

Ingenix CareTracker EHR: Meeting Meaningful Use Requirements

CT #	CORE REQUIREMENTS (must meet all of these)	NIST TESTING REQUIREMENT BRIEF STATEMENT	PROVIDER SELF ASSESSMENT STATEMENT	SUPPORTING FUNCTIONALITY IN CARETRACKER	CARETRACKER MEASUREMENT
C 1	Record demographics as structured data for preferred language, race, ethnicity, date of birth, and gender (50% requirement).	<p>“§170.304 (c) Record demographics.</p> <p>Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, and date of birth. Enable race and ethnicity to be recorded in accordance with the standard specified at §170.207(f). (50%).”</p>	My practice enters patient demographics (including date of birth, language, ethnicity, and gender) for at least 50% of my patient population.	<p>Practice management>Patient Demographics (gender & DOB) and Patient Details (language & ethnicity).</p> <p>NOTE: V7.1 there will be a pop-up presented to the user if these are not complete. V7.2 all items will be on 1st screen.</p>	Report/Dashboard Item
C 2	Record and chart changes in vital signs (BP, height, weight, & display BMI); additionally, plot and display growth charts for children age 2 to 20 including BMI (50% requirement).	<p>“§170.302 (f) Record and chart vital signs:</p> <p>(1) Vital signs. Enable a user to electronically record, modify, and retrieve a patient’s vital signs including, at a minimum, the height, weight, and blood pressure.</p> <p>(2) Calculate body mass index. Automatically calculate and display body mass index (BMI) based on a patient’s height and weight.</p> <p>(3) Plot & display growth charts. Plot & electronically display, upon request, for patients 2-20 years old. (50%)”</p>	My practice records and charts changes in vital signs including BP, Height, Weight, and BMI for at least 50% of all my unique patients AND if my practice has patients who are less than 21 years of age we also plot growth charts, including BMI for at least 50%.	Medical Record,>Vital Signs Health History Pane and/or Progress Notes.Vital Signs; Flow Sheets for Growth or BMI Charts as indicated.	Report/Dashboard Item
C 3	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT (80% of all unique patients admitted have at least one entry or an indication of “no problems are known” recorded as structured data).	§170.302 (c) Maintain up-to-date problem list. Enable a user to electronically record, modify, and retrieve a patient’s problem list for longitudinal care...enable the user to electronically record, modify, and retrieve a patient’s problem list over multiple encounters...using structured data and code such as ICD-9-CM (80%).	My practice maintains an up-to-date problem list of current and active diagnoses based on ICD-9-CM with at least one entry or an indication of “none” recorded as structured data for at least 80% of all my patients.	Patient Medical Record>Health History Pane>Problem List which is populated manually or through charge entry. Best Practice includes utilizing “Mark Reviewed” to indicate current accuracy and actively managed problems with updatedand status, and state.	Report/Dashboard Item
C 4	Maintain active medication list with at least one entry or indication of “no currently prescribed medications” as structured data (80% requirement).	§170.302 (d) Maintain active medication list. Enable a user to electronically record, modify, and retrieve a patient’s active medication list as well as medication history for longitudinal care (entered and stored internally over time) (80%).	My practice maintains active medication list for at least 80% of my patients.	“Patient Medical Record > Health History Pane > Medications: Actively manage and review this list during visits; documenting no known medications qualifies. Best practice includes utilizing mark reviewed; utilizing date for medication completion when writing eRx and/or reviewing medication list in progress note and marking reviewed on history tab of progress note.”	Report/Dashboard Item
C 5	Maintain active medication allergy list with at least one entry or indication of “no known medication allergies” as structured data (80% requirement).	§170.302 (e) Maintain active medication allergy list. Enable a user to electronically record, modify, and retrieve a patient’s active medication allergy list as well as medication allergy history for longitudinal care (80%).	My practice maintains an active medication allergy list for at least 80% of my patients.	Patient Medical Record> Health History Pane>Allergies: Actively manages and updates this list during visits; documenting No Known Allergies qualifies. Best practices may include utilizing marked reviewed in HHP or reviewing list in progress notes and mark reviewed on history tab of progress note.	Report/Dashboard Item

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C 6	Record smoking status for patients 13 years old or older as structured data (50% requirement).	§170.302 (g) Smoking status. Enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; unknown if ever smoked (50%).	My practice records smoking status for patients 13 years old or older for at least 50% of my patients.	Patient Medical Record>Health History Pane>History>Social History is complete with indication of a smoking status/tobacco use from this list: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; unknown if ever smoked.. Or in Progress Note>History Tab this information is completed. Or in Progress Note on P4P Tab Tobacco Use is completed. NOTE: CT to update all P4P tab on all templates to include these same statuses as required on "history field".	Report/Dashboard Item
