

PowerSoftMD - Meaningful Use

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01 Menu – Implement Drug Formulary Checks

Objective

Implement drug formulary checks.

Measure

The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.

Exclusion

Any EP who writes fewer than 100 prescriptions during the EHR reporting period

Remember you can go directly to the government's web site:

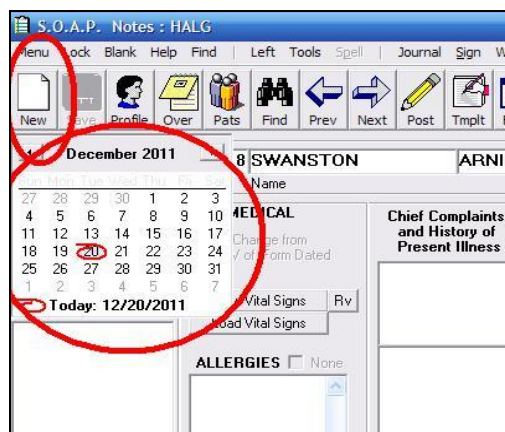
www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

To Check Formularies:

- 1) From the Primary, Menu select the top “SOAP” Icon and select the patient.

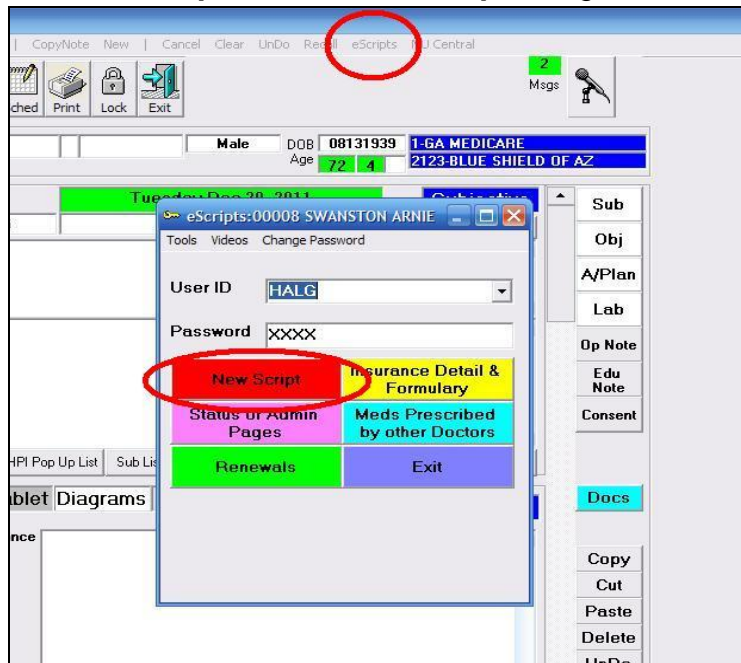


- 2) Click **New** button, select current date for a new note



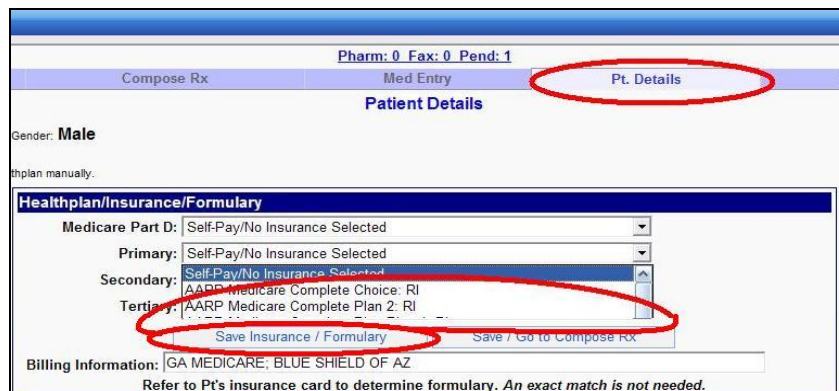
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3) At top menu, select “eScripts”, click **New Script** to sign in to eScripts



4) Click on the **Pt. Details** Tab

5) Select Health plan from drop down menus, click **Save Insurance/Formulary**



6) Click on the **Compose Rx** Tab

7) Check the **Include Obsolete** checkbox

8) At top left text field, type in the name of a drug, click **Drug Search**

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Pharm: 0 Fax: 0 Pend: 0

Compose Rx Med Entry Pt. Details

Compose Rx

9 Gender: **Male** TRICARE North Rh

healthplan manually.

acetam Drug Search Doctor's List

3 letter min. recommended Include 'obsolete' drugs

Allergy / Intolerance Search

Allergy	Severity	memo
Sulfa (Sulfonamides)	Mild	

9) In the result window, Note the formulary status to the left of every drug

Not In Formulary	acetaminophen-calcium-caffeine-glycine 500 mg-185 mg-50 mg-80 mg Tab	OTC
acetaminophen-codeine		Monograph Leaflet Analgesic Narcotic Codeine Combinations
(acetaminophen-codeine)		(Show Brands)
Preferred	acetaminophen-codeine 120 mg-12 mg/5 mL Elixir	Generic
Not In Formulary	acetaminophen-codeine 120 mg-12 mg/5 mL Oral Soln	
Approved	acetaminophen-codeine 120 mg-12 mg/5 mL Oral Susp	
Not In Formulary	acetaminophen-codeine 300 mg-15 mg Tab	Generic
Not In Formulary	acetaminophen-codeine 300 mg-30 mg Tab	Generic

10) If desired, select a drug from results & enter the Sig, click **Save Rx**

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02 Menu – Incorporate Clinical Lab-Test Results

Objective

Incorporate clinical lab test results into EHR as structured data.

