites:</strong></th>
<th><strong>Use free text 'Norvasc'</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Norvasc (amlodipine)</strong> (Brand: NR Generic: P1, TM)</td>
<td>Tablet 2.5 mg</td>
</tr>
<tr>
<td></td>
<td>Tablet 5 mg</td>
</tr>
<tr>
<td></td>
<td>Tablet 10 mg</td>
</tr>
</tbody>
</table>
170.302(H) Incorporate Clinical Lab-Test Results As Structured Data

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.</td>
</tr>
</tbody>
</table>
| Reporting Capabilities | - DENOMINATOR: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.  
- NUMERATOR: Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.  
The resulting percentage (Numerator ÷ Denominator) must be more than 40% in order for an EP to meet this measure. |

Note: The provider is permitted, but not required, to limit the measure of this objective to labs ordered for those patients whose records are maintained using certified EHR technology. Structured data does not need to be electronically exchanged in order to qualify for the measure of this objective. The EP is not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.

Vālant EMR 4.00 Conformance

Vālant EMR conforms to this measure by providing the means to either importing clinical lab results as structured data or manually keying in clinical lab results.

Vālant EMR 4.00 Where and How

Import Lab Results is the component that provides for the importing of a patient’s lab results directly into his-or-her Patient Chart where it will be appear as an imported panel under Lab Panels.

In order for Import Lab Results to function properly, a few things need first be considered and preparations made prior to the importation of the patient’s data.

1. The patient’s lab results must have been delivered as a text file (sometimes called a “flat” file) configured with the .TXT format extension. If the patient’s lab results were delivered using a
different type of file—for example a Microsoft Word document or an Excel spreadsheet—it must first be converted or copy-and-pasted into a text file.

2. Within this text file, the patient information and lab results need to be organized in a specific line order for the file to import into the Patient Chart. If this line structure is not staged properly, the patient lab results may not display correctly under Lab Panels or the lab results may not import at all.

3. If not already listed, the Measurement Types (e.g., hemoglobin or creatine) that make up the patient’s lab results will automatically be added to the Patient Chart under Measurements along with their corresponding data types, unit type, and clinical codes.

To import a patient’s lab file:

1. From the left-hand menu, select File Actions ▶ Import Lab Results

2. From the Open popup box, navigate to the location of the lab file (TXT-formatted) you want to view. If formatted correctly, the lab file will be displayed in a re-formatted Import Lab Results popup window; to continue importing the lab results to the Patient Chart, select Save in this popup window, otherwise select Cancel.

3. To view the lab results (if saved to the Patient Chart), select Open Patient Chart and the patient’s name from the patient drop-down list

4. Once you are in the Patient Chart, select the Lab Panels tab, then click on the new Imported Panel in the upper Panels windows; the Measurements, Values, and Ranges of the imported lab results will be displayed in the lower window.

To manually type in a patient’s lab results

1. Go to Open Patient Chart ▶ Lab Panels ▶ New Lab Panels and select New Lab Result button.

2. If already listed as a Measurement Type, the lab result and its corresponding data types, unit type, and clinical codes can be entered here, selecting Okay when finished, then Save.
3. If not already listed, the **Measurement Types** (e.g., *hemoglobin* or *creatinine*) that make up the patient’s lab results will automatically be added to the **Patient Chart** under **Measurements** along with their corresponding data types, unit type, and clinical codes.

The following is an example of ‘structured data’ lab results as used in a text file to **Import Lab Results** as well as an explanation of the actual names of the line fields used.

