**eQIP BH Milestone 2 - Process**

These Checklists have been developed to help you track your Organization’s progress toward meeting the eQIP Milestones. A fully completed Checklist must be sent to your Grant Manager as a first step toward attesting to meeting eQIP Milestone 2.

Remember, in order to meet a specific Milestone, **each** required functionality must be achieved in **every** facility for which you received an EMRAM score. It is very important that you cross-check this checklist against the original EMRAM Gap assessment(s) that you received from HIMSS for each of your clinical facilities. This is to ensure that you have addressed every gap and are reporting on each facility that received a score. MeHI will also be reviewing those documents.

The Milestone 2 Checklist tracks your progress toward meeting each of the required functionalities of EMRAM Stages 1-3. REMEMBER, some of the EMRAM functionalities have been clarified and requirements modified from the original. To help better explain the requirements for each functionality, this checklist maps to the current “Frequently-Asked-Questions” (FAQ) – and FAQ number – that corresponds to each Stage. If you wish to access the complete FAQ document, visit MeHI’s eQIP Grantee Page and look under “Q&As”:

Webpage: [**http://mehi.masstech.org/eqip-bh-grantee**](http://mehi.masstech.org/eqip-bh-grantee)

**NOTE**: The “Grantee Notes” column must be completed for this tracking form to be accepted. In this column, please document how your organization achieved these functionalities to meet Stages 1-3 of EMRAM. These notes should include sufficient details for a reviewer to understand how the functionality was achieved. To provide some examples:

* The date in which the specific functionality was achieved at your Organization
  + Example: *We rolled our EHR system, “XYZ System”, in January 2016. All Providers were trained by April 2016. With this rollout, our providers are now able to enter patient notes during a patient session.*
* If you had already met a requirement prior to the start of the grant (i.e. a “YES” on your EMRAM gap analysis) at one or more of your facilities, mark this in the “Grantee Notes Column”
  + Example: *Met in 6 of 7 facilities prior to the start of grant; rolled-out in “Location” facility on October 22, 2016*.
* If you are requesting a wavier
  + Example: *XX Org is requesting a wavier for EMRAM 3.10. Reason: We do not prescribe any medication to our patients.*

Once you have sufficiently documented your organization progress notes and believe that you have met the requirements for eQIP Milestone 2, notify your Grant Manager via email with the completed Milestone 2 Functionality Checklist attached. Your Grant Manager will contact you upon review.

*As a reminder, you are required to submit an updated Health IT description at the time of attestation. The template will be provided to you by the eQIP Program Manager, along with the attestation forms, once your milestone achievement is approved.*

**BH Milestone 2 Checklist: EMRAM Stages 1-3**

In order for your Organization to successfully meet this Milestone, your Organization must meet each required functionality in all of the facilities for which it received an EMRAM score. As a reminder, if all of your Organization’s clinical sites were at the same Stage at the time of your EMRAM survey submission, you may have only received one EMRAM score for all of your facilities. However, you must note if facilities met functionalities at different times.

In Table 1, for all required functionalities that your Organization has achieved, check the box in the “Requirement met in all clinical sites” column. For requirements that are denoted as “OR” stages, which are highlighted in blue, appropriately mark which of the requirements your Organization has met. The “MeHI Notes” column describes any clarifications / modifications from the original chart. The “FAQ #” maps the functionality to an FAQ that corresponds to that item.

The “Grantee Notes” column MUST be completed to include justification detailed explanation of how your Organization met the specified functionality.