Measure

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.

Exclusion

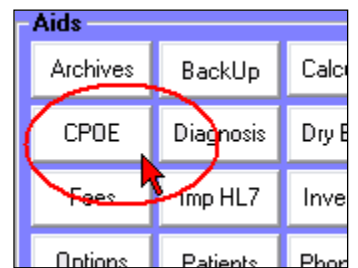
An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

Remember you can go directly to the government’s web site:

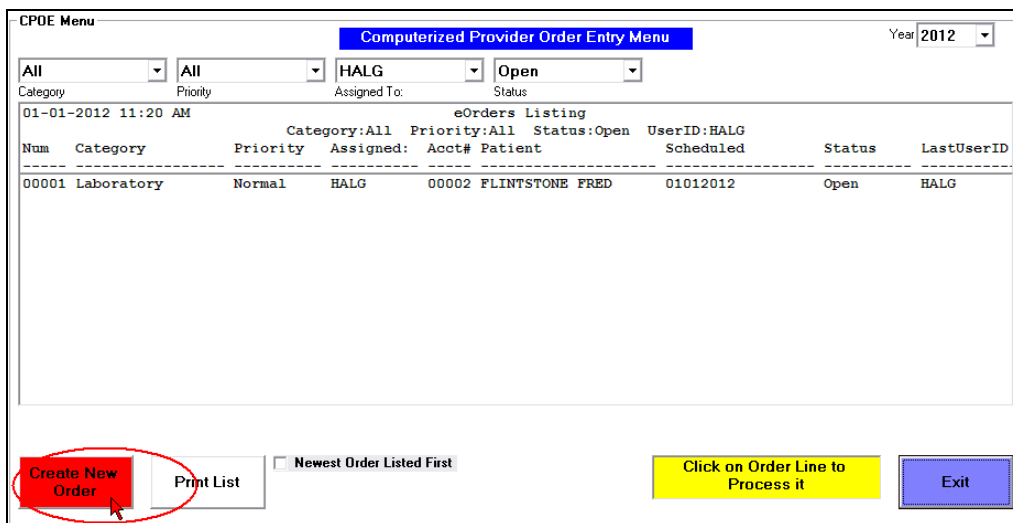
www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

Entering New Orders:

- 1) From the Primary Menu, click the “CPOE” button at the lower-left side of the screen. You may also directly go to the CPOE system from a patient’s SOAP Note screen by using the top Window toolbar option, then selecting “CPOE – eOrders”.



- 2) To create an order, press the “Create New Order” button and select a patient.



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3) Next, select a **Category** for the patient's order.

The screenshot shows the 'CPOE New Orders' window. At the top left, a 'Tools' button is circled in red. The main form area is titled 'Create New Order' and contains the following fields and controls:

- Account No:** 00003
- Patient Name:** SPRINGER JERRY I
- Assigned To:** HALG
- Priority:** Normal
- Location:** Office
- Doctor:** 01
- Category:** Laboratory (circled in red)
- Lab Name:** (empty)
- Specimen Number:** (empty)
- Scheduled Date:** 01012012
- Scheduled Time:** (empty)
- Status:** Open

Below the form, a text area displays the order details: '01012012 11:21AM HALG: Creatinine, routine Fasting Blood Glucose in AM Complete Blood Count w/ Differential, every other day times 5'. At the bottom, a toolbar contains buttons for 'Time Stamp', 'Action', 'Short Cuts' (circled in red), 'Print Order', 'Cancel', and 'Save/Exit'.

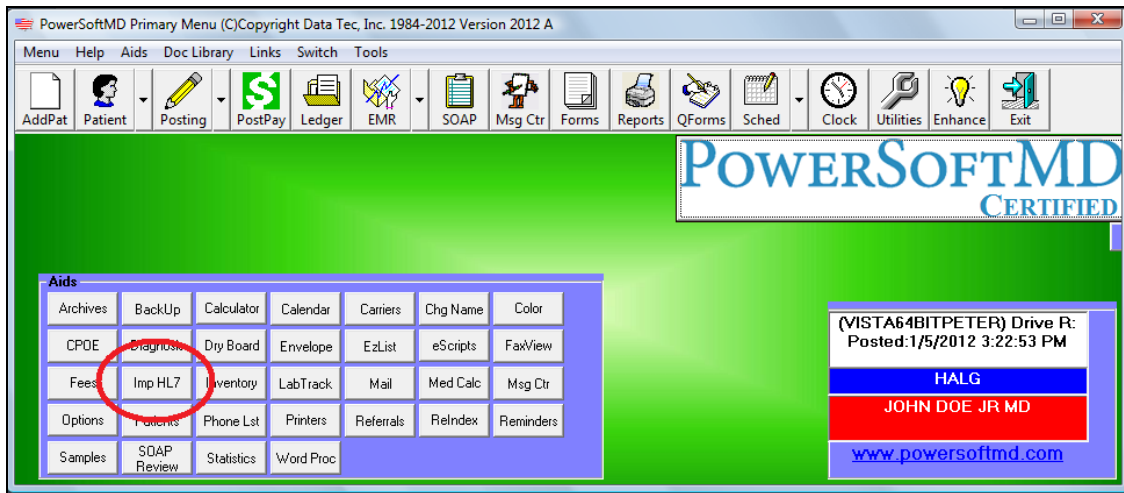
You may create and use a list of commonly text by using the top toolbar “**Tools**” option then “**Edit Short Cuts**”. You may also create the list of “**Actions**” by using “**Tools**” then “**Edit Actions**”. This will let you enter and update orders quickly and easily. Both the Short Cuts and Action text may use the same macros used with SOAP Notes.