<table>
<thead>
<tr>
<th>Sample Lab Results (in the TXT file)</th>
<th>Line Field Names by Line (For Reference Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ValantLabResultsImportFile</td>
<td>&lt;!-- Lab Results File</td>
</tr>
<tr>
<td>McCarthy</td>
<td>&lt;!-- Patient Family Name</td>
</tr>
<tr>
<td>Charles</td>
<td>&lt;!-- Patient Given Name</td>
</tr>
<tr>
<td>MCCCHA</td>
<td>&lt;!-- Patient ID Number</td>
</tr>
<tr>
<td>Mid-town Laboratories</td>
<td>&lt;!-- Lab Facility Name</td>
</tr>
<tr>
<td>908 Drue Street</td>
<td>&lt;!-- Lab Facility Street Address</td>
</tr>
<tr>
<td>Eklutna</td>
<td>&lt;!-- Lab Facility City</td>
</tr>
<tr>
<td>Alaska</td>
<td>&lt;!-- Lab Facility State</td>
</tr>
<tr>
<td>99567</td>
<td>&lt;!-- Lab Facility Zip</td>
</tr>
<tr>
<td>4/13/2011</td>
<td>&lt;!-- Test Report Date</td>
</tr>
<tr>
<td>Hematology</td>
<td>&lt;!-- Test Type</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>&lt;!-- Test Specimen Source</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>&lt;!-- Condition/Disposition of Specimen</td>
</tr>
<tr>
<td>Eosinophil Count</td>
<td>&lt;!-- Test Name</td>
</tr>
<tr>
<td>26449-9</td>
<td>&lt;!-- LOINC Code</td>
</tr>
<tr>
<td>1-3%</td>
<td>&lt;!-- Normal Range</td>
</tr>
<tr>
<td>2%</td>
<td>&lt;!-- Test Result Value</td>
</tr>
<tr>
<td>4/13/2011</td>
<td>&lt;!-- Test Result Unit of Measure</td>
</tr>
<tr>
<td>Hematology</td>
<td>&lt;!-- Test Report Date</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>&lt;!-- Test Type</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>&lt;!-- Test Specimen Source</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>&lt;!-- Condition/Disposition of Specimen</td>
</tr>
<tr>
<td>718-7</td>
<td>&lt;!-- Test Name</td>
</tr>
<tr>
<td>male:14-18 female:36-48</td>
<td>&lt;!-- LOINC Code</td>
</tr>
<tr>
<td>16</td>
<td>&lt;!-- Normal Range</td>
</tr>
<tr>
<td>g/dl</td>
<td>&lt;!-- Test Result Value</td>
</tr>
<tr>
<td></td>
<td>&lt;!-- Test Result Unit of Measure</td>
</tr>
</tbody>
</table>
170.302(I) List All Patients Who Have A Particular Medical Condition

Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Generate at least one report listing patients of the EP with a specific condition.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>N/A</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>Eligible professionals (EPs) must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.</td>
</tr>
</tbody>
</table>

**Vālant EMR 4.00 Conformance**

Vālant EMR conforms to this measure by providing the means to generate and filter/sort patient lists by the following conditions and/or combinations of conditions:

- Age
- Sex
- Diagnosis
- Medication
- Medication Allergy
- Measurement

**Vālant EMR 4.00 Where and How**

1. Go to Tools ▶ Patient’s List and filter/sort by condition or combination of conditions
170.302(M) Identify And Provide Patient-Specific Educational Materials

Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 10% of all unique patients seen by the EP are provided patient-specific education resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Reporting Capabilities | - DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.  
- NUMERATOR: Number of patients in the denominator who are provided patient-specific education resources. 
The resulting percentage (Numerator ÷ Denominator) must be more than 10% in order for an EP to meet this measure. |

Vālant EMR 4.00 Conformance

Vālant EMR conforms to this measure by providing patient-specific education resources through logic built into the application which evaluates information about the patient and suggests education resources that would be of value.

Vālant EMR 4.00 Where and How

1. Under Patient Chart ➤ Measurements, when a patient’s Fasting Blood Glucose > 220 or if there is a Diagnosis of Alcohol Abuse, a link will show up under the Resources tab to direct the patient to an educational/informative web site (http://en.wikipedia.org/wiki/Blood_sugar or http://www.nlm.nih.gov/medlineplus/)

Diagnosis of alcohol abuse and link to medlineplus web site
**170.302(J): Reconciliation Medications**

The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

<table>
<thead>
<tr>
<th><strong>Measure</strong></th>
<th>The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion</strong></td>
<td>An EP who was not the recipient of any transitions of care during the EHR reporting period</td>
</tr>
</tbody>
</table>
| **Reporting Capabilities** | - **DENOMINATOR:** Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.  
- **NUMERATOR:** Number of transitions of care in the denominator where medication reconciliation was performed. |

The resulting percentage (Numerator ÷ Denominator) must be more than 50%

**Vālant EMR 4.00 Conformance**

Vālant EMR conforms to this measure by providing patient-specific education resources through logic built into the application which evaluates information about the patient and suggests education resources that would be of value.

