MeHI
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at the MassTech Collaborative

Meaningful Use Information Session

September 19, 2019

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Welcome


healthcare
providers
PVT
MAPIR
MeHI
query
Mass HIway
PY2019
Massachusetts
API
Attestation
EP
INFORMATION
Data
Security Risk Analysis
Eligible Professional
patient
Stage 3
Reporting Period
CPOE
CARE
Medication Reconciliation
Clinical Decision Support
Informatics
MEANINGFUL USE
health
MU
Patient Encounter
CDS
Secure
Electronic
Messaging
CEHRT
Public Health Reporting
Stage 3
HIE
Care Coordination
Medicaid
Electronic Prescribing
Electronic
Health
Record
PATIENT ENGAGEMENT
Massachusetts
eHealth Institute
SRA
Clinical Quality Measures
HEALTH IT
EHR
eRx
Patient Volume Threshold
Patient Portal
Patient Education
HEALTH INFORMATION EXCHANGE
Interoperability
people
documentation
Program Year 2019

Today's Agenda

- Welcome and Introductions
- Overview of Stage 3 Meaningful Use
- Break
- Objective 5: Patient Electronic Access
- Objective 6: Coordination of Care through Patient Engagement
- Lunch
- Objective 7: Health Information Exchange
- Q & A and Closing
- Optional Networking

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Overview of Stage 3 Meaningful Use

Bhawna Sehgal

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Overview of Stage 3 Meaningful Use

1. Protect Patient Health Information
2. Electronic Prescribing
3. Clinical Decision Support
4. Computerized Provider Order Entry
5. Patient Electronic Access to Health Information
6. Coordination of Care through Patient Engagement
7. Health Information Exchange (HIE)
8. Public Health and Clinical Data Registry Reporting

Objective 1: Protect Electronic Health Information

Protect electronic health information (PHI) created or maintained by CEHRT through implementation of appropriate capabilities

Measure

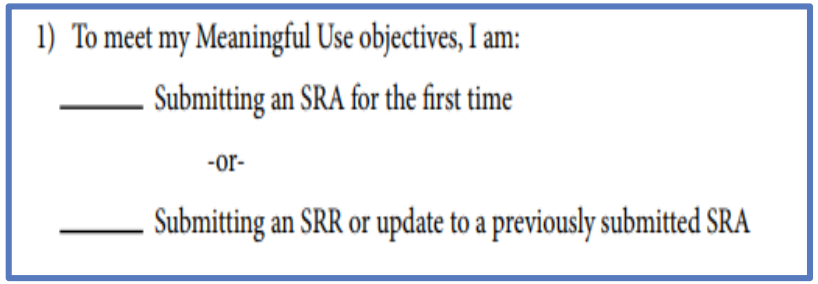
Conduct or review security risk analysis (SRA), including:

- Address security to include encryption and other technical, administrative, and physical safeguards
- Identify the potential risks and vulnerabilities and include in the risk management process
- Correct identified security deficiencies and implement updates as necessary

SRA must be conducted or reviewed within the calendar year of the EHR reporting period (Jan 1 – Dec 31, 2019)

Supporting Documentation: Protect Electronic Health Information

- Security Risk Analysis/Review Cover Sheet
  - ✓ Complete by initialing next to all the applicable responses
  - ✓ Signed by the authorized person



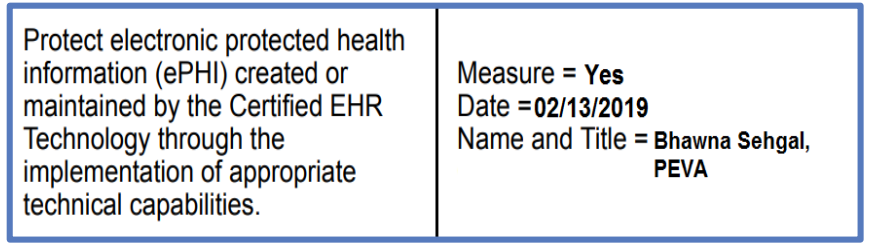
1) To meet my Meaningful Use objectives, I am:

_____ Submitting an SRA for the first time

-or-

_____ Submitting an SRR or update to a previously submitted SRA

- Security Risk Analysis (SRA)/Review (SRR)
  - ✓ Date analysis/review was conducted
  - ✓ All locations/practices EP worked during the selected EHR reporting period.
  - ✓ Name and Title of the person who performed the analysis /review
  - ✓ Signature of the authorized person
  - ✓ Required safeguards and mitigation plan



Protect electronic protected health information (ePHI) created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Measure = **Yes** Date = **02/13/2019** Name and Title = **Bhawna Sehgal, PEVA**

Objective 2: Electronic Prescribing (eRx)

Generate and transmit permissible prescriptions electronically (eRx)

Measure

More than 60% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT

Exclusions

An EP may take an exclusion if any of the following apply:

- EP writes fewer than 100 prescriptions EHR reporting period
- No pharmacy within organization and no pharmacies accepting eRx within 10 miles of EP's practice at start of reporting period

Supporting Documentation: Electronic Prescribing (eRx)

- An EHR-generated MU dashboard or report for the selected EHR reporting period that shows the EP's name, numerator, denominator and percentage for the e-prescribing measure

NOTE: Although the example dashboard shows the EP wrote less than 100 prescriptions the EP has the **option** to claim the exclusion OR enter the volumes in MAPIR as the threshold was satisfied.

Objective 3: Clinical Decision Support (CDS)

Use clinical decision support (CDS) to improve performance on high-priority health conditions

Measure 1

Implement 5 CDS interventions related to 4 or more CQMs for the entire EHR reporting period

Measure 2

Enable and implement drug-drug & drug-allergy interaction checks for the entire EHR reporting period

Exclusion for Measure 2

Any EP who writes fewer than 100 medication orders during the entire EHR reporting period

Supporting Documentation: Clinical Decision Support

- Screen prints of 5 CDS interventions
  - ✓ Dated within the EHR reporting period or Vendor letter
  - ✓ Name of the EP & facility/organization or Global Letter

- Screen print displaying drug-drug and drug-allergy interaction check
  - ✓ Dated within the EHR reporting period or Vendor letter
  - ✓ Name of the EP & facility/organization or Global Letter

- MU Dashboard displaying CQMs for full calendar year (365 days)
  - ✓Name of the EP
  - ✓Numerator and denominator for the reported CQMs

If the CDS don't align with the reported CQMs, upload a letter explaining relevance of the selected CDS to the patient population

Objective 4: Computerized Provider Order Entry (CPOE)

Use CPOE for medication, laboratory, and diagnostic imaging orders entered by licensed healthcare professional who can enter orders into medical record per state, local, and professional guidelines

Measure 1 More than 60% of medication orders created during EHR reporting period are recorded using CPOE

Measure 2 More than 60% of laboratory orders created during EHR reporting period are recorded using CPOE

Measure 3 More than 60% of radiology orders created during EHR reporting period are recorded using CPOE

Exclusions – Any EP who during EHR reporting period:

- Measure 1: writes fewer than 100 medication orders
- Measure 2: writes fewer than 100 laboratory orders
- Measure 3: writes fewer than 100 radiology orders

Supporting Documentation: Computerized Provider Order Entry (CPOE)

- An EHR-generated MU dashboard or report for the selected EHR reporting period that shows the EP's name, numerator, denominator and percentage for the measure

CPOE Medications Medicaid Only	CPOE Medications	Total	70	70
		Total	70	70

NOTE: Although the example dashboard shows the EP wrote less than 100 medication orders, the EP has the **option** to claim the exclusion OR enter the volumes in MAPIR as the threshold was satisfied.

Objective 5: Patient Electronic Access to Health Information

EP provides patients with timely electronic access to their health information and patient-specific education

Measure 1: For more than 80% of all unique patients seen by the EP:

- the patient is provided timely access to view, download, and transmit their health info
- the patient's health info is available for the patient to access using any app of their choice configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT

Measure 2 : For more than 35% of unique patients, EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials

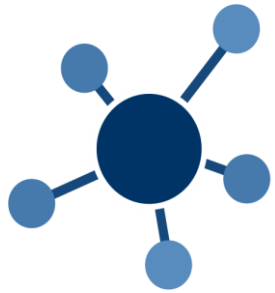
Exclusion: Patient Electronic Access

Exclusions: Measure 1 and 2

- The EP have no office visits during the EHR reporting period
- The EP conducts 50% or more patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability on the first day of the EHR reporting period may exclude the measure
- *Supporting documentation detail will be highlighted later in the Session*

Objective 6: Coordination of Care through Patient Engagement

Use CEHRT to engage with patients or their authorized representatives about the patient's care.