- 4) You can also set the “**Status**” to **Open** or **Complete**. Leave the Order **Open** if it is to be completed later.
- 5) Press “Save/Exit” to store.

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HL7 Files: To Receive, Display and Incorporate Results:

- 1) From the Primary Menu, select the bottom-left “**Imp HL7**” button, find the correct order to associate:



- 2) Select the folder with the HL7 files (Example: The C:\LabIn\ folder)
- 3) On the pop-up, select the HL7 file you want to display with the blue “**View HL7 Lab Results**” button.
- 4) Verify the following data is included...
 - a. For positive patient identification, either the patient's name and identification number, or a unique patient identifier and identification number
 - b. The name and address of the laboratory location where the test was performed.
 - c. The test report date.
 - d. The test performed.
 - e. Specimen source, when appropriate.
 - f. The test result and, if applicable, the units of measurement or interpretation, or both.
 - g. Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability.
- 5) Close the results display & any other windows that open
- 6) To Import, click the red “**Import HL7 Results**” button

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Disease Registry: To Receive, Display and Incorporate Results:

First, Open the Patient's Disease Registry.

The screenshot shows the 'Patient Disease Registry Info' window for patient FLINTSTONE FRED E. The patient's age is 76 years and 7 months. The 'Lab Results' tab is selected. The following table displays the laboratory test results:

Test Name	Value	Request Date	Flag	Code	CodeType	Data Entry Date
Albumin	5.4 g/dl	05232012	Normal			05202012
Alkaline Phosphatase						
ALT						
Bilirubin, Direct						
Bilirubin, Total						
BUN						
Total Cholesterol						
HDL Cholesterol						
LDL Cholesterol	150 mg/dl	05232012	High			05202012
Creatinine						
Eosinophil Count						
Glucose (Blood Sugar)						

At the bottom of the window, there are buttons for 'Save', 'Cancel', and 'Save/Exit'. A 'View/Print History' button is also present on the right side.

- 1) Select the Lab Results tab.
- 2) Enter the numeric or positive/negative results.
- 3) Enter the Date the Lab was requested, the Date of Service.
- 4) Save and Exit.

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03 Menu – Patient Lists

Objective

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

Measure

Generate at least one report listing patients of the EP with a specific condition.

Exclusion

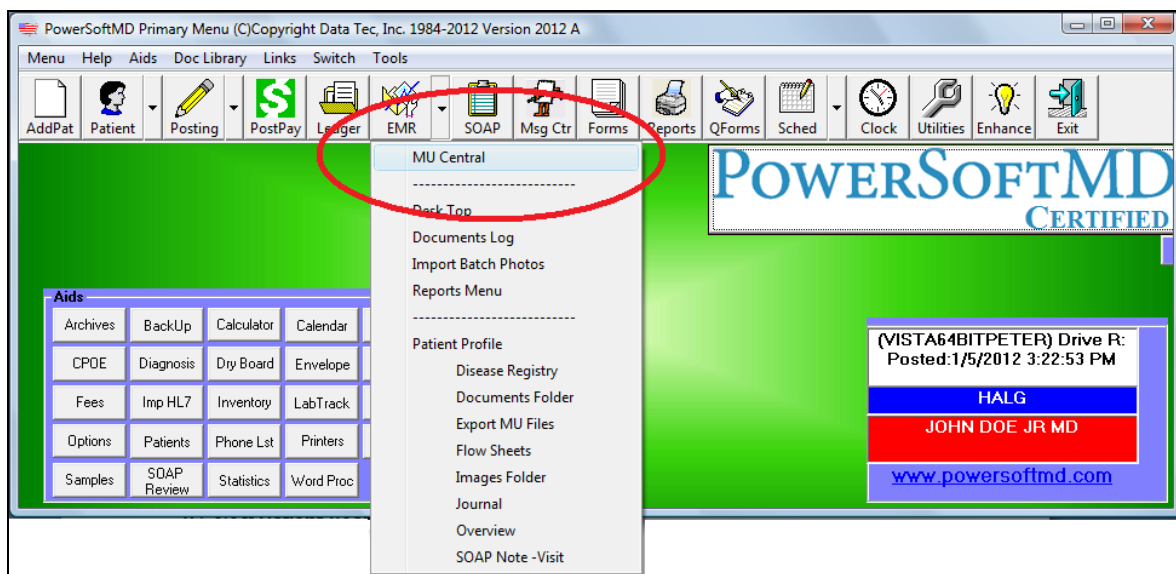
No exclusion.

