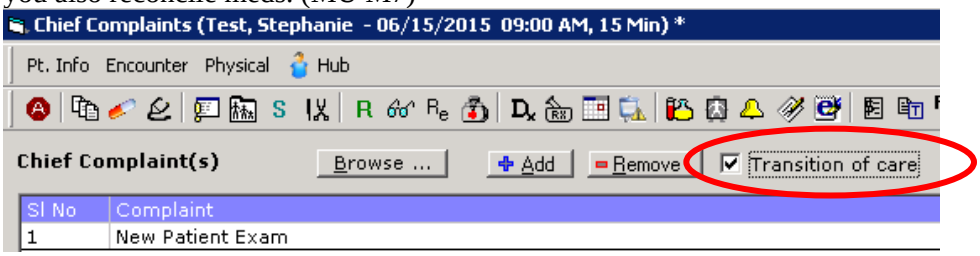
HEALTH CENTER NETWORK
NEW YORK
CARING FOR OUR COMMUNITIES TOGETHER

Meaningful Use Stage 1 Progress Note Documentation
Quick Reference Guide

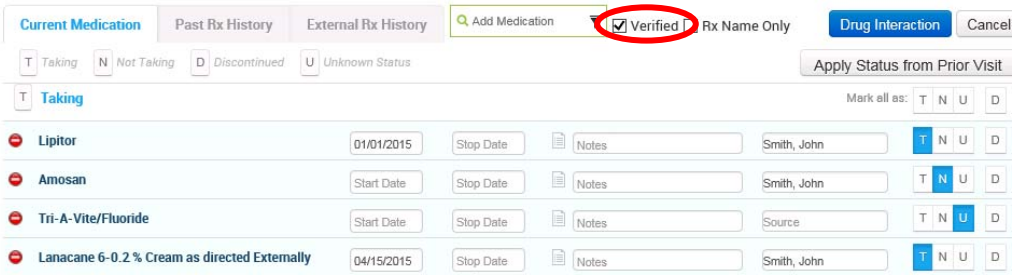
1. Chief Complaints

Check the Transition of Care checkbox **if** the patient has transitioned into your care (new patient) or if they were recently seen by a specialist, in the Emergency Room or In Patient. This gives you credit if you also reconcile meds. (MU M7)



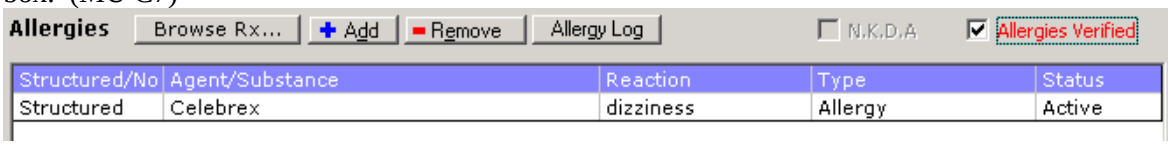
2. Current Medications

Document all of the patient's current medication. The provider should review the medication with the patient and check the verify box. (MU6)



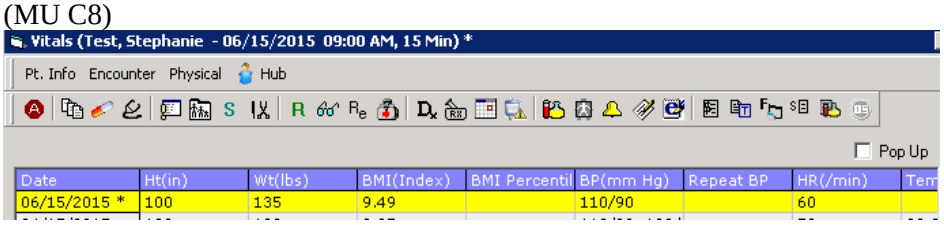
3. Allergies

Document all of the patient's allergies. The provider should review, add the type and check the Verified box. (MU C7)