Measure 1 More than 5% of all unique patients seen by the EP are actively engaged with the EHR made accessible by the EP and either:

- View, download, or transmit to a third party their health information
- Access their health information through the use of an Application Programming Interface (API) that can be used by applications chosen by the patient and configured to the API in the EP's CEHRT
- A combination of (1) and (2)

Measure 2 For more than 5% of all unique patients seen by the EP, a secure message was sent using CEHRT

Measure 3 For more than 5% of all unique patients, the patient generated health data or data from a nonclinical setting is incorporated into the CEHRT

Exclusions: Coordination of Care

Exclusions: Measure 1, 2, and 3

- The EP has no office visits during the EHR reporting period
- The EP conducts 50% or more patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability on the first day of the EHR reporting period.

- *Supporting documentation detail will be highlighted later in the Session*

Objective 7: Health Information Exchange

Measure 1

For more than 50% of transitions of care and referrals, the referring EP must create and electronically exchange a summary of care record using CEHRT.

Measure 2

For more than 40% of transitions and referrals received and patients encounters where the EP has never before seen the patient, the EP must incorporate the electronic summary of care record into the patient's EHR

Measure 3

For more than 80% of transitions received and encounters where the EP has never before seen the patient, EP performs a clinical information reconciliation for the following three clinical information sets:

1. Medication
2. Medication allergy
3. Current problem list

Exclusions: Health Information Exchange (HIE)

Exclusions: Measure 1, 2, and 3

- The total transitions of care and referrals received are fewer than 100 times during the EHR reporting period
- The EP conducts 50% or more of encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability on the first day of the EHR reporting period

- *Exclusion criteria and supporting documentation detail will be highlighted later in the Session*

Objective 8: Public Health and Clinical Data Registry Reporting

EP is in active engagement with public health agency to submit electronic public health data using CEHRT

Measure 1: Immunization Registry

EP is in active engagement with a public health agency to submit immunization data

Measure 2: Syndromic Surveillance

In MA: Required only for EPs who practice in a freestanding Urgent Care facility

Measure 3: Electronic Case Reporting

EP is in active engagement with a PHA to submit case reporting of reportable conditions

Measure 4: Public Health Registry Reporting

EP is in active engagement with a PHA to submit data to public health registries

Measure 5: CDR Reporting

EP is in active engagement to submit data to a CDR

Supporting Documentation: Public Health Measure

- Measure 1: Immunization Registry Reporting
  - ✓MIIS Immunization Acknowledgement, Registration of Intent, or Scorecard
  - ✓EP's claiming an exclusion must submit an exclusion letter signed by the EP
- Measure 2: Syndromic Surveillance Reporting
  - ✓Documentation from the Syndromic Surveillance Registry, if the EP is practicing in a freestanding urgent care facility. All other EPs can claim an exclusion
- Measure 3: Electronic Case Reporting
  - ✓Documentation from the electronic Case Reporting (eCR) Registry
- Measure 4: Public Health Registry Reporting
  - ✓Documentation from a Public Health Registry
- Measure 5: Clinical Data Registry Reporting
  - ✓All EPs claim exclusion, registry is not available in MA for program year 2019

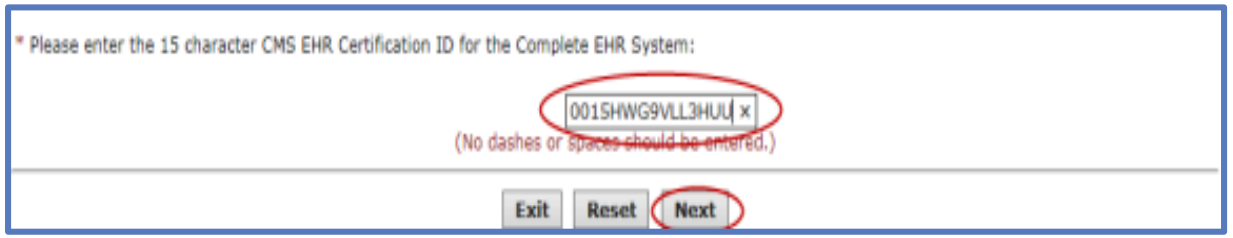
Supporting Documentation: MU Aggregation Form

All attesting EPs must complete an MU Aggregation form prior to submittal.

- Use the most current version: MU Aggregation Form
- List only the location(s) the EP worked during the MU reporting period
- Upload the SRA for all the locations mentioned on the form w/ EHR
- Combine MU data from all the mentioned locations with EHR
- Upload an MU Dashboard per location the EP worked w/ EHR
- Specify an applicable reason, if failed to upload the dashboard

MAPIR TIPS

- 2015 Edition – CMS ID is a combination of numbers & upper case letters only



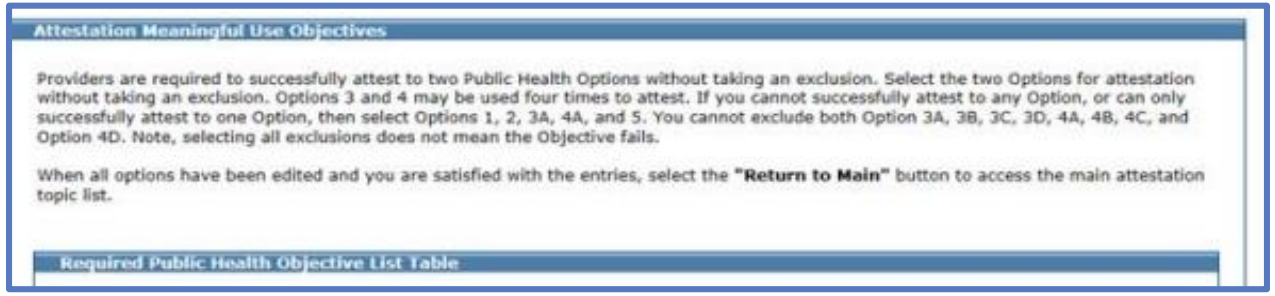
- Objective 0 – be sure to read the questions thoroughly and respond accordingly to avoid a rejected status

Objective 0	Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of Certified EHR Technology, including by permitting timely access to such technology and demonstrating capabilities as implemented and used by you in the field? Actions related to supporting information exchange and the prevention of health information blocking: During the EHR Reporting Period, 1. Did you or your organization knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of Certified EHR Technology?	Question 1 = Yes Question 2 = No Question 3 = Decline to answer Question 4 = Decline to answer Actions related to supporting information exchange and the prevention of health information blocking: Question 1 = Yes Question 2 = Yes Yes Yes Yes Question 3 = Yes	Rejected

- Objective 6 and 7: Coordination of Care and HIE
  - ✓ EPs must attest to all three measures and must meet the threshold for at least two measures to meet the objective

MAPIR TIPS

- Public Health- An EP must satisfy two measures for this objective. If the EP cannot satisfy at least two measures, they may take exclusions from all measures they cannot meet.



- Rejected Measure – verify all objectives are accepted on the summary page of application

Attempt	Potential Outcome	Date/Time Signed	Available Action
1	Rejected	02/28/2019 08:55:25 PM EST	View

- PVT, Opt Out Audit Log, and Request and Query HIE log must be provided in Excel format
- Name files in accordance to the objective

Questions

Questions?

Break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Objective 5:
Patient Electronic Access

Thomas Bennett

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at the MassTech Collaborative

Purpose of This Session

We want to help you:

- Meet the measures for Objective 5
- Save time by getting it right the first time and avoid application cycling
- Ensure accuracy of your supporting documentation

At the end of this session, attendees will take away:

- Why electronic patient engagement is important
- Options and strategies for meeting the measures while minimizing potential issues
- Examples of approved supporting documentation

Why Electronic Patient Engagement (EPE)?