Remember you can go directly to the government's web site:

www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

To Generate Patient Lists:

- 1) From the Primary Menu, select the drop-down arrow next to the EMR Icon and select **MU Central**



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2) Under the Reports/Reminders section, select "Patient Search List"

MU Central

<p>Reports/Reminders</p> <ul style="list-style-type: none"><input type="checkbox"/> Audit Log Report<input type="checkbox"/> Automate Measure Calculation<input type="checkbox"/> Patient Search List<input type="checkbox"/> Patient Reminder List<input type="checkbox"/> View/Update Patient Reminders<input type="checkbox"/> Calculate & Submit Clinical Quality Measures	<p>Patient Updates/Tasks</p> <ul style="list-style-type: none"><input type="checkbox"/> Demographics<input type="checkbox"/> Smoking Status<input type="checkbox"/> Medication Reconciliation<input type="checkbox"/> Refer Patient to Doctor or Facility <p>Exchange Clinical Information</p> <ul style="list-style-type: none"><input type="checkbox"/> Send Clinical Information<input type="checkbox"/> Receive Clinical Information
<p>File Tasks/Transmissions</p> <ul style="list-style-type: none"><input type="checkbox"/> Encrypt/Decrypt Files<input type="checkbox"/> Hash Code - Compare Files<input type="checkbox"/> Submit to Immunization Registry<input type="checkbox"/> Submit Public Health Surveillance	<p>Patient Requests</p> <ul style="list-style-type: none"><input type="checkbox"/> Clinical Summary<input type="checkbox"/> Electronic Copy Health Record CCR <p>Timely Access</p> <ul style="list-style-type: none"><input type="checkbox"/> Define Patient's Remote UserID<input type="checkbox"/> Export Info to Patient VFolder<input type="checkbox"/> Create VFolders for All Users
<p>Other</p> <ul style="list-style-type: none"><input type="checkbox"/> Define Clinical Decision Support Rules	

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3) On this screen, select the measure select the tabs for the criteria you are searching for and then click Red "Run" button.

The screenshot shows the 'MU Patient Search List' application window. It features several search criteria sections: 'Activity Date Range' with fields for 'Beginning Date' (01011980) and 'Ending Date' (01232012), and a checked 'Ignore Date Range' option; 'Patient Status' with checked options for 'Active', 'In-Active', and 'Deceased'; and a 'Doctor' dropdown menu set to '01'. Below these are tabs for 'Allergies', 'Immunizations', 'Procedures', 'Demographics', 'Problems', 'Medications', and 'Lab Results', with 'Demographics' and 'Problems' checked. The 'Problem/Diagnosis Selection' section includes radio buttons for 'OR - Any Problem in List' (selected) and 'AND - All Problems in List must be found'. A text input field contains 'Text Str =Diabetes'. At the bottom, there is a 'Number Items in List' field set to '1', and buttons for 'Add To List', 'Add Diag Code To List', and 'Clear List'. A large red 'Run' button is prominent at the bottom left, along with 'Print Patient List Report' and 'Exit' buttons.

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04 Menu – Patient Reminders

Objective

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

Measure

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.

Exclusion

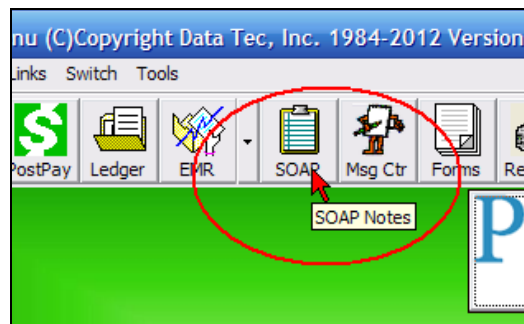
An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

Remember you can go directly to the government’s web site:

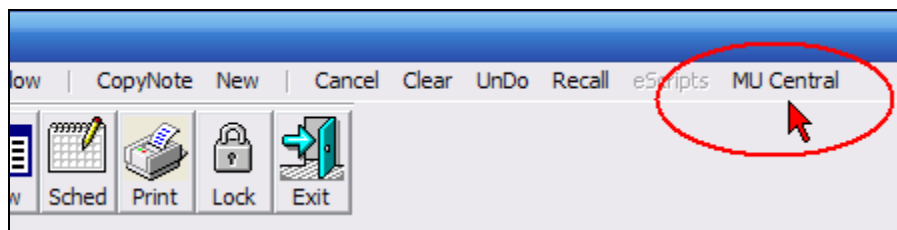
www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

To Generate Patient Reminders:

- 1) From the Primary Menu, select the SOAP Note Icon.