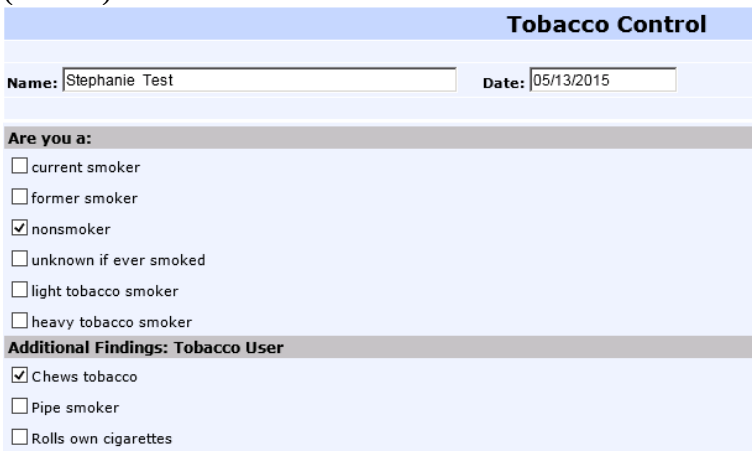
4. Vitals

Document at least the height and weight for all patients, plus the blood pressure for patient's age 3+. (MU C8)



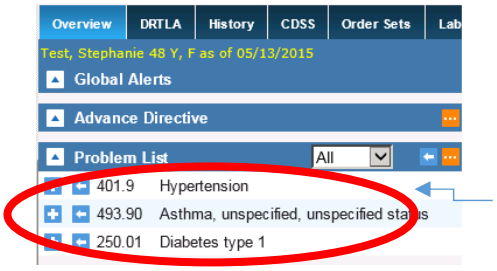
5. **Smoking Smart Form/Social History Structured Data**

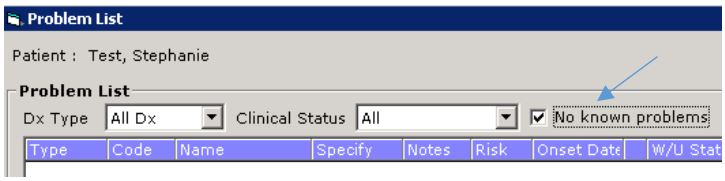
Document the smoking and tobacco status for all patients age 13+. You can document or update this form as often as you want. MU needs it once during the reporting period and UDS once every 2 years. (MU C9)



6. **Problem List**

Ensure all patients have an updated problem list or check the No Known Problem box. Add problems from Assessments or the Right Chart Panel (ICW). It doesn't matter who adds it, just that it has something and it is accurate. You can add "No Known Problems" using the Orange Ellipsis button and then check the box. (MU C5)





7. **Treatment – ePrescribe**

ePrescribe permissible prescriptions unless the patient request a printed version or the pharmacy doesn't accept ePrescriptions. Do not use RX pads for permissible prescriptions – use eCW. (MU C1 and C3)

8. **Patient Education**

Print patient education for relevant conditions. Use the purchased education product (Krames, Adams, HealthWise from eCW. You can also Order it from an Order Set. (MU M6)

9. **Preventive Medicine Counseling** (Quality Measures and UDS)

- Counsel the patient for tobacco use if applicable
- BMI management (adult) if over/under weight
- Nutrition AND Physical activity (Peds) if over/under weight