- Leverages Health IT for improved efficiencies
  - scheduling, testing, reminders
- Improves care coordination
  - patient has access to current med list, problem list, lab results – making it easier and more likely that they will share that information with other providers
- Increases accuracy and timeliness of information shared
- Allows patient-generated health data to be incorporated into EHR

Objective 5: Patient Electronic Access (PEA)

EP provides patients with timely electronic access to their health information and patient-specific education

Measure 1: For **more than 80%** of patients:

(1) the patient is provided timely access to view, download, and transmit their health info*; and

(2) the patient's health info is available for the patient to access using any app of their choice configured to meet the technical specs of the Application Programming Interface (API)** in the provider's CEHRT

Measure 2: For **more than 35%** of patients, EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials

* When patients decline to participate in electronic access to their health information, the EP can use **Opt Out** to count those patients in order to meet the thresholds for both Measure 1 and Measure 2. More to come on using Opt Out.

** You can think of an Application Programming Interface (API) as the messenger that takes your request to an EHR and then delivers the EHR's response back to you. More to come on APIs.

PEA – Basic Supporting Documentation requirements

Upload Supporting Documentation

Measure 1: Access to View, Download and Transmit (VDT) and API Access*

- An EHR-generated MU dashboard or report for the selected MU reporting period that shows the EP's name, numerator, denominator and percentage for this measure.
- Documentation that shows an API was **enabled** prior to or during the MU reporting period.
- A copy of the instructions provided to patients with
  - a) how to authenticate their access through an API and
  - b) information on available applications that leverage API

Measure 2: Electronic Access to Patient Specific Education

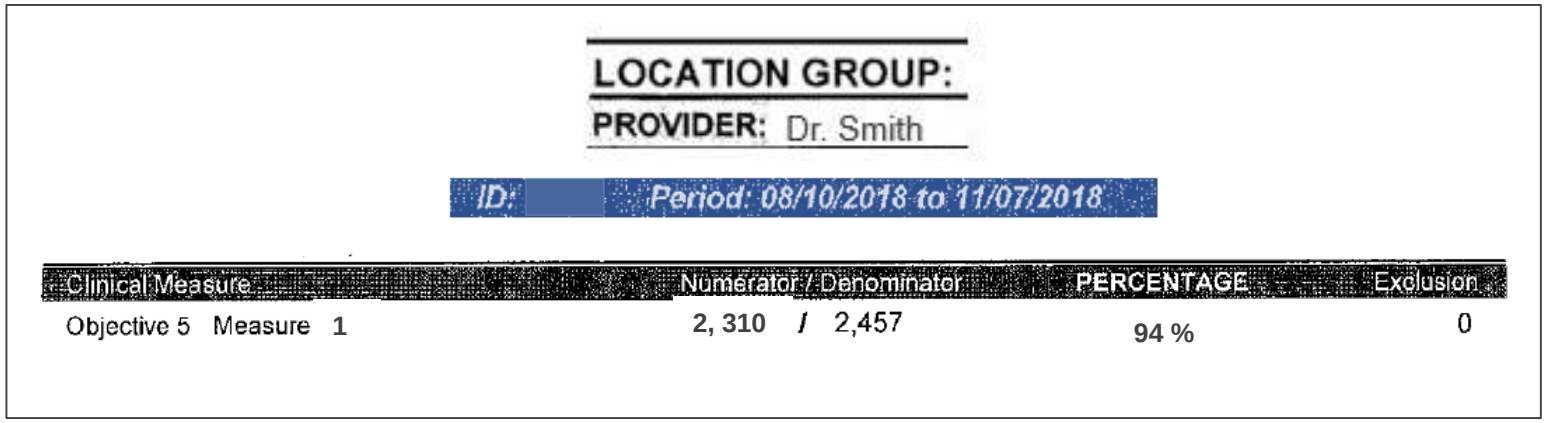
- EHR-generated MU Dashboard or report

* If the EP used the **Opt Out** method to meet the measure threshold(s), additional supporting documentation is required to show how the EP added **Opt Out** patients to the numerator(s). More to come on using **Opt Out**.

PEA - Measure 1: supporting documentation to prove access to View, Download and Transmit (VDT) and API Access

EHR-generated MU dashboard or report

- Selected MU reporting period
- Attesting EP's name
- Recorded numerator, denominator and percentages for this measure



LOCATION GROUP:

PROVIDER: Dr. Smith

ID: *Period: 08/10/2018 to 11/07/2018*

Clinical Measure	Numerator / Denominator	PERCENTAGE	Exclusion
Objective 5 Measure 1	2, 310 / 2,457	94 %	0

The MU dashboard shows 94% of Dr. Smith's unique patients were provided timely access to view, download and transmit their health information.

The displayed percentage more than satisfies the required 80%+ threshold.

PEA - Measure 1: supporting documentation to prove access to View, Download and Transmit (VDT) and API Access

Copy of instructions provided to patients with:

- How to authenticate their access through an API
- Information on available applications that leverage API

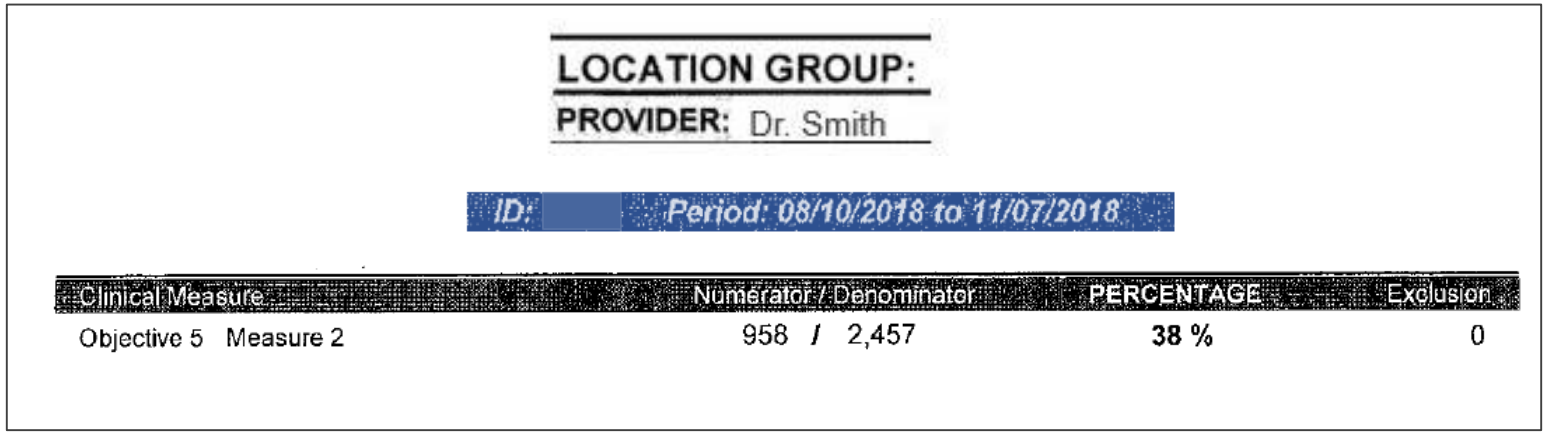
Documentation showing API was enabled prior to or during MU reporting period

- Must include enabled date
- May come in different formats:
  - EHR screenshot with enabled date and provider/location name
  - Vendor letter confirming API was enabled before or during EHR reporting period

PEA - Measure 2: Supporting Documentation to prove Electronic Access to Patient Specific Education

EHR-generated MU dashboard or report

- Selected MU reporting period
- Attesting EP's name
- Recorded numerator, denominator and percentages for this measure



LOCATION GROUP:
PROVIDER: Dr. Smith

ID: [redacted] Period: 08/10/2018 to 11/07/2018

Clinical Measure	Numerator / Denominator	PERCENTAGE	Exclusion
Objective 5 Measure 2	958 / 2,457	**38 %**	0

The MU dashboard shows 38% of Dr. Smith's patients received e-educational resources.

The displayed percentage more than satisfies the required 35%+ threshold

Using Opt Out

What is Opt Out for PEA?

Opt Out is an alternative strategy EPs can use to attest successfully when patients decline to participate in electronic access to their health information.

Opt Out allows you to count those patients toward meeting the thresholds for both Measure 1 and Measure 2 of Objective 5.

