Washington State Health Care Authority

Note to Providers:
An audit may include a review of any of the documentation needed to support the information that was entered in the attestation. The level of the audit review may depend on a number of factors, and it is not possible to detail all supporting documents that may be requested as part of the audit. You should submit all supporting documentation retained at the time of attestation. Some examples of suggested documentation are listed below.

Objective	Suggested Documentation
General - Various Objectives	• CEHRT generated dashboard, EHR system manual, audit trails, patient lists supporting numerator/denominators, screenshots/walk-throughs of system functionality, policies/procedures
1 – Protect Electronic Health Information	• SRA Report (with remediation plan, include responsible parties and timeframes) • Provide status on items not remediated at the time of report
2 – Measure 1 – Clinical Decision Support & Measure 2 – Drug/Drug/Allergy Interaction Checks	• One or more screenshots from the certified EHR system that are dated during the EHR reporting period selected for attestation.
3 – Computerized Provider Order Entry (CPOE)	• Copy of a patient order from each of the 3 categories (medication, lab, radiology), identifying who entered the order
4 – ePrescribing (eRx)	• Screenshots for e-prescription(s) showing formulary being queried during reporting period
5 – Health Information Exchange	• Screenshot demonstrating transfer of care during reporting period • Summary of care document for a patient visit in the numerator
6 – Patient Specific Education	• Screenshots or other examples of system functionality (showing the EHR can suggest patient education based on info stored in the EHR) • Example of the patient education provided for a patient in the numerator
7 – Medication Reconciliation	• Screenshots for a patient that had a medication reconciliation done as a result of a transition of care
8 – Patient Electronic Access	• Screenshots of the patient portal demonstrating ability for patients to view & download their information • Screenshots or other examples demonstrating patients viewed, downloaded or transmitted health information
9 – Secure Electronic Messaging	• Screenshots showing system functionality • Copy of secure message(s) sent to patient(s)
10 – Public Health Reporting	• Letter or other evidence showing date of registration, testing or submission information (depending on what Active Engagement Option is being reported).
EXCLUSIONS	• Report from the certified EHR system that shows a zero denominator for the measure or otherwise documents that the provider qualifies for the exclusion.

Please ensure documentation or screenshots are labeled, legible, and dated within the reporting period whenever possible to ensure they can be associated with the appropriate objectives/measures.