C 7	Provide patient with clinical summary for patients for each office visit within 3 business days (more than 50% for all office visits).	§170.304(h) Clinical summaries. Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list. If the clinical summary is provided electronically it must be: (1) Provided in human readable format; and (2) Provided on electronic media or through some other electronic means in accordance with standards (for problems, meds, results). (50%)	My practice provides at least 50% of all my patients with a clinical summary for last encounter that may include a completed progress note as a selection on the summary for each office visit within 3 business days of the visit.	Patient>Medical Record>Chart Summary>Clinical Toolbar>Printer Icon. Printed chart summary is handed or mailed to patient at end of visit or attached to a Health Tracker message sent to patient within 3 days of visit. NOTE: V71 changes include ability to print an administratively defined Personal Health Record (PHR) or CCD using View Report. Health Tracker enrolled patients will automatically receive an email notification of an update to their medical record and can access their own record via Health Tracker. Documentation of this message will be on Correspondence Pane and will also satisfy this criteria.	Report/Dashboard Item
C 8	Provide patients with electronic copy of their health information (problems, medication, medication allergies, diagnostic test results) upon request (50% of patients must receive electronic copy within three days).	“§170.304(f) Electronic copy of health information (50% receive electronic copy within three days). Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, laboratory test results and procedures in human readable format; and on electronic media or through some other electronic means”	“My practice, when requested, can provide at least 50% patients with this request with an electronic copy of their health information within three days.”	When request is made the practice creates a ToDo for the patient: Type- Correspondence; Reason—Medical Record Request, complete actions and closes ToDo within 3 business days of request. Possible actions to complete include: CCD delivered via Health Tracker, CCD burned on a password/encrypted portable media and delivered to patient as result of this request prior to closure of ToDo. NOTE: V71 ToDo Category: Interoffice, Type: EHR, Reason: Med Record Request PATIENT.	Report/Dashboard Item
C 9	Generate and transmit permissible prescriptions electronically — eRx (40% requirement).	“§170.304 (b) Electronic prescribing. Enable a user to electronically generate and transmit prescriptions and prescription-related information. (40%)”	I, as the eligible prescribing provider, generate and transmit permissible prescriptions electronically (eRx) for at least 40% of my patients.	Medical Record > Clinical Tool Bar Prescription Writer and Clinical Today > Quick Tasks > Renewals are used by the eligible provider to generate and transmit non-controlled substance prescriptions.	Report/Dashboard Item
C 10	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines. (30% for patients with at least one medication ordered through CPOE).	“§170.304 Computerized provider order entry. Enable a user to electronically record, store, retrieve, and modify, at a minimum, the following order types: Medications; Laboratory; and Radiology/imaging orders. (30%) OR —Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. Note: <i>CareTracker has asked HHS/ONC for clarification of this testing requirement as it does not match the Federal Register Final Rule.</i> ”	I, the eligible professional, use Computerized Provider Order Entry to record medication orders (HHS/ONC clarification requested on testing procedure that includes laboratory imaging orders) for at least 30% of my patients.	Patient Medical Record>Health History Pane>Medication List displays a least one active medication. Medications entered via the prescription writer or renewals will automatically be added to the medication list and are considered CPOE.	Report/Dashboard Item
C 11	Implement drug-drug and drug-allergy interaction checks (functionality is enabled for these checks for the entire reporting period).	“§170.302 (a) Drug-drug, drug-allergy interaction checks (1) Notifications. Automatically and electronically generate and indicate in real-time, notifications at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, and computerized provider order entry (CPOE). (2) Adjustments. Provide certain users with the ability to adjust notifications provided for drug-drug and drug-allergy interaction checks.”	I receive drug to drug and drug to allergy interaction information when I write new prescriptions for my patients. I have been receiving this for the 90 day period for which I am applying for funding.	Prescription Writer will automatically present data based on set preferences; In Patient Medical Record>Health History Pane>Medication List Interaction Icon is “active” for those patients for whom interactions were presented.	Self Attestation

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C 12	Implement capability to electronically exchange key clinical information among providers and patient authorized entities (Perform at least one test of EHR's capacity to exchange information).	<p>“§170.304(i) Exchange clinical information and patient summary record. (One test—self attestation, no %age) Electronically receive and display a patient's summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, and medication allergy list in accordance with the standard. Upon receipt of a patient summary record formatted in the alternative standard, display it in human readable format.</p> <p>(2) Electronically transmit. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list.”</p>	I have at least one referring provider activated in the CareTracker Referring Provider Portal and have exchanged clinical data after documenting patient consent to do so.	Practice management>Referring Provider Portal Activation; Then messaging that referring provider with a consent recorded in patient record.	Self Attestation. View invitations accepted in Admin Referral Network Invites.