Measure 1 and Measure 2: Using Opt Out

Using Opt Out to meet Measure 1 and Measure 2

- Add Opt Out patients to your Measure 1 and Measure 2 numerators if patients are provided all necessary info to:
  - Access their health information and educational resources electronically
  - Obtain access through an authorized representative or
  - Otherwise opt back in without further action required by the EP
- EPs must still offer Opt Out patients all four functionalities (view, download, transmit, and access to API) and PHI needs to be made available for VDT
- If your EHR automatically includes Opt Out patients in the MU dashboard, simply upload the MU dashboard to MAPIR

Measure 2: Using email for educational resources

Using email to meet Measure 2

- Add patients to your Measure 2 numerator if patients were provided patient-specific educational materials via email
  - Patients cannot be counted twice (only add patients to the numerator if they were not also counted as Opt-Out patients)

- If your EHR automatically includes patients who receive educational resources via email in the MU dashboard, simply upload the MU dashboard to MAPIR

Supporting Documentation if using Opt Out and/or sending educational resources by email for PEA

Upload Supporting Documentation

Conditional supporting documentation applies to EPs who:

- manually added patients who opted out of PEA to the Measure 1 and Measure 2 numerators, and/or
- added patients who received patient-specific education resources via email to the Measure 2 numerator

because the EP's MU dashboard didn't automatically add these patients.

Supporting Documentation if using Opt Out and/or sending educational resources by email for PEA

Measure 1 and 2:

In addition to the EHR-generated MU Dashboard, submit:

- Letter confirming Opt Out patients were provided all necessary information to access their health information
- Opt Out audit log or report with the unique IDs of the Opt Out patients that were added to the numerators for Measure 1 and Measure 2
  - Redact any Patient Health Information
  - Report must be in Excel format

Measure 2 Only:

In addition to the EHR-generated MU Dashboard, submit:

- Letter confirming patients were emailed patient-specific educational resources.
- Educational Email audit log or report with unique IDs of the patients added to the Measure 2 numerator because educational emails were sent.
  - Redact any Patient Health Information
  - Report must be in Excel format

Opt Out Supporting Documentation if manually tracking Opt Out patients

Opt Out Letter

Central Massachusetts Internal Medicine
100 North Drive,
Westborough, MA 01581
508-000-0000

04/24/2019

To Whom It May Concern:

Letter Confirming the Opt-Out patients were provided all necessary information to access their information, obtain access through a patient-authorized representative, or otherwise opt-back-in without further follow up action required by the provider.

The letter must include a description of how a patient's Opt-Out action was recorded (for example a form, or other method). The letter must be signed by an authorized official at the location where the Opt-Outs occurred (EP, Designee, Clinical or Medical Director).

Sincerely,

Clark Kent, MD
Clark Kent, MD

Medical Director

Opt Out Supporting Documentation if manually tracking Opt Out patients

Opt Out Audit Log of Opt Out patients added to MU Dashboard numerator(s) for Measure 1 and Measure 2

- Unique IDs of the qualifying “Opt Out” patients added
- Log or report should be in Excel format
- Redact any PHI
- Only include patients who opted out *

Patient ID	Patient DOB	Service Date	Provider	Reason for Opt-Out
1111111	1/1/2000	1/1/2019	Clark Kent, MD	Declined patient portal
2222222	1/10/2009	1/10/2019	Clark Kent, MD	No internet access
3333333	1/12/2002	1/12/2019	Clark Kent, MD	Declined patient portal
4444444	1/8/1996	1/14/2019	Clark Kent, MD	Declined patient portal
5555555	3/15/2001	1/14/2019	Clark Kent, MD	Declined patient portal

* You can, but are not required to, use a single Opt Out Audit Log for both measures.
(For instance if the Opt Out reason is that they declined access to the patient portal and the patient portal is used to provide electronic access for both VDT and educational resources, you only need one audit log)

Educational Email Supporting Documentation if manually tracking patients who were sent educational resources by email

Educational Email Letter

Central Massachusetts Internal Medicine
100 North Drive,
Westborough, MA 01581
508-000-0000

04/24/2019

To Whom It May Concern:

Letter confirming patients were emailed patient-specific educational resources.

The letter must be signed by an authorized official at the location from which the educational emails were sent (EP, Designee, Clinical or Medical Director).

Sincerely,

Clark Kent, MD
Clark Kent, MD

Medical Director

Educational Email Supporting Documentation if manually tracking patients who were sent educational resources by email

Education Email Audit log for patients added to MU Dashboard numerator for Measure 2

- Unique IDs of the qualifying patients who were sent patient-specific educational emails *
- Log or report should be in Excel format
- Redact any PHI
- Only include patients who were sent educational emails, and are not also included as Opt-Outs to electronic access to educational resources in the measure 2 numerator (don't count them twice in measure 2)

Patient ID	Patient DOB	Service Date	Provider	Date education was emailed
2111111	1/2/2000	1/1/2019	Clark Kent, MD	1/2/2019
3222222	1/12/2009	1/10/2019	Clark Kent, MD	1/11/2019
4333333	1/14/2002	1/12/2019	Clark Kent, MD	1/13/2019
5444444	1/6/1996	1/14/2019	Clark Kent, MD	1/20/2019
6555555	3/20/2001	1/14/2019	Clark Kent, MD	1/25/2019

* This assumes the EP has the patient's actual email address, but do not include it in the Audit Log as that is considered PHI. You cannot send the educational emails to a fake address.

Objective 5 - PEA: Entering Data Into MAPIR

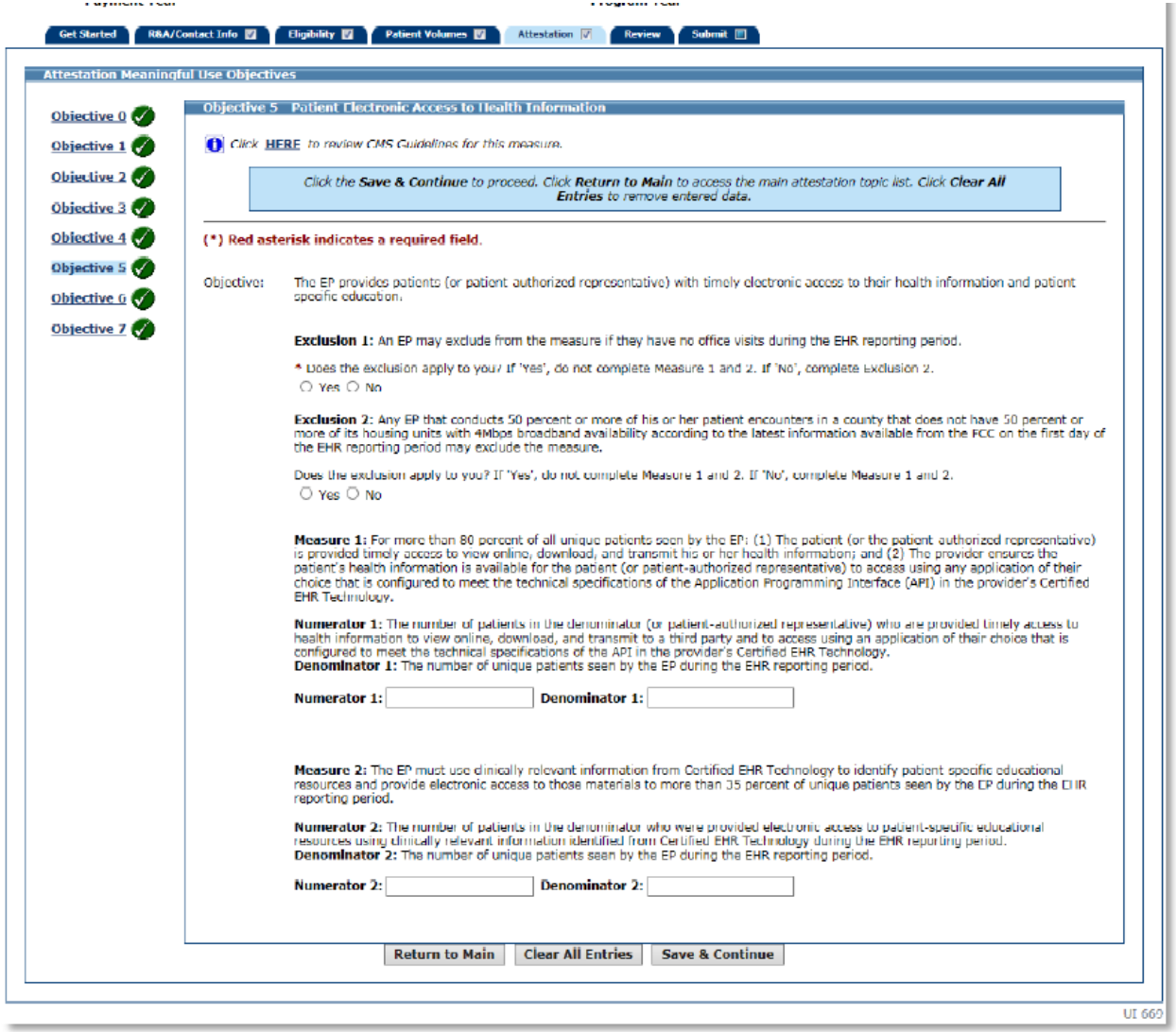
Attestation Tab > Meaningful Use > Objective 5: Patient Electronic Access

Note: Opt out and Educational Emails are not options you can select in MAPIR.