**Table 1: Functionality checklist**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STAGE 1: Desktop access to clinical information, unstructured data, multiple data sources, intra-office/informal messaging**  ● The first use of computers for access to information, but the information is not yet stored in a patient centric Clinical Data Repository (proxy for EMR)  ● Multiple data sources searched with no permanent patient record stored electronically – paper based  ● Electronic storage of chart notes after transcription, but notes are only free text, not structured  ● Access to hospital’s EMR for viewing  ● Electronic access on physician and/or nurse desktops to online reference material (e.g. eligibility information, lab results) | | | | | | |
| **STAGE** | **CATEGORY** | **REQUIREMENT** | **MeHI Notes** | **FAQ #** | **Grantee Notes** | **REQUIREMENT MET IN ALL CLINICAL SITES** |
| 1.1 **OR** | Information Exchange | Web browser on physician/nurse desktops for access only to online reference material, eligibility information, lab results, etc. | The term “physician” should be broadly applied to include other members of the care team at your organization. | 3.9 | *EXAMPLE ONLY: Met in all of our clinical facilities prior to the start of the grant.* |  |
| 1.2 | Information Exchange | Web access only to hospital’s clinical information | This means that the facility must be able to access clinical information from a hospital on-demand.  For BH outpatient facilities, for example, clinicians may have access to electronic records of their patients via a web-accessible virtual desktop (e.g., Citrix), via a connection internally to a LAN/WAN, or via a browser access to a hospital’s Provider Portal.  A HIway webmail account is not web access to a hospital’s EHR, thus it would not meet the requirement | 3.10  3.11  3.10 |  |  |
| 1.3 | Physician Documentation | Transcribed reports are stored electronically | The term “physician” should be broadly applied to include other members of the care team at your organization. | 3.9 |  |  |
| **STAGE 2: Beginning of a Clinical Data Repository (CDR) with orders and results, computers may be at point-of-care, access to results from outside facilities**  ● The first appearance of a patient centric CDR for core EMR functionality and data storage Electronic access to data for results review is available within the EMR, scanned or linked, from an outside facility (e.g. hospital, laboratory, or diagnostic imaging center)  ● Computers may be at point-of-care for use by nurses in charting or order entry (O/E), but use is partial or optional  ● Most nurse charting and O/E is at a central location, not in exam room | | | | | | |
| **STAGE** | **CATEGORY** | **REQUIREMENT** | **MeHI Notes** | **FAQ #** | **Grantee Notes** | **REQUIREMENT MET IN ALL CLINICAL SITES** |
| 2.1 | System Installed | EMR Live and Operational |  |  |  |  |
| 2.2 **OR** | Clinician Charting | At point of care | Clinician refers to any member of the care team at your organization (physician, nurse, etc.).  Here, clinician charting refers to entering events and updates related to the patient (history, physical exam results, treatment goals, progress notes, etc.) at the point of care.  “At point of care” refers to a private space where care providers meet with their clients, such as in a private office space where the professional meets with the client to provide therapeutic services. | 3.9  3.13  3.14 | *EXAMPLE ONLY: We rolled our EHR system “XYZ System”, in January 2016. All Providers were trained by April 2016. With this rollout, our providers are now able to enter patient notes during a patient session.* |  |
| 2.3 **OR** | Clinician Charting | At clinician station | Clinician refers to any member of the care team at your organization (physician, nurse, etc.).  Here, clinician charting refers to entering events and updates related to the patient (history, physical exam results, treatment goals, progress notes, etc.) at the clinician work station.  “At the clinician station” means a place where the clinician can access a computer and the patient’s electronic medical record. This may be in an office or at a shared computer station. | 3.9  3.13  3.15 |  |  |
| 2.4 **OR** | Clinician Order Entry | At clinician station | Clinician refers to any member of the care team at your organization (physician, nurse, etc.).  Clinician order entry documents a medical order by a clinician that requires action to be taken by another staff, either within your organization or outside of your organization. Examples of clinician order entry could be an order for medication, dosing, labs, admission, radiology, referral to a clinical program within your organization, or referral to a clinical program outside of your organization. Another example could be documentation in your EHR stating that a clinician in your organization ordered a patient to perform a health action, such as visit their PCP to receive a flu shot. The presence of this documentation of an ordered action can meet the requirement of clinician order entry.  “At the clinician station” means a place where the clinician can access a computer and the patient’s electronic medical record. This may be in an office or at a shared computer station. | 3.9  3.13  3.15 |  |  |
| 2.5 | Clinician Order Entry | At point of care | Clinician refers to any member of the care team at your organization (physician, nurse, etc.).  Clinician order entry documents a medical order by a clinician that requires action to be taken by another staff, either within your organization or outside of your organization. Examples of clinician order entry could be an order for medication, dosing, labs, admission, radiology, referral to a clinical program within your organization, or referral to a clinical program outside of your organization. Another example could be documentation in your EHR stating that a clinician in your organization ordered a patient to perform a health action, such as visit their PCP to receive a flu shot. The presence of this documentation of an ordered action can meet the requirement of clinician order entry.  “At point of care” refers to a private space where care providers meet with their clients, such as in a private office space where the professional meets with the client to provide therapeutic services. | 3.9  3.13  3.14 |  |  |