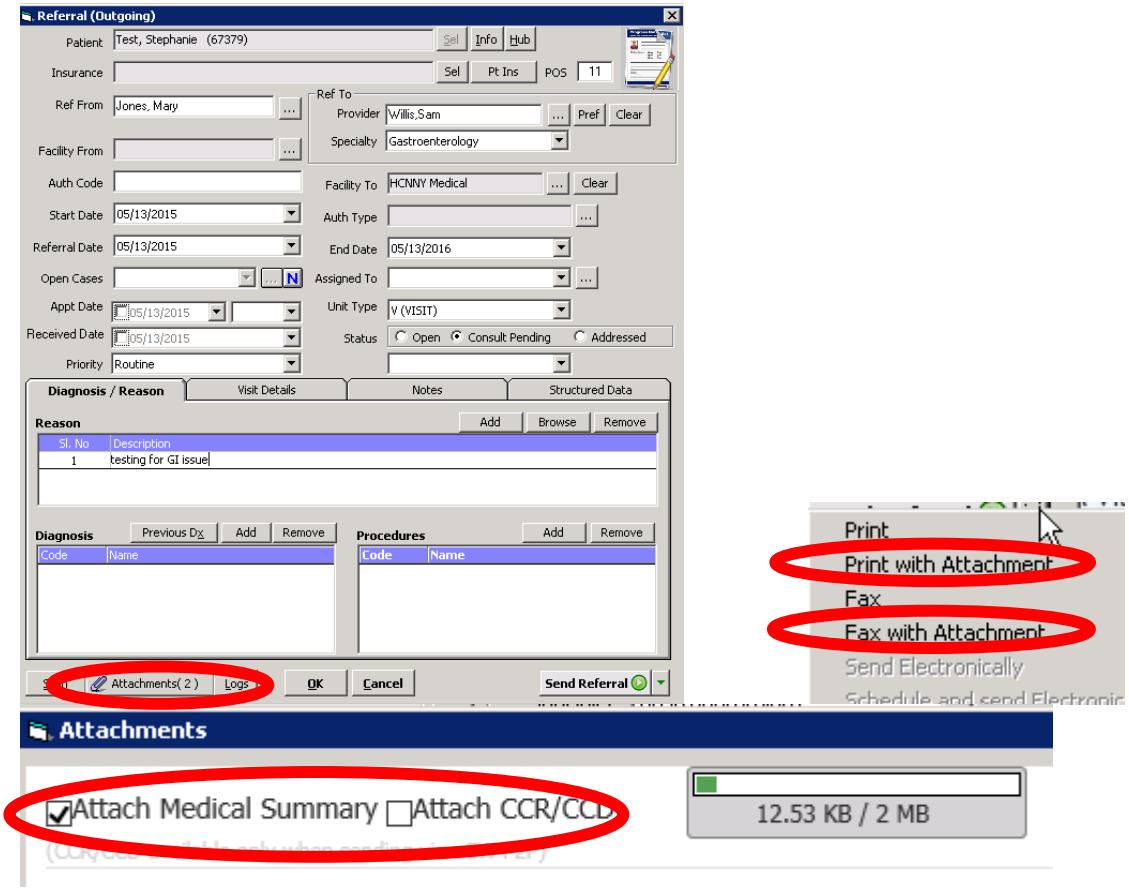
10. **Asthma Severity**

- Document Severity using the Asthma Smart Form (Quality Measures and UDS)

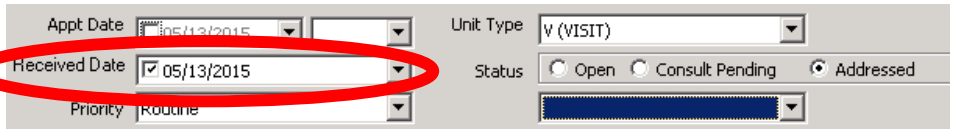
11. **Perform appropriate Screenings – Mammogram, pap smear, colorectal, A1C, LDL, Chlamydia, etc. (Quality Measures/UDS)**

12. **Treatment – Referrals**

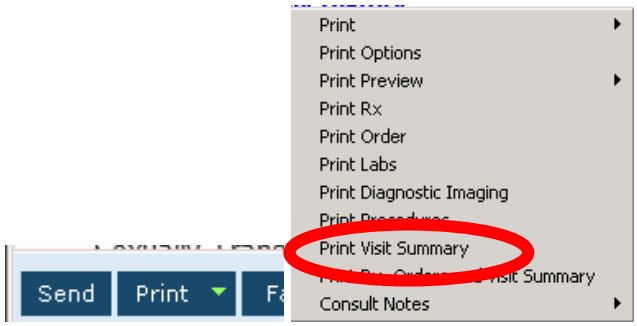
Providers or the referral clerk should ensure that all referrals have a clinical summary attached. You should see a paperclip at the bottom of the referral. You MUST PRINT OR FAX WITH ATTACHMENT. (MU M8 and CMS50)



Follow up on referral from the R Jelly bean. Ensure you get the consult note back and check the Received box on the referral to indicate you got the consult back. You can scan the note to the referral. You can also add structured data. (CQM CMS50 Close Loop Referral. Also PCMH)



13. **Print the Visit Summary and give it to the patient after every visit.**
    - Print from either the Progress Note Print Button (green carat) or front desk from appointment screen. (MU C13)


Print
Print Options
Print Preview
Print Rx
Print Order
Print Labs
Print Diagnostic Imaging
Print Visit Summary
Consult Notes
Send
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