C 13	Implement one clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance for that rule.	<p>“§170.304 (e) Clinical decision support. (1) Implement rules. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) based on the data elements included in: problem list; medication list; demographics; and laboratory test results. (2) Notifications. Automatically and electronically generate and indicate in real-time, notifications and care suggestions based upon clinical decision support rules.”</p>	I have activated at least one relevant Care Management Rule other than immunizations; I populate my registries routinely, and I review the patient's unmet Patient Care Management activities during each office visit. I use recalls from Patient Population Management to notify patients.	Activate (Admin>Set Up), populate (Clinical Today>Population Management), and manage at least one Care Management criteria other than immunizations (Patient Medical Record>Health History Pane>Patient Care Management: Cervical Cancer, Colorectal Cancer, Mammograms, PSA, BP Mgmt, Cholesterol, Diabetes)	Self Attestation. Admin> view Care Managment Activations for # rules activated other than adult or child immunizations for the group for whom the provider is associated.
C 14	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities (conduct or review a security risk analysis in accordance with the requirements and implement security updates as necessary).	Test procedures 170.302 (p,q,r,s,v,w) for access, integrity, time out, emergency access, encryption, audit log.	“CareTracker is a certified EHR and as such meets the vendor application security criteria. I, the eligible professional, have conducted or reviewed a security risk analysis per 45 CFR 164.308 (a)(1) and my practice has a security risk analysis process as part of our risk management process.”	CCHIT Certification, ARRA Certification, Provider Self Attestation of Security Status/Process within practice.	CCHIT Certification Complete, ARRA Certification (pending), Provider Self Attestation of Security Status within practice.
C 15	Report ambulatory clinical quality measures to CMS or states (For 2011, provide aggregate numerator, denominator, and exclusions through attestation, 2012 submit electronically). (CMS Website provides this clarification: EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures. A maximum of 9 measures would be reported if the EP needed to attest to the 3 required core, the three alternate core, and the 3 additional measures.)	<p>“§170.304 (j) Calculate and submit clinical quality measures. Electronically calculate all of the core clinical measures specified by CMS for eligible professionals (3 Core and if needed 3 Alternate Core). Electronically calculate, at a minimum, three additional clinical quality measures specified by CMS for eligible professionals. Enable a user to electronically submit calculated clinical quality measures in accordance with the standard and implementation specifications.”</p>	<p>“I have familiarized my self with the 6 required Core/Alternate Core Quality Measure Reports, and have chosen 3 other reports for a total of 6 and have begun to document the necessary data in order to aggregate results for reporting CMS for 2011. 6 Core/Alternate Core Reports are:</p> <ul style="list-style-type: none"> • NQF 0421/PQRI 128 Adult Weight Screening and Follow-Up • NQF 0013 Hypertension: Blood Pressure Management • NQF 0028 Prevent Care and screening Measure Pair—Tobacco Use Assessment and Tobacco Cessation Intervention • NQF 0041/PQRI 110 Preventive Care and screening: Influenza Immunization for Patients > 50 Years Old • NQF 0024 Weight Assessment and Counseling for Children and Adolescents • NQF 0038 Childhood Immunization Status” 	<p>Current reports are found in Reporting>Medical Reports>Quality Measure Reports. 6 required reports include the following—Weight Screening, BP Measurement for Hypertension, Influenza, Smoking Status and Cessation Counseling, Childhood Immunizations, Child and Adolescent Weight Management.</p> <p>NOTE: V 7.1 Will include updated reports to meet the published requirement, 6 standard reports as noted above, and there will be 6 other reports from which to choose 3. These will be found in Reporting>Medical Reports>Meaningful Use Quality Measure Reports (meeting the 2009 XML Standard Format requirements).</p>	<p>Self Attestation of Aggregation of Data via CareTracker Reporting for each specific quality measurement. Several reports have been approved and are available for any CareTracker Client to run today. The remaining reports are being validated and all will be available in Q4 2010.</p>

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M 16	Implement drug-formulary checks (generate at least one report for entire reporting period).	"§170.302 (b) Drug-formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list."	My practice utilizes a Medicare Certified ePrescribing application which presents me with formulary information when I am ePrescribing if the patient has a participating pharmacy benefit manager.	Prescription Writer> formulary information in medication search results and on screen formulary information to the right of where the provider enters the sig: "Formulary" at top right—if patient has info available.	Self Attestation; provider will have utilized formulary information automatically available in CareTracker Rx Writer Module.