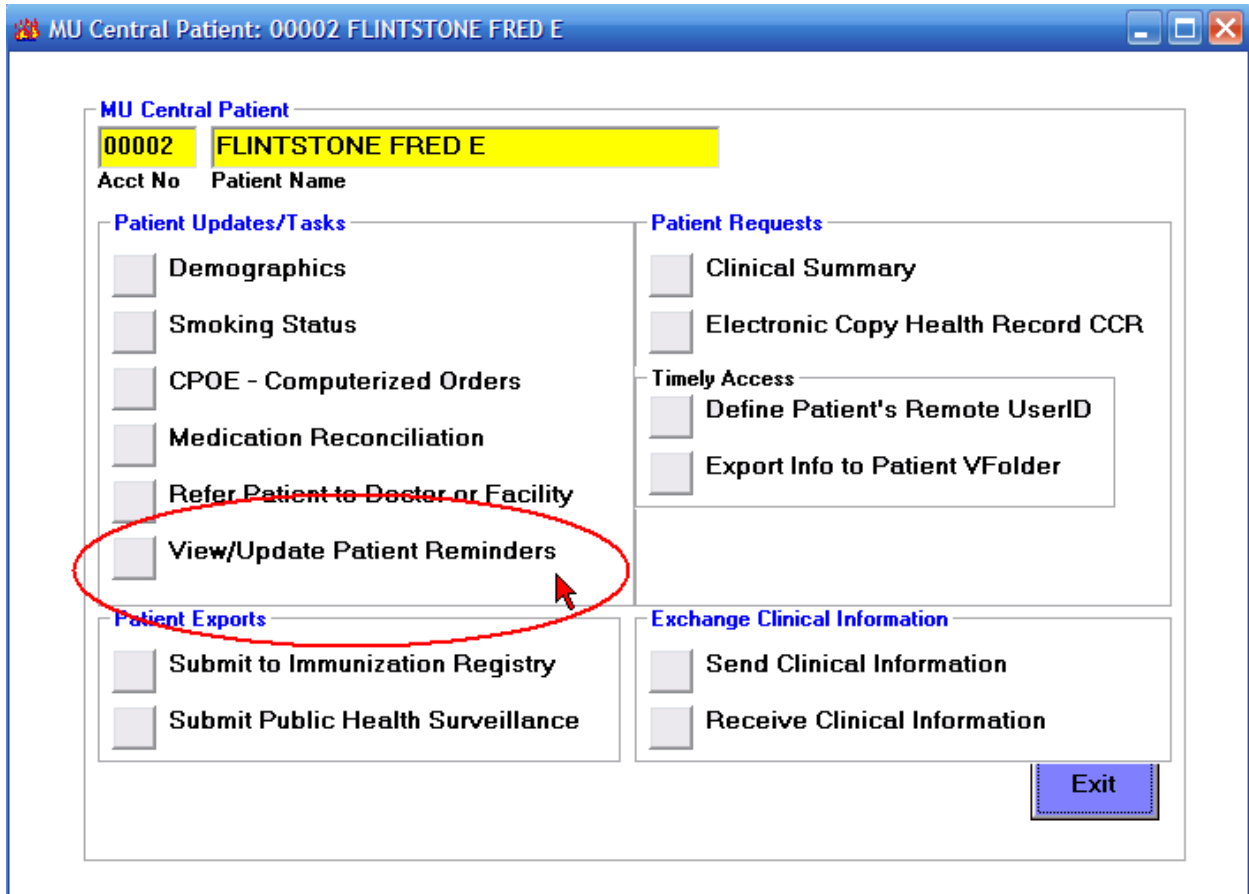


- 2) From the SOAP Note screen select the “MU Central” toolbar option.



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3) On the "MU Central Patient" Menu select the "View/Update Patient Reminders" option.



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4) On this screen, you can select the patient's preferred reminder method, comments, etc. as well as update when the reminders were sent.

Reminders: 00002 FLINTSTONE FRED E

Tools

00002 FLINTSTONE FRED E Male 10101935 Patient Reminders

AccNo Name Sex Birth Date

Preferred Method	Date	Comment	Contact Info
<input type="checkbox"/> USPS Mail			
<input checked="" type="checkbox"/> Home Phone		Call after 6 PM	713 334-8888
<input type="checkbox"/> Work Phone			713 999-3333
<input checked="" type="checkbox"/> Cell Phone			713 965-3174
<input type="checkbox"/> Fax			
<input type="checkbox"/> SMS Texting			
<input type="checkbox"/> eMail			

Reminder Reason

Save View History Print History Cancel Save/Exit

To View Reports on these Reminders:

- 1) From the Primary Menu, select the drop-down arrow next to the EMR Icon and select **MU Central**
- 2) Under the **Reports/Reminders** section, select **"Patient Reminder List"**

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- 3) On this screen, you can search for patients based on Allergies, Immunizations, Procedures, Demographics, Problems, Medications, and Lab Results. You can also search by a date range, active, deceased, and much more. Once you've got your criteria, you can "Print" these reports.

MU Patient Search List

Activity Date Range

01011980 01232012

Beginning Date Ending Date

Ignore Date Range

Patient Status

Active In-Active Deceased

01

Doctor

Allergies Immunizations Procedures

Demographics Problems Medications Lab Results

Problem/Diagnosis Selection

Type of Matching

OR - Any Problem in List

AND - All Problems in List must be found

Text Str =Diabetes

1 Number Items in List

Add To List Add Diag Code To List Clear List

Run Print Patient List Report Exit

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05 Menu – Provide Patient with Timely Access

Objective

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.

Measure

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.

Exclusion

Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period Remember you can go directly to the government's web site:

www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

Initial Setup: You must have the "Easy File Sharing Web Server" running ahead of time and set up to receive clinical information into the patient's virtual folder. This is typically X:\EZWFOLDERS\PATIENTNUMBER\ where X is the networked drive letter and PATIENTNUMBER is the patient's account number.