Upload the Opt Out Audit Log and/or Educational Email Audit Log, and the Opt Out Letter and/or Educational Email Letter to MAPIR.

Add the numerator(s) from the report(s) to the numerator(s) in your dashboard, to equal the numerator(s) entered in MAPIR to meet measure 1 and/or measure 2.

Enter the denominators from your dashboard.



Patient Portal Workflow Issues

Potential Problem	Potential Solution
No institutionalized method of providing access that links to CEHRT data capture for numerator/denominator	Train staff in exact steps to give access and capture the fact in CEHRT
Confidentiality and privacy issues difficult to standardize	Work with EHR vendor to ensure security of ePHI
Not all staff are knowledgeable about patient engagement and how to encourage patients to use portal	Staff training on features and benefits of portal

Patient Portal: Patient or Client Issues

Potential Problem	Potential Solution
Giving access to minors	Use patient-authorized representative
Patient or caregiver not tech-savvy	Coach patient, client, or caregiver in using electronic devices
No computer access	Have laptops/tablets/kiosks available Staff can assist patients as needed
Location challenges	Introduce use of other devices per 2015 Edition requirements
Not interested in using portal	Educate on benefits of portal or document as “Opted Out”

Patient Portal Technical Issues

Potential Problem	Potential Solution
Method of giving access not recognized by CEHRT logic for generating numerator/denominator	Work with vendor; possibly requiring patch of some sort
Access method used by practice does not fulfill CMS/attestation requirements	Communicate with MeHI before EHR reporting period if there are concerns
Portal module doesn't interface with CEHRT properly	Contact vendors
CEHRT dashboard fails to accurately report true numerator/denominator	Work with vendor to understand logic of how numerator/denominator is populated

Questions

Questions?

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Objective 6: Coordination of Care Through Patient Engagement

Maggie Lellman
Lis Renczkowski

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Objective 6: Coordination of Care Through Patient Engagement

Use CEHRT to engage with patients or authorized representatives about the patient's care

Measure 1: **More than 5%** of patients:

(1) view, download, or transmit their health info;
(2) access their health info through apps chosen by the patient and configured to the API in the provider's CEHRT; or
(3) a combination of 1 and 2

Measure 2: For **more than 5%** of patients, a secure message was sent to the patient

Measure 3: Patient-generated health data or data from nonclinical setting is incorporated into CEHRT for **more than 5%** of patients

Note: EPs must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure.

MU Supporting Documentation: Coordination of Care Through Patient Engagement

Upload Supporting Documentation

Measure 1: Patients Viewed, Downloaded or Transmitted (VDT), or Accessed their health information using an API

- EHR-generated MU Dashboard or report

Measure 2: Secure Messaging

- EHR-generated MU Dashboard or report

Measure 3: Incorporation of Patient Generated Health Data or Data from a Non-Clinical Setting

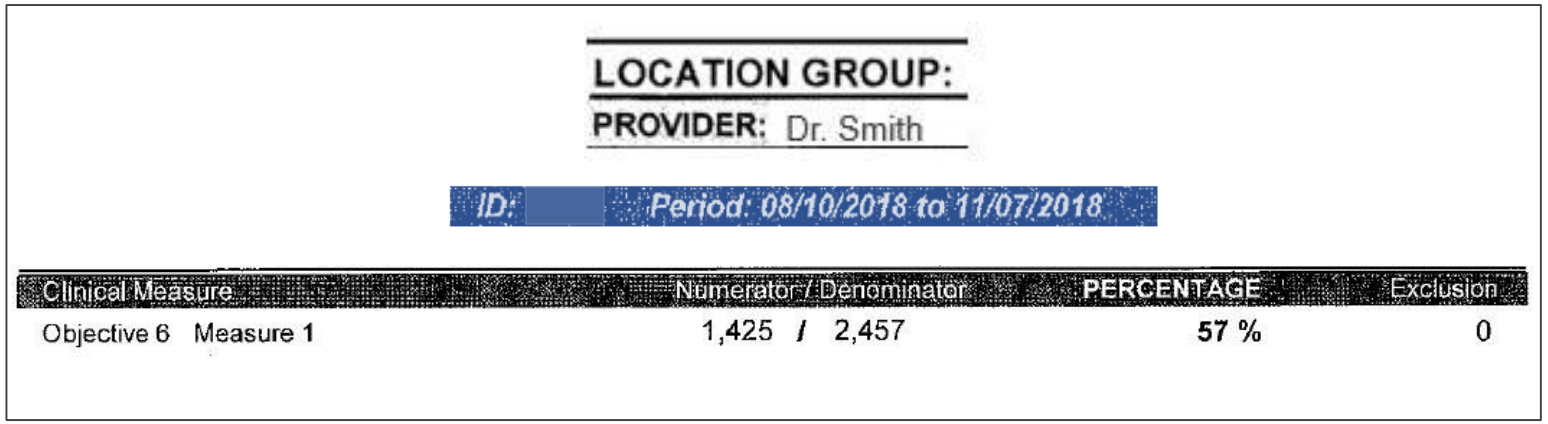
- EHR-generated MU Dashboard or report

Note: EPs must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure.

EPE - Measure 1: Supporting Documentation to prove patients Viewed, Downloaded or Transmitted (VDT) their health info, or accessed their health info using API

EHR-generated MU dashboard or report

- Selected MU reporting period*
- Attesting EP's name
- Recorded numerator, denominator and percentages for this measure



LOCATION GROUP:

PROVIDER: Dr. Smith

ID: *Period: 08/10/2018 to 11/07/2018*

Clinical Measure	Numerator / Denominator	PERCENTAGE	Exclusion
Objective 6 Measure 1	1,425 / 2,457	57 %	0

The MU dashboard shows 57% of Dr. Smith's unique patients actively engaged with EHR via VDT or through an API.

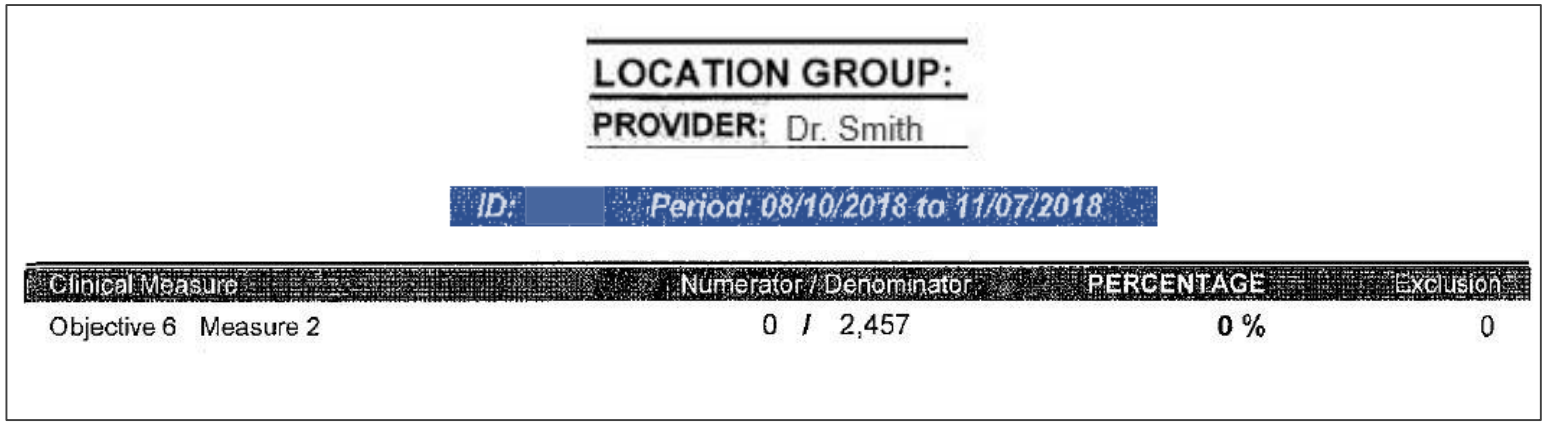
The displayed percentage more than satisfies the required 5%+ threshold.