M 17	Incorporate clinical lab-test results into EHR as structured data (40 percent of all tests ordered with results in a positive/negative or numerical format).	"§170.302 (h) Incorporate laboratory test results. 1) Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. 2) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). 3) Incorporate results. Electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record."	My practice writes lab orders in CareTracker and either receives electronic lab results as structured data or my practice manually enters key lab results via orders for at least 40% of my patients.	Medical Record>Clinical Tool Bar> Orders or Order Sets utilized. Home Dashboard>Results or Clinical Today>Provider Quick Task>Results; and Orders>Manual Data Entry AND linking electronic results to orders.	Report/Dashboard Item
M 18	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach (generate at least one report with a list of patients with a specific condition).	"§170.302 (i) Generate patient lists. Enable a user to electronically select, sort, retrieve, and generate lists of patients according to, at a minimum, the data elements included in: (1) Problem list; (2) Medication list; (3) Demographics; and (4) Laboratory test results."	I have generated at least one report from the CareTracker Report Writer filterable by problems, medications, demographics, and laboratories to use for quality improvement, reduction of disparities, research, and outreach.	Reporting > Medical Reports > Other Medical Reports > Example is Global Patient by Diagnosis, or NOTE: V 7.1 Clinical Query Builder will meet this criteria.	Self Attestation: Document that at least one of these reports was generated and results included at least one patient.
M 19	Use certified EHR to identify patient-specific education resources and provide to patient if appropriate (10 percent requirement).	§170.302 (m) Patient-specific education resources. Enable a user to electronically identify and provide patient-specific education resources according to, at a minimum, the data elements included in the patient's: problem list; medication list; and laboratory test results as well as provide such resources to the patient. (printed, faxed, or emailed).	My practices uses CareTracker Krames Patient Education Resources or Practice Specific Documents loaded into CareTracker to assist with educating our patients and copies of the handouts dispensed can be found in more than 10% of our patients records.	Medical Record>Clinical Tool Bar>Patient Education searched and printed for patient. Record of what was printed can be located in Patient Medical Record>Health History Pane>Correspondence. AND Medical Record>Clinical Tool Bar>Prescription Writer> Patient Teaching Handout for script can be reviewed and/or printed and is logged toward meeting this criteria.	Report/Dashboard Item
M 20	The eligible provider who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation (50 percent requirement).	§170.302 (j) Medication Reconciliation. Enable a user to electronically compare two or more medication lists.	My practice has set up appointment type that identify appointments that are related to a transition or relevant for medication reconciliation. When my patient's have relevant encounters or care transitions I review all available medication information in comparison to the patient's CareTracker Medication List and update the CareTracker list to ensure accuracy at least 50% of the time.	Patient Medical Record> Health History Pane>Medications: Actively manages and review this list with during relevant visits (defined by practice and at transition of care), review inactive medications, review CCDs from other providers, utilizes PBM provided "history as of MM/DD/YYYY" link at top when patient has been scheduled for an appointment or the "Request Medication History" button, utilizing "mark reviewed" button to document review or reviews medication list in progress note and marks reviewed on history tab of progress note. Documenting no known medications qualifies. NOTE: V7.1 Appointment types and during Appointment booking a new "check box" to mark when the appointment is related to a transition in care or provider deemed relevant appointment reason will be added to assist in determining the # of encounter for which medication reconciliation is appropriate.	Report/Dashboard Item

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M 21	The eligible provider 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 and referral (50 percent requirement).	<p>“§170.304(i) Exchange clinical information and patient summary record.</p> <p>(1) Electronically receive and display. Electronically receive and display a patient’s summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, and medication allergy list in accordance with the standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted in the alternative standard, display it in human readable format.</p> <p>(2) Electronically transmit. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list in accordance with: (i) The standard (and applicable implementation specifications) listed in the rule/testing document details.”</p>	I print and send (mail or fax) a chart summary when I refer a patient to another provider or when care is transitioned. OR I send a CCD via the Referring Provider Portal when I refer a patient to another provider or when care is transitioned. Separately or together I do this for at least 50% of my patients.	At direction of provider the practice creates a Patient ToDo Type Correspondence Reason Referral Request or Transition in Care with Chart Summary and / or CCD attached to mail, fax, or send via the Referring Provider Portal when a referral is ordered or transition in care is identified. NOTE: V7.1 New ToDo Category: Interoffice, Type: EHR, Reason: Med Record Request PROVIDER.	Report/Dashboard Item