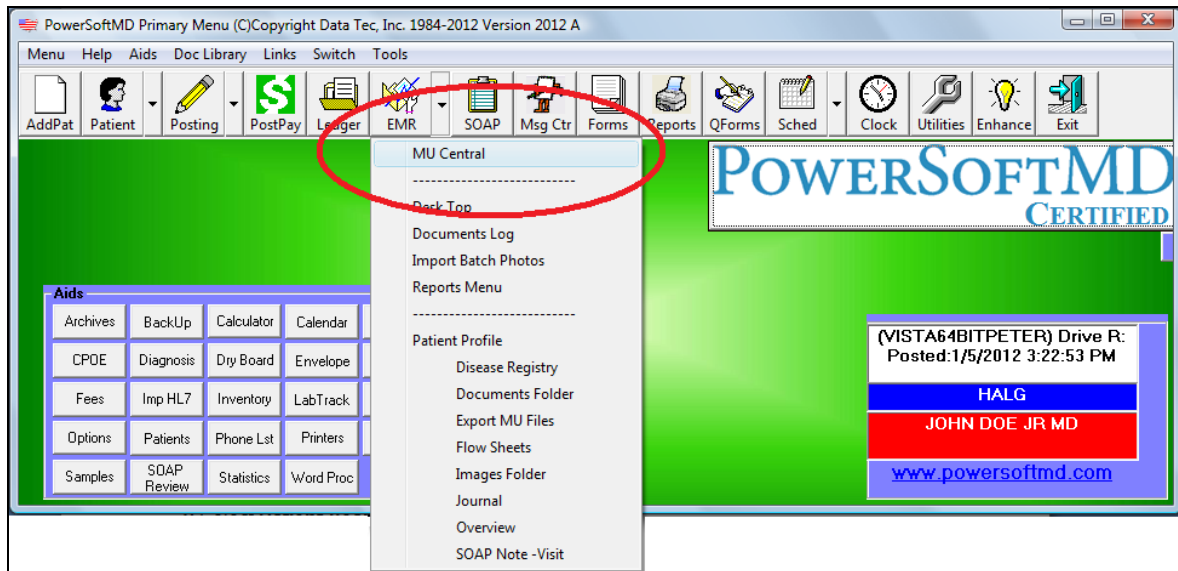
Additionally, you must have a hardware/networking technician set up a secure web address for the patient to log in to.

To Provide a Patient with Timely Access:

You will need to install the Easy File Web Server software and set up users. Data Tec can help you learn how to use the software.

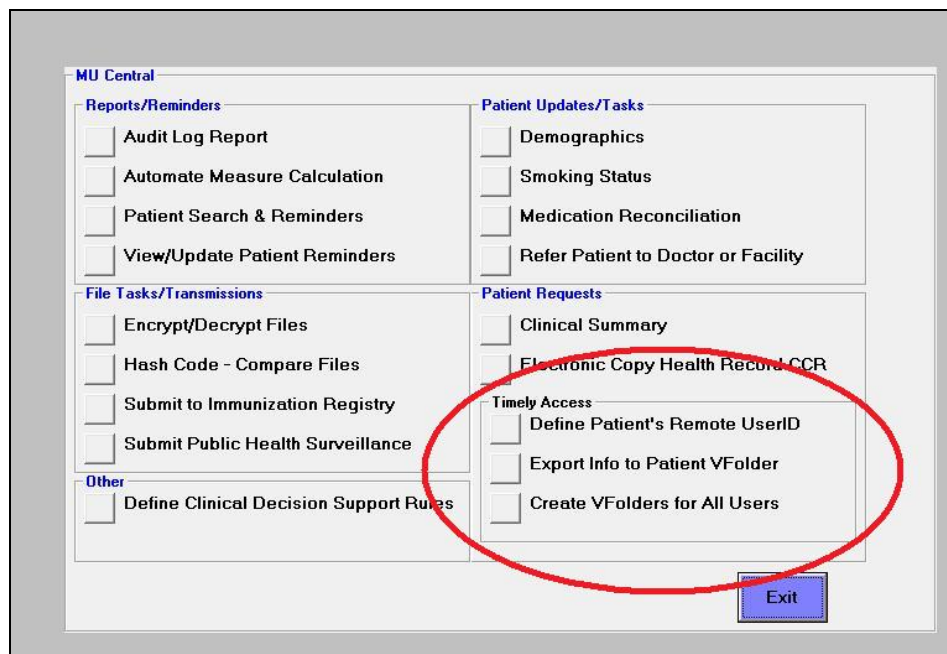
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- 1) From the Primary Menu, select the drop-down arrow next to the EMR Icon and select **MU Central**



- 2) Under the **Timely Access** section in the lower right-hand side, select **Define Patient's Remote UserID**

This screen will generate the **UserID** and the associated **Virtual Folder** where their information will be stored. Note, you can print this information out to be used in the next step.



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- 3) From the “**Easy File Management Web Server**” application, define the UserID assigning their initial password and only allowing them to access their specific Virtual folder.
- 4) To export the patient information into their Virtual folder, use the **Export Info to Patient VFolder** option from the MU Central menu. When using this option, their request for timely information will be automatically logged.
- 5) On Easy File Management Web Server, go to “Users” and set up a user with access to the X:\EZWV\FOLDERS\P00000Z where X: is the shared drive letter and Z is the patient account number.

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06 Menu – Patient Specific Education Resources

Objective

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

Measure

More than 10 percent of all unique patients seen by the EP are provided patient specific education resources.

Exclusion

No exclusion

Remember you can go directly to the government's web site:

www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

PLEASE NOTE: Patient Education is a service that must be activated ahead of time by the PowerSoftMD staff.

Please call PowerSoftMD for more information: (636) 256-7401

To Provide a Patient with Education Resources:

Our eScripts has a built in approved Educational resource you can use to meet this requirement.