*API access and VDT must occur within same calendar year as MU reporting period

EPE - Measure 2: Supporting Documentation to prove Secure Messaging

EHR-generated MU dashboard or report

- Selected MU reporting period
- Attesting EP's name
- Recorded numerator, denominator and percentages for this measure



LOCATION GROUP:

PROVIDER: Dr. Smith

ID: *Period: 08/10/2018 to 11/07/2018*

Clinical Measure	Numerator / Denominator	PERCENTAGE	Exclusion
Objective 6 Measure 2	0 / 2,457	**0 %**	0

The MU dashboard shows Dr. Smith failed to send or respond to a secure message to or from a patient using CEHRT.

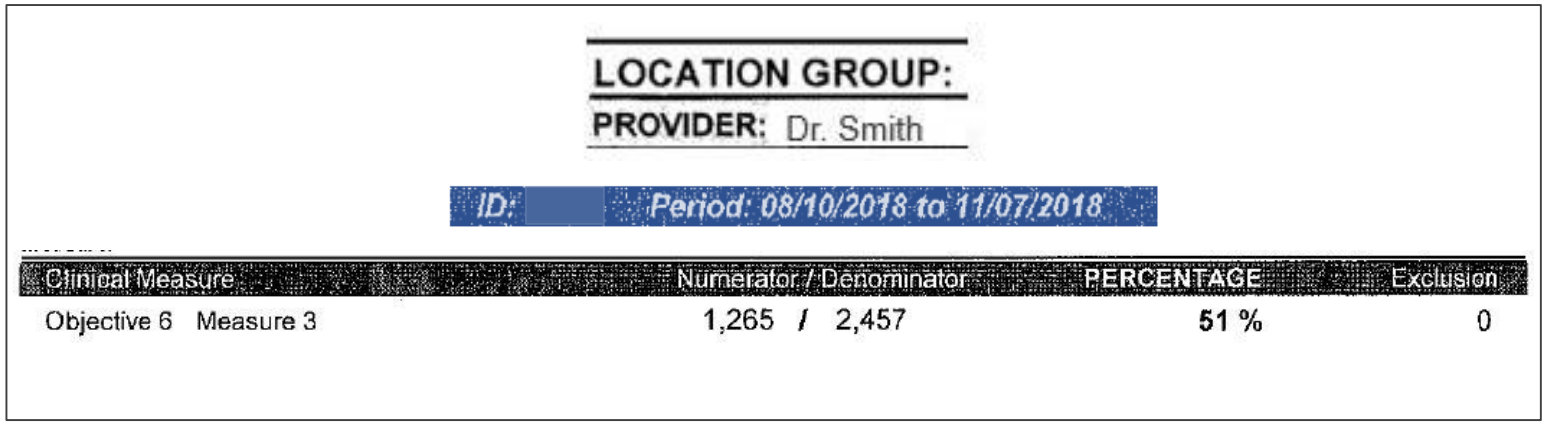
The displayed percentage confirms Dr. Smith failed to satisfy the 5%+ threshold.

Note: The EP must demonstrate that two of the 3 measures were satisfied in order to prove meaningful use. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure.

EPE - Measure 3: Supporting Documentation to prove incorporation of patient-generated health data or data from a non-clinical setting

EHR-generated MU dashboard or report

- Selected MU reporting period
- Attesting EP's name
- Recorded numerator, denominator and percentages for this measure



LOCATION GROUP:

PROVIDER: Dr. Smith

ID: *Period: 08/10/2018 to 11/07/2018*

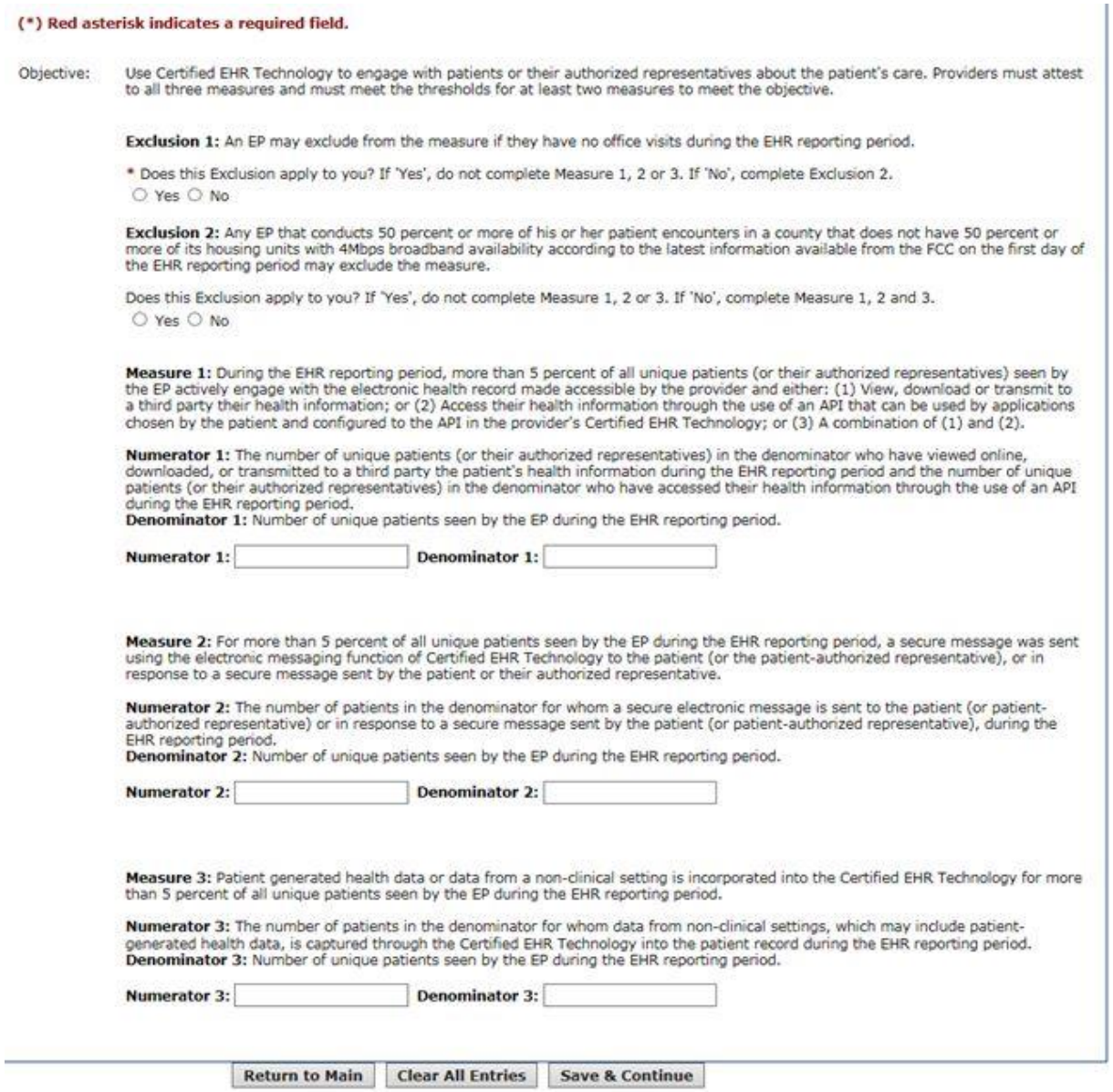
Clinical Measure	Numerator / Denominator	PERCENTAGE	Exclusion
Objective 6 Measure 3	1,265 / 2,457	51 %	0

The MU dashboard shows 51% of Dr. Smith's unique patient's health data was generated from a non-clinical setting and incorporated into CEHRT.

The displayed percentage more than satisfies the required 5%+ threshold.

Objective 6: Entering Data Into MAPIR

Attestation Tab > Meaningful Use > Objective 6: Coordination of Care Through Patient Engagement



(*) Red asterisk indicates a required field.

Objective: Use Certified EHR Technology to engage with patients or their authorized representatives about the patient's care. Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.