**Vālant EMR 4.00 Where and How**

1. From the *left-hand menu column*, select **Open Patient Chart**, then select a **Patient** from the *drop-down menu on the popup*
2. From the Dashboard, select **New Medications** or select the **Medications** tab and select **New Medications**
3. Provided the patient has a prior electronic medication history, in **DrFirst** access the patient’s **Medications**, select **Medications History**, and change dates (e.g., from *1 year* to *2 years*) to reconcile earlier medication data.
**170.304(I) Provide Summary Records During Encounters And Transitions Of Care**

The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

<table>
<thead>
<tr>
<th>Measure</th>
<th>The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.</td>
</tr>
</tbody>
</table>
| Reporting Capabilities | -DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.  
-NUMERATOR: Number of transitions of care and referrals in the denominator where a summary of care record was provided.  
The resulting percentage (Numerator ÷ Denominator) must be more than 50% in order for an EP to meet this measure. |

**Vālant EMR 4.00 Conformance**

Vālant EMR conforms to this measure by providing the means to generate and export a CCD patient file or import a CCD or CCR patient file.

**Vālant EMR 4.00 Where and How**

**Create/Export a CCD File**

1. From the left-hand menu column, select **Open Patient Chart**, then select a **Patient** from the drop-down menu on the popup.
2. From any tab on the **Patient Chart**, select the **Options** button in the lower right-hand corner, then select the **Export to CCD** option. In the **Export to CCD** popup window, select the **Provider**, **Start Date**, and **End Date** of the measurement period to be displayed in the CCD file.
3. This file (XML format) can now be digitally copied to a USB flash drive, burned to a CD or DVD, or electronically transferred to an online health repository (like Microsoft Health Vault, Google Health, or some other third-party solution).
4. It can also be displayed for viewing or printing through **File Actions ➤ Display CCD/CCR**.
Options > Export to CCD

Better Behavioral Health Clinical Summary

Created On: May 12, 2011

Patient: George George
55 Woodland St
Osh Kosh, WI, 98002
tel+1-(206)555-4433

MRN: GEOGEO

Birthdate: February 23, 1955
Sex: Male

Guardian: Next of Kin:

Table of Contents

- Summary Purpose
- Problems
- Allergies and Adverse Reactions
- Medications
- Vital Signs

Summary Purpose

Note: Mental Health

Problems

<table>
<thead>
<tr>
<th>Axis</th>
<th>ICD Code</th>
<th>Diagnosis</th>
<th>Diagnosis Date</th>
<th>Last Changed Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>00.00</td>
<td>Undetermined Diagnosis</td>
<td>May 4, 2011</td>
<td></td>
<td>Active</td>
</tr>
<tr>
<td>III</td>
<td>346.10</td>
<td>Migraines, common</td>
<td>Apr 18, 2011</td>
<td></td>
<td>Active</td>
</tr>
<tr>
<td>III</td>
<td>45</td>
<td>meningitis</td>
<td>Apr 18, 2011</td>
<td></td>
<td>Active</td>
</tr>
</tbody>
</table>

Allergies and Adverse Reactions

CCD (XML) file, Generated and Displayed as HTML file in browser

Import/Display CCD/CCR File
Continuity of Care Documents (CCD) and Continuity of Care Records (CCR) are different health standards used to create flexible patient documents. Both CCD and CCR files contain relevant health summaries and other timely patient information which can be sent electronically from one provider to another. While the Valant EMR 4.00 application supports the importation and display of files of both the CCD and CCR standards, it creates exportable files using only the CCD file format.

1. From the left-hand menu, select File Actions ➤ Display CCD/CCR
2. From the Open popup box, navigate to the location of the CCD or CCR (XML-formatted) file you want to view, then select the Open button (depending on your browser or browser settings you may have to click a second Open button in another popup box).

![Example of an Imported CCR (XML) file, generated and displayed as HTML in browser](image-url)
### 170.302(L) Show Ability To Provide Data To Public Health Agencies

Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performed at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology’s capacity to submit electronic syndromic surveillance data to public health agencies and follow up submission if the test was successful (unless none of the public health agencies to which the EP submits such information has the capacity to receive the information electronically) to meet this measure.</td>
</tr>
</tbody>
</table>

#### Vālant EMR 4.00 Conformance

Vālant EMR conforms to this measure by providing the means to generate a HL7 v2.5.1 file to submit to a public health agency in compliance with Centers for Disease Control and Prevention’s (CDC) “Influenza Case Notification Message Mapping Guide”


#### Vālant EMR 4.00 Where and How

1. **Open Patient Chart ► Patient [select Patient] ► Options ► Report Influenza Outbreak**
2. This generates an **HL7** health file that can be transmitted to a public health agency


![Example of an HL7 Influenza Outbreak file](image-url)
170.302(K) Immunization Registries

Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.</td>
</tr>
<tr>
<td>Reporting Capabilities</td>
<td>Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test was successful</td>
</tr>
</tbody>
</table>

Vālant EMR 4.00 Conformance

Vālant EMR conforms to this measure by providing the means to generate a HL7 v2.5.1 file to submit to a public health agency in compliance with Centers for Disease Control and Prevention’s (CDC)

Vālant EMR 4.00 Where and How

1. Open Patient Chart ► Patient ► Options | Export Immunizations
2. This generates an HL7 health file that can be transmitted to a public health agency

NOTE: Copy-Paste data to nist.gov site to test the data on the HL7 file http://xreg2.nist.gov:8080/HL7V2MuValidation2011/#message%2Ffiles.htm

- Select test: 2.5.1 Immunization Message VXU_V04
- Validation Context: VXU_V04_2.5.1_GeneralVCWithRXA.6
- Load Data
- Validate
### 170.304(D) Send Patients Preventive And Follow-Up Care Reminders

Send reminders to patients per patient preference for preventive/follow-up care.

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.</td>
</tr>
</tbody>
</table>
| Reporting Capabilities                                                 | -DENOMINATOR: Number of unique patients 65 years old or older or 5 years older or younger.  
-NUMERATOR: Number of patients in the denominator who were sent the appropriate reminder.  
The resulting percentage (Numerator ÷ Denominator) must be more than 20 percent in order for an EP to meet this measure.            |

**Vālant EMR 4.00 Conformance**

Vālant EMR conforms to this measure by providing the means to set and schedule patient reminders.

**Vālant EMR 4.00 Where and How**

1. Go to **Tools ▶️ Reminders**
2. Select **New Reminder** button
3. Fill in **Reminder Date**, **Patient**, **Assign to**, and **Reminder**
4. **Reminders** will appear on the EMR Dashboard
170.304(G) Provide Patients Timely Electronic Access To Their Health Information

Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.

<table>
<thead>
<tr>
<th>Measure</th>
<th>At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP’s discretion to withhold certain information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion</td>
<td>EXCLUSION: If an EP neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy during the EHR reporting period, they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.</td>
</tr>
</tbody>
</table>
| Reporting Capabilities | -DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.  
-NUMERATOR: Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) The resulting percentage (Numerator ÷ Denominator) must be at least 10 percent in order for an EP to meet this measure. |

Vālant conforms with this measure by providing the functionality to make by request an electronic copy of a patient’s health information via the generation and exportation of a CCD file.

**Vālant EMR 4.00 Where and How**

1. From the left-hand menu column, select Open Patient Chart, then select a Patient from the drop-down menu on the popup
2. From any tab on the Patient Chart, select the Options button in the lower right-hand corner, then select the Export to CCD option. In the Export to CCD popup window, select the Provider, Start Date, and End Date of the measurement period to be displayed in the CCD file.
3. This file (XML format) can now be digitally copied to a USB flash drive, burned to a CD or DVD, or electronically transferred to an online health repository (like Microsoft Health Vault, Google Health, or some other third-party solution).
4. It can also be displayed for viewing or printing through a browser (having web access) by saving then clicking on file to open, or through the Save and Open function.
Options > Export to CCD

Better Behavioral Health Clinical Summary

Created On: May 12, 2011

Patient: George George
55 Woodland St
Osh Kosh, WI, 98002
tel: 1-(206)555-4433

Birthdate: February 23, 1955
Sex: Male
Guardian: Next of Kin:

MRN: GEOGEO

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<tr>
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<tbody>
<tr>
<td>I</td>
<td>000.00</td>
<td>Undetermined Diagnosis</td>
<td>May 4, 2011</td>
<td></td>
<td>Active</td>
</tr>
<tr>
<td>III</td>
<td>346.10</td>
<td>Migraine, common</td>
<td>Apr 18, 2011</td>
<td></td>
<td>Active</td>
</tr>
<tr>
<td>III</td>
<td>45</td>
<td>meningitis</td>
<td>Apr 18, 2011</td>
<td></td>
<td>Active</td>
</tr>
</tbody>
</table>

Allergies and Adverse Reactions

CCD (XML) file, Generated and Displayed as HTML file in browser
5 Appendix 1: Quality Measures

Here is an example as to how to read and implement the requirements for Quality Measures in the Vālant EMR 4.00 application using (NQF 0018) Controlling High Blood Pressure as an example; additional explanations are inline in red.