- 1) From the Primary Menu, select “**SOAP note**” and select the patient
- 2) On the patient’s SOAP note screen, select the SOAP note date from the left column or open a new note
- 3) If it was an old note click the yellow “**Browse**” to take the note out of browse mode
- 4) Click “**Escripts**” in the upper-right and click “**New Script.**” Once in this window, select “**Mobile Unit/Resources**” in the upper-left:

Example Medical Practice Pharm: 0 Fax: 0 Pend: 0 Data Tec Inc.

Compose Rx Med Entry Pt. Details Diagnoses Admin

Mobile Unit/Resources Hal Smith LVN Designated Dr/Prescriber: H. Smith

Patient: **JERRY I SPRINGER** DOB: 4/4/1959 Gender: Male

Encounter ID:

RXHUB: Formularies not automatically available - select healthplan manually.

Drug Search Doctor's List

3 letter min. 5 recommended Include 'obsolete' drugs

Allergy / Intolerance Search

Allergy	Severity	memo
Bee Sting	Mid	

Select: Current Medications for JERRY I SPRINGER Drug Review D / C

Rx Date Stage	Drug	Sig	#	Refill	Loc	Source	Doc /
12/17/11	Zolene HC 10 mg/10 mg/1 mg/mL Ear Drops	1 drop in both ears daily	1	0		H. Smith	EDIT
12/17/11	Zolene HC 10 mg/10 mg/1 mg/mL Ear Drops	1 drop in both ears daily	1	0		H. Smith	EDIT
12/17/11	Zolene HC 10 mg/10 mg/1 mg/mL Ear Drops	1 drop in both ears daily	1	0		H. Smith	EDIT

Instant Renewal Select Pharmacy (Assign in Pt. Details or auto-assign via Transmit Page)

Discontinued / Previous Cancelled Mid-Process Pharmacy Communication Order Log

Tinted Rx are external: entered via MedEntry or imported, source shown.

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- 5) On this screen, select the “**Patient Education Library**” link in the middle of the screen:
- 6) On the left column, you can search for Patient Education based on Problems, ICD9 codes, CPT codes, age, gender or any words you want.
- 7) Print the information out then exit SOAP Notes. You can use “Ctrl-P” to print.
- 8) Once you’ve selected the codes you want and you return to the SOAP note, answer The prompt asking you “**Did you Print out any Educational Information**”, and reply “**Yes**”.

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07 Menu – Medication Reconciliation

Objective

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.

Measure

The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

Exclusion

An EP who was not the recipient of any transitions of care during the EHR reporting period.

Remember you can go directly to the government's web site:

www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

To Perform Medication Reconciliation:

You can put a patient's Medication Regimen on their eScript record. Each time you change their Regimen the changed medications are stored for later comparison.

- 1) From the Primary Menu, select the drop-down arrow next to the EMR Icon and select **MU Central**
- 2) On the **MU Central** screen, select "**Medication Reconciliation**"
 - Click on a note date from "**Date Selection List 1**"
 - Click on a note date from "**Date Selection List 2**"
- 3) You can view these medications side-by-side and compare them; you can also print these out for reconciliation:

Medication Reconciliation Display

00002 | FLINSTONE FRED E | Male | 10101935

Acc# No Name Sex Birth Date

01052012	Medications List 1	01112012	Medications List 2
12172011	Aspir-Lox 325 mg 1 tablet by mouth DAILY DrugID(2631)	01062012	asparaginase 10 000 unit 1 Add'l Sig Injection Select F
12172011	Aspir-Lox 325 mg 1 tablet by mouth DAILY DrugID(2631)	01112012	asparaginase 10 000 unit 1 unit intramuscular inject DA
12172011	Aspir-Lox 325 mg 1 tablet by mouth DAILY DrugID(2631)		
12172011	Aspir-Lox 325 mg 1 tablet by mouth DAILY DrugID(2631)		
12172011	Zoladex 10.8 mg 1 unit inject below the skin DAILY Dru		
12172011	Zoladex 10.8 mg 1 unit inject below the skin DAILY Dru		
12172011	Zoladex 10.8 mg 1 unit inject below the skin DAILY Dru		

Date Selection List 1

- 01112012
- 01062012
- 01052012
- 01032012

Date Selection List 2

- 01112012
- 01062012
- 01052012
- 01032012

Print List 1 Print List 2 Exit

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08 Menu – Transition of Care Summary

Objective

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.

Measure

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 percent of transitions of care and referrals.

Exclusion

An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

Remember you can go directly to the government's web site:

www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

To Provide the Summary Care Record:

- 1) From the Primary Menu, select the drop-down arrow next to the EMR Icon and select **MU Central**
- 2) On the **MU Central** screen, select “**Send Clinical Information**”
- 3) On the next screen, you will need to know the drive letter you want to send the care record to; usually, this would be a USB drive. (This drive letter is typically a letter of the alphabet after D, such as E, F, G, etc.)

To Receive the Summary Care Record:

- 1) From the Primary Menu, select the drop-down arrow next to the EMR Icon and select **MU Central**
- 2) On the **MU Central** screen, select “**Receive Clinical Information**”

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3) On the next screen, you will need to know the drive letter of the CD or USB drive you received the data on. The drive letter will usually show up when you insert the USB stick.