M 22	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice (perform at least one test if the registry has the capability to receive electronically). <i>NOTE: EP must complete one of Immunization or Syndromic Surveillance unless has an exception for both.</i>	<p>“§170.302(k) Submission to immunization registries. Electronically record, modify, retrieve, and submit immunization information in accordance with:</p> <p>(1) the standard (and applicable implementation specifications) specified in §170.205(e)(1) or §170.205(e)(2);</p> <p>and</p> <p>(2) At a minimum, the version of the standard specified in §170.207(e).”</p>	Provider needs to ascertain if their state will accept immunization registry data electronically. If electronically capable notify CareTracker via a ToDo of the need to generate test file ASAP. CareTracker will activate the Immunization “Save and Send” feature for the test once the coding is completed.	Clinical Tool Bar>Immunization writer>utilize the save and send button.	Self Attestation of one electronic test submitted to the appropriate state agency if ready to receive. Or attest that state is not ready to receive or practice does not administer immunization which would grant an exception.*
M 23	Capability to submit electronic syndromic surveillance data to public health agencies and actual transmission in accordance with applicable law and practice (perform at least one test unless public health agencies do not have the capacity to receive electronically) <i>NOTE: Must complete one of Immunization or Syndromic Surveillance unless EP has an exception for both.</i>	§170.302 (l) Public health surveillance. Electronically record, modify, retrieve, and submit syndrome-based public health surveillance information in accordance with the standard (and applicable implementation specifications) specified in §170.205(d)(1) or §170.205(d)(2).	My practice has run the syndromic surveillance report for influenza (or others) and can send it to my states public health agency.	Administration>Import/Export>Patient Data>Patient Data Export>Selection>HL7>Encounter Date>Diagnosis Example “Influenza ICD9 Code(s)”. NOTE: V7.1 Clinical Query Builder will also assist. Clarification of export format is pending from HHS/ONC.	Self Attestation. If PHA is not ready to receive an exception may be granted, or, if no patients under 6 or over 64, an exception will be granted.*
M24	Send appropriate reminders to patients per patient preference for preventative/ follow up care during the 90 day reporting period for patients 65 and older or 5 years and younger (20 percent requirement).	§170.304 (d) Patient Reminders. Enable a user to electronically generate a patient reminder list for preventive or follow-up care according to patient preferences based on, at a minimum, the data elements included in: Problem list; Medication list; Medication allergy list; Demographics; and Laboratory test results. 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.	My practice has activated the appropriate Care Management Rules for my patient population and actively enters and minimally maintains data for at least 20% of our patients 65 years or older or 5 years old or younger using the recall function according to communication preference and scheduling appropriate appointments. OR with V7.1 I use the Clinical Query Builder to generate recalls for Patient Care Management or other reminder requirements for my practice.	Record patient notification preferences in patient demographics. Activate Patient Care Management (Admin>Set Up), populate (Clinical Today>Population Management), and manage at least one Care Management criteria for the population under 6 or over 65. Use recalls or schedule appointments to manage tests/ vaccinations that are due for completion. NOTE: V 7.1 Utilize the Clinical Query Builder to capture a list of patient’s requiring pertinent reminders and generate recalls based on this list.	Report/Dashboard Item
M 25	Provide patients with timely electronic access to their health information, including laboratory results, problem list, medication list, and medication allergies within four business days of the information being available to the eligible provider (10 percent requirement).	§170.304 (g) Timely access. Enable a user to provide patients with online access to their clinical information, including, at a minimum, lab test results, problem list, medication list, and medication allergy list.	My practice has activated the Health Tracker option (new) to share data with patients (practice can set areas for inclusion to meet criteria). My practice has at least 10% of our patients signed up to use Health Tracker. This option will make the data available immediately to all registered Health Tracker Patients.	NOTE: V7.1 Administration>Set Up>General Section>Health Tracker>Personal Health Record activated. Actively register patients to participate in Health Tracker.	Report/Dashboard Item

* 1 of 5 chosen must be M22 or M23 unless both are exceptions. If both are exceptions provider must still meet 5 other criteria.