| **STAGE 3: Electronic messaging, computers have replaced the paper chart, clinical documentation and clinical decision support**  ● Electronic charting includes vitals, nursing intake assessment, encounter procedures, etc. completed in exam room  ● Problem lists, e-prescribing for new & refill required  o ePrescribing supported by Clinical Decision Support System (CDSS) for new medications and refills  o All medications on-line to support Med Reconciliation  ● Reminders to staff pertaining to patients (not to patients directly)  ● Physician notes are dictation/ transcription or VR with text results scanned to chart with link | | | | | | |
| **STAGE** | **CATEGORY** | **REQUIREMENT** | **MeHI Notes** | **FAQ #** | **Grantee Notes** | **REQUIREMENT MET IN ALL CLINICAL SITES** |
| 3.1 | Clinical Data Repository | For nursing documentation | The term “physician” (or here is “nursing”) should be broadly applied to include other members of the care team at your organization. | 3.9 |  |  |
| 3.2 | Clinical Data Repository | For current encounter vital signs including height, weight, blood pressure, temperature, etc. | Vital signs refers to any trends or attributes related to the patient that are intended to chart overtime – such as alcohol consumption, emotional level, etc. | 3.17 |  |  |
| 3.3 | Clinical Decision Support | Basic medication screening (drug/drug, drug/allergy) |  |  |  |  |
| 3.4 **OR** | Clinician Charting | At point of care | Clinician refers to any member of the care team at your organization (physician, nurse, etc.).  Here, clinician charting refers to entering events and updates related to the patient (history, physical exam results, treatment goals, progress notes, etc.) at the point of care.  “At point of care” refers to a private space where care providers meet with their clients, such as in a private office space where the professional meets with the client to provide therapeutic services. | 3.9  3.13  3.14 |  |  |
| 3.5 AND | Clinician Charting | At clinician station | Clinician refers to any member of the care team at your organization (physician, nurse, etc.).  Here, clinician charting refers to entering events and updates related to the patient (history, physical exam results, treatment goals, progress notes, etc.) at the clinician work station.  “At the clinician station” means a place where the clinician can access a computer and the patient’s electronic medical record. This may be in an office or at a shared computer station. | 3.9  3.13  3.15 |  |  |
| ***This requirement is different than that of Stage 2. Here in Stage 3, you must meet either 3.4 OR 3.5 (above two in blue), AND either 3.6 OR 3.7 (below two in blue).*** | | | | | | |
| 3.6 **OR** | Clinician Order Entry | At point of care | Clinician refers to any member of the care team at your organization (physician, nurse, etc.).  Clinician order entry documents a medical order by a clinician that requires action to be taken by another staff, either within your organization or outside of your organization. Examples of clinician order entry could be an order for medication, dosing, labs, admission, radiology, referral to a clinical program within your organization, or referral to a clinical program outside of your organization. Another example could be documentation in your EHR stating that a clinician in your organization ordered a patient to perform a health action, such as visit their PCP to receive a flu shot. The presence of this documentation of an ordered action can meet the requirement of clinician order entry.  “At point of care” refers to a private space where care providers meet with their clients, such as in a private office space where the professional meets with the client to provide therapeutic services. | 3.9  3.13  3.14 |  |  |
| 3.7 | Clinician Order Entry | At clinician station | Clinician refers to any member of the care team at your organization (physician, nurse, etc.).  Clinician order entry documents a medical order by a clinician that requires action to be taken by another staff, either within your organization or outside of your organization. Examples of clinician order entry could be an order for medication, dosing, labs, admission, radiology, referral to a clinical program within your organization, or referral to a clinical program outside of your organization. Another example could be documentation in your EHR stating that a clinician in your organization ordered a patient to perform a health action, such as visit their PCP to receive a flu shot. The presence of this documentation of an ordered action can meet the requirement of clinician order entry.  “At the clinician station” means a place where the clinician can access a computer and the patient’s electronic medical record. This may be in an office or at a shared computer station. | 3.9  3.13  3.15 |  |  |
| 3.8 | Electronic Messaging | Internal clinic communications |  |  |  |  |
| 3.9 | Medication Management | Medication lists on-line for all patients | We are expecting that medication data for each patient who is currently prescribed medication and who is currently receiving any type of clinical services by your organization be entered into your EHR. The medication list would be part of the patient’s record and would be updated, as necessary. | 3.18 |  |  |
| 3.10 | Medication Management | e-Prescribing for refill medication requests | The medication list would be part of the patient’s record and would be updated, as necessary. | 3.18 | *EXAMPLE ONLY: XX Org is requesting a wavier for EMRAM 3.10. Reason: We do not prescribe any medication to our patients.* |  |
| 3.11 | Medication Management | e-Prescribing for new medications | The medication list would be part of the patient’s record and would be updated, as necessary. | 3.18 | *EXAMPLE ONLY: XX Org is requesting a wavier for EMRAM 3.11. Reason: We do not prescribe any medication to our patients.* |  |
| 3.12 | Medication Management | Medication reconciliation | Medication Reconciliation can be met by reconciling medications received electronically via a CCD, as well as manually incorporation medication received via client self-report. | 3.36 |  |  |
| 3.13 | Physician Documentation | Problem lists | Clinician refers to any member of the care team at your organization (physician, nurse, etc.).  Problem list may be used to document the client’s diagnoses. For example, if you are using DSM IV, typically DSM IV codes have an ICD-9 code associated with them. Most EHRs list diagnoses with their corresponding ICD-9 code. | 3.9  3.19 |  |  |