Exclusion 1: An EP may exclude from the measure if they have no office visits during the EHR reporting period.

* Does this Exclusion apply to you? If 'Yes', do not complete Measure 1, 2 or 3. If 'No', complete Exclusion 2.

○ Yes ○ No

Exclusion 2: Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

Does this Exclusion apply to you? If 'Yes', do not complete Measure 1, 2 or 3. If 'No', complete Measure 1, 2 and 3.

○ Yes ○ No

Measure 1: During the EHR reporting period, more than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) Access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's Certified EHR Technology; or (3) A combination of (1) and (2).

Numerator 1: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the EHR reporting period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the EHR reporting period.
Denominator 1: Number of unique patients seen by the EP during the EHR reporting period.

Numerator 1: [ ] **Denominator 1:** [ ]

Measure 2: For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of Certified EHR Technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative.

Numerator 2: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the EHR reporting period.
Denominator 2: Number of unique patients seen by the EP during the EHR reporting period.

Numerator 2: [ ] **Denominator 2:** [ ]

Measure 3: Patient generated health data or data from a non-clinical setting is incorporated into the Certified EHR Technology for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.

Numerator 3: The number of patients in the denominator for whom data from non-clinical settings, which may include patient-generated health data, is captured through the Certified EHR Technology into the patient record during the EHR reporting period.
Denominator 3: Number of unique patients seen by the EP during the EHR reporting period.

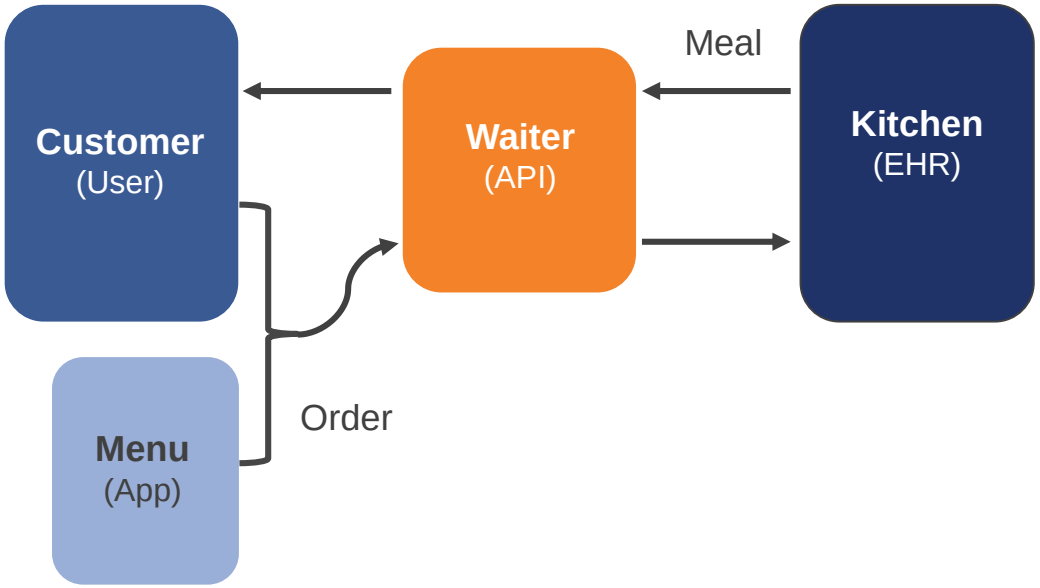
Numerator 3: [ ] **Denominator 3:** [ ]

Return to Main | Clear All Entries | Save & Continue

What is an Application Programming Interface (API)?

A Restaurant Analogy

- User = Customer
- App = Menu
- API = Waiter
- EHR/backend = Kitchen



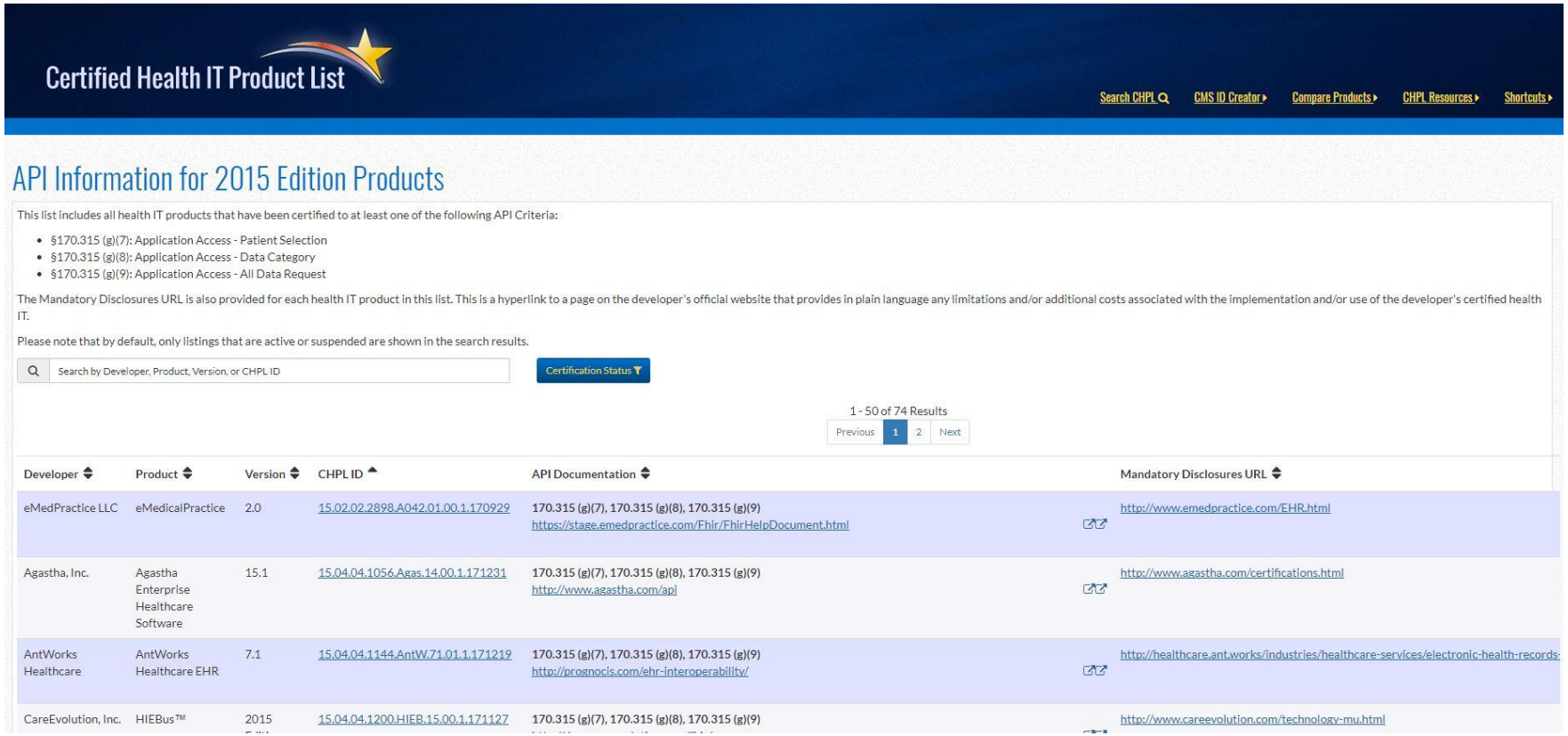
video: what is an API?

What is an Application Programming Interface (API)?