(NQF 0018) Controlling High Blood Pressure

Initial Patient Population =
AND: “Patient characteristic: birth date” (age) >=17 and <=84 years to capture all patients who will reach the ages between 18 and 85 years during the “measurement period”; Patient must be between the ages of 18 and 85...

Denominator =
AND: All patients in the initial patient population;
AND: “Diagnosis active: hypertension” <= 6 months after “measurement start date”;
AND: “Encounter: encounter outpatient”; AND NOT:
OR: “Procedure performed: procedures indicative of ESRD”;
OR: “Diagnosis active: pregnancy”;
OR: “Diagnosis active: ESRD”;
...within 6 months of the initial office visit AND have an active diagnosis of Hypertension...

Numerator =
AND: MINIMUM “Physical exam finding: diastolic blood pressure” < 90 mmHg during MOST RECENT “Encounter: encounter outpatient”; AND: MINIMUM “Physical exam finding: systolic blood pressure” < 140 mmHg during MOST RECENT “Encounter: encounter outpatient”; ...AND have a diastolic blood pressure reading of less-than 90 AND a systolic blood pressure reading of less-than 140 during the most recent office visit (“Encounter”).

Exclusions = None

Before adding the Patient codes, and depending on the individual Quality Measure, a list of codes must have first been entered into one, two, or all of these three areas:

Transaction Codes > Non-Billing Codes
Reference Data > Other Codes
Reference Data > Immunization Types

(See Appendix 2: Code Cheat Sheets for Quality Measures at the back of this document for a quick-and-dirty look at what codes to enter)
Then, add the following items to the **Patient's Chart**:

| **Patient | Age** | \n|---|---|\n| Between ages of 17 and 84. Patient must be between the ages of 17 and 84 at initial visit or between 18 and 85 sometime during the 6 month measurement period. |

| **Measurement Period** | \n|---|\n| Less than 6 months after “measurement start date”. If the measurement period falls outside of this 6 month range, the Quality Measure calculation will not function. |

| **VALANT Manual Add-Ins** | **Denominator** | \n|---|---|\n| Patient Chart > [Patient] > Codes |
| Encounter: Outpatient (*e.g.*, **Encounter Office Visit**) |
| Manually add this to the Patient’s initial visit (from New Code > Non-Billing Code) |

(AND)

| **Encounter: Outpatient (*e.g.*, **Encounter Office Visit**) |
| Manually add this to the Patient’s initial visit (from New Code > Non-Billing Code) |

(either CPT codes or ICD9 codes can be used to populate the code list)

ICD9  V70.0  **OR**  CPT  99201 or 99202 or 99203 or 99204 or 99205  
[manually add a code for each date of visit]

| **Reference Data > Diagnosis** | \n|---|\n| Diagnosis active: Hypertension - ICD9  401.0 |
| Manually add this New Diagnosis this to the Patient’s most recent visit (Axis III) |

| **Axis III** | **New Diagnosis** | \n|---|---|\n| Date  Diagnosis  Status  Billing |
| 1/16/2011  401.0: Hypertension - Diagnosis  Active  2 |
Numerator

diastolic blood pressure < 90 [Added at most recent visit]
Manually add measurement for each date of visit
systolic blood pressure <140 [Added at most recent visit]
Manually add measurement for each date of visit

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/16/2011</td>
<td></td>
<td>130/85 mm[Hg]</td>
</tr>
<tr>
<td>12/16/2010</td>
<td></td>
<td>140/90 mm[Hg]</td>
</tr>
</tbody>
</table>
### Appendix 2: Code Cheat Sheets for Quality Measures

#### Transaction Codes > Non-Billing Codes

<table>
<thead>
<tr>
<th>Code ID</th>
<th>Description</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90656</td>
<td>Influenza Vaccine</td>
<td></td>
</tr>
<tr>
<td>90707</td>
<td>MMR Shot</td>
<td></td>
</tr>
<tr>
<td>92014</td>
<td>Encounter Ophthalmological Services</td>
<td></td>
</tr>
<tr>
<td>97802</td>
<td>Counseling for Nutrition / Dietary Counseling</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>Encounter Office &amp; Outpatient Consult</td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td>Encounter Office Visit</td>
<td></td>
</tr>
<tr>
<td>99204</td>
<td>Encounter Office Visit</td>
<td></td>
</tr>
<tr>
<td>99385</td>
<td>Encounter Prevent. Main. Srv. 18 or oldr</td>
<td></td>
</tr>
<tr>
<td>99406</td>
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Reference Data > Other Codes

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## Reference Data > Immunization Types Codes

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