MU Central

Reports/Reminders

- Audit Log Report
- Automate Measure Calculation
- Patient Search List
- Patient Reminder List
- View/Update Patient Reminders
- Calculate & Submit Clinical Quality Measures

File Tasks/Transmissions

- Encrypt/Decrypt Files
- Hash Code - Compare Files
- Submit to Immunization Registry
- Submit Public Health Surveillance

Other

- Define Clinical Decision Support Rules

Patient Updates/Tasks

- Demographics
- Smoking Status
- Medication Reconciliation
- Refer Patient to Doctor or Facility

Exchange Clinical Information

- Send Clinical Information
- Receive Clinical Information

Patient Requests

- Clinical Summary
- Electronic Copy Health Record CCR

Timely Access

- Define Patient's Remote UserID
- Export Info to Patient VFolder
- Create VFolders for All Users

Exit

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09 Menu – Submission to Immunization Registries

Objective

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

Measure

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).

Exclusion

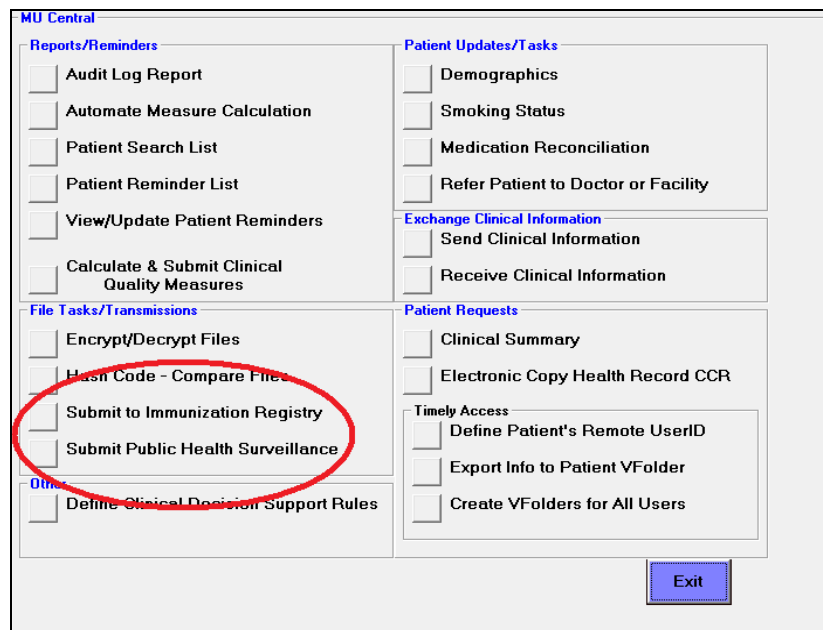
An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

Remember you can go directly to the government's web site:

www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

To Submit to Immunization Registries:

- 1) From the Primary Menu, select the drop-down arrow next to the EMR Icon and select **MU Central**
- 2) On the **MU Central** screen, select “**Submit to Immunization Registry**”:



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- 3) On this screen, select your patient and click **“Export Vaccination HL7 Records”**
You can then view the HL7 file and send it to the public health registry.
- 4) Use whatever technique your public health registry wants you to use to transmit the information to them. As an option you can set up a secure web access for them Using your “Easy File Web Server” system.

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10 Menu – Syndromic Data Surveillance

Objective

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

Measure

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).

Exclusion

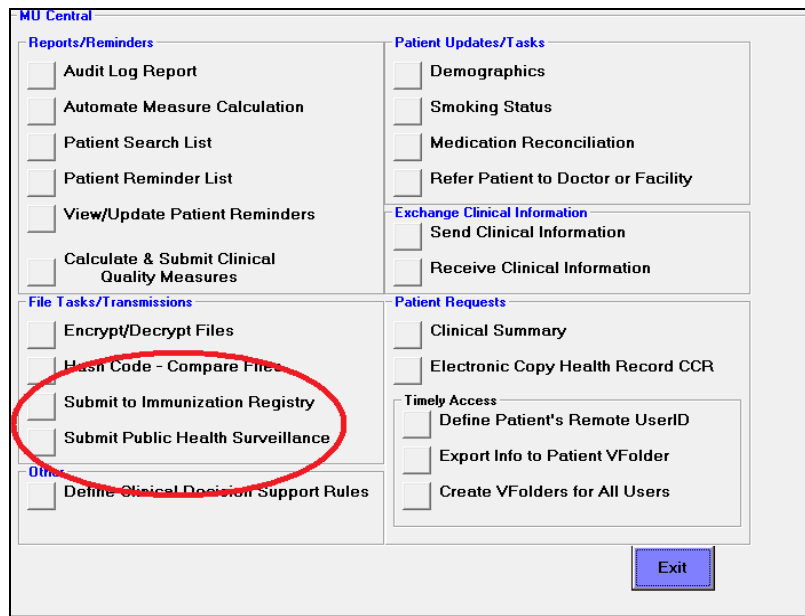
An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.

Remember you can go directly to the government’s web site:

www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

To Submit Syndromic Surveillance Data:

- 1) From the Primary Menu, select the drop-down arrow next to the EMR Icon and select **MU Central**
- 2) On the **MU Central** screen, select “**Submit to Immunization Registry**”:



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- 3) On this screen, select your patient and click “**Export Surveillance HL7 Records**”
You can then view the HL7 file and send it to the public health entity.
- 4) Use whatever technique your public health registry wants you to use to transmit the information to them. As an option you can set up a secure web access for them
Using your Easy File Web Server system.