- A set of requirements that governs how one software application interacts with another software application
  - Allows developers to create apps to use data in the EHR system
  - All the specifications for working with the EHR system
  - Published and available
- Example: Patient Portals are often interfaced to the EHR via an API
- Per CMS specification sheet: set of programming protocols established for multiple purposes. APIs may be enabled to provide the patient with access to their health information through a third-party application with more flexibility than is often found in many current “patient portals.”
- APIs are widely used to exchange data but APIs are not standardized
  - Developers need to support APIs of each EHR vendor
- ONC requires a fully functioning API for 2015 Certification

Where to Find Out About Your EHR's API

- Links to CEHRT APIs are available on the Certified Health IT Product List (CHPL) website



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Business/Clinical Strategy: How to Meet PEA & EPE Measures

Provide patients with list of pre-vetted Mobile Apps that interface to your EHR to:

- Increase your ability to help patients in using VDT via an App
  - PEA Measure 1: Provide VDT access to patient
  - EPE Measure 1: Patient uses VDT
- Increase your ability to Securely Message with your patients via an App
  - EPE Measure 2: Securely message with patient
- Increase your ability to Incorporate Patient-Generated Data into your EHR
  - EPE Measure 3: Patient-generated data incorporated into CEHRT

Provide your CEHRT's API technical spec to patients to meet API requirements

- PEA Measure 1: Provide API specification to patient
- EPE Measure 1: Health info available/accessed by patients using App of their choice configured to technical specs of CEHRT's API

Business/Clinical Strategy:
How to Improve Care and Exceed MU Measures

Passive Electronic Patient Engagement (EPE) Strategy	Pro-Active EPE Strategy	Increased ability to meet your EPE related measures

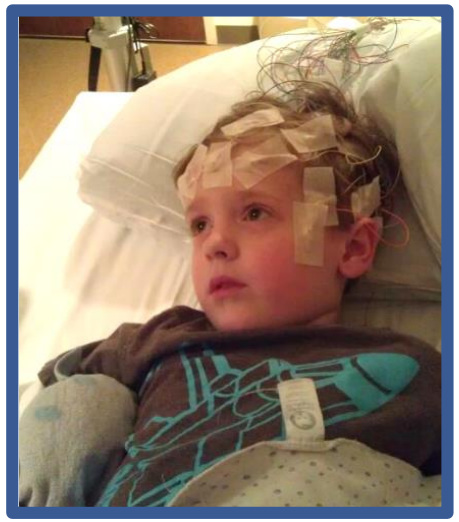
Provide Patient Portal Access	▪ Provide Patient Portal Access
	▪ Provide list of pre-vetted Mobile Apps that
	  ▪ Support VDT, Patient Input, Secure Messaging
	  ▪ Connect to your EHR via API
		If connected to your dashboard, the Mobile Apps-based activity counts towards patient VDT, Patient Input, Secure Messaging

Provide pamphlet on how to use the Patient Portal	▪ Physicians actively explain how these EPE tools enable them to provide better care ▪ Staff available to assist patients who need to select and learn to use the EPE options	Improves EPE use, as patients trust physicians/staff and tend to follow their advice

Dump the patient info and lab results into the Patient Portal	▪ Upload patient info and lab results into the Patient Portals and Apps in meaningful way
	▪ Add educational info; use EPE to assist in:
	  ▪ interpreting data/trends
	  ▪ care adherence
		Raises interest in using Patient Portal and Mobile Apps as it involves patients in their care and enhances understanding

Provide API information to patient	Provide API information to patient	Must be done to meet API measure
Let patient decide what Mobile Apps to use and answer their API questions when Apps don't work	Avoid these questions by helping patients select from your pre-vetted Mobile Apps	The Q&A overhead is not likely to improve patient care, and is your staff even equipped to answer?

Story: Imagine the EPE Possibilities



Toby's Story

- First seizure Sept 2011 at age 2
- Formal diagnosis Nov 2011: Generalized Epilepsy
  - Suspected Myoclonic-Astatic Epilepsy (MAE)
  - Tried and failed 7 medications
- Began ketogenic diet – summer 2012
  - Dramatic reduction in number & severity of seizures
- Seizure-free since January 2015; clear EEG at last neuro visit

What About an App?

- Ketogenic diet requires daily testing of ketone levels
- App for parents/patients to
  - Track and report daily ketone levels
  - Record meals and recipes
  - Document/describe seizure activity & other symptoms
  - Communicate with physician
- A developer could create an app
  - Would need API specifications from neurologist's EHR

Implementation Strategy:
Engaging Patients Through Mobile Apps

- Design your PEA & EPE Strategy for using Patient Portals and Mobile Apps
  - How can the Apps enhance your ability to provide care and engage patients?
- Talk to EHR Vendor
  - Get their API Technical Specification
  - Get list of Mobile Apps the vendor knows work well
- Review and select the Mobile Apps
  - What are the Apps that would enable your PEA & EPE strategy?
  - What would your patients be likely to use?
- Implement your PEA & EPE strategy
  - Define and set up the inputs/outputs of the VDT, Secure Messaging, Patients Data
  - Define and set up the workflow process that enables its use
- Recommend the Mobile Apps to your patients
  - Physician discussion, pamphlet, website, patient portal, etc.
  - Don’t forget to still give patients the API Technical Specification

Questions

Questions?

Lunch


healthcare
providers
PVT
MAPIR
MeHI
query
Mass HIway
PY2019
Massachusetts
API
Attestation
EP
INFORMATION
Data
Security Risk Analysis
Eligible Professional
patient
Stage 3
Reporting Period
CPOE
Clinical Decision Support
CARE
Medication Reconciliation
Patient Encounter
CDS
Secure
Electronic
Messaging
CEHRT
MEANINGFUL USE
Public Health Reporting
Stage 3
health
Informatics
MU
HIE
Care Coordination
Medicaid
Electronic Prescribing
Electronic
Health
Record
PATIENT ENGAGEMENT
Massachusetts
eHealth Institute
SRA
Clinical Quality Measures
HEALTH IT
EHR
eRx
Patient Volume Threshold
Patient Portal
Patient Education
HEALTH INFORMATION EXCHANGE
Interoperability
people
documentation
Program Year 2019

Objective 7:
Health Information Exchange (HIE)

Thomas Bennett
Maggie Lellman

Purpose of This Session

We want to help you:

- Meet the measures for Objective 7, Health Information Exchange (HIE)
- Save time by getting it right the first time and avoid application cycling
- Ensure accuracy of your supporting documentation

At the end of this session, attendees will take away:

- Why HIE is important
- Options and strategies for meeting the measures while minimizing potential issues
- Examples of approved HIE supporting documentation

Objective 7: Health Information Exchange

Provide a Summary of Care (SoC) record when transitioning a patient to another setting of care (measure 1),

receive or retrieve a summary of care record upon receipt of a transition or upon the first encounter with a new patient (measure 2),

and incorporate summary of care information from other providers into patient EHR using the functions of CEHRT (measure 3)

Objective 7: Health Information Exchange

Measure 1

For **more than 50%** of transitions and referrals, the referring EP:

1. Uses CEHRT to create Summary of Care (SoC) record
2. Electronically exchanges the summary of care record

Measure 2

For **more than 40%** of transitions and referrals received, and encounters where the EP has never before seen the patient, EP incorporates electronic summary of care record in patient's EHR

- A record cannot be considered incorporated if it is discarded without the reconciliation of clinical information, or if it is stored in a manner not accessible for EP use within the EHR

Measure 3 (former Stage 2 Medication Reconciliation objective)

For **more than 80%** of transitions received and encounters where the EP has never before seen the patient, EP performs a clinical information reconciliation for the following three clinical information sets:

1. Medication
2. Medication allergy
3. Current problem list

Health Information Exchange – (continued)

Exclusions

Measure 1

Any EP who transfers a patient to another setting less than 100 times during the EHR reporting period

Measure 2

Any EP with fewer than 100 total transitions received and first-time patient encounters during the EHR reporting period

Measure 3

Any EP with fewer than 100 total transitions received and first-time patient encounters during the EHR reporting period

Objective 7: Health Information Exchange

MEDICAID PROMOTING INTEROPERABILITY PROGRAM
ELIGIBLE PROFESSIONALS OBJECTIVES AND MEASURE
FOR 2019
OBJECTIVE 7 of 8

Health Information Exchange	
Objective	The eligible professional (EP) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT)
Measures	An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.
	Measure 1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) Electronically exchanges the summary of care record
	Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she incorporates into the patient's EHR an electronic summary of care document.
	Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she performs a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies.

The CMS specification sheet was updated in August 2019 to provide clarification about EPs who claim exclusions for 2 of the measures:

- An EP must attest to all three measures and meet the threshold for two measures for this objective.
- If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure.
- If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

Potential Problems and Solutions

HIE Technical Issues

Potential Problem	Potential Solution
Interfaces not working	Engage vendors
Transmission mechanism problems	Schedule periodic conference calls with key players to monitor and improve process
Not all components are certified	Identify all technical products required from source to destination and assure compliance
CEHRT functionality	Engage vendors
Numerator/Denominator not captured/reported correctly	Engage vendors
Query HIE not enabled	Engage vendors

Potential Problems and Solutions

HIE Workflow Issues – Sender

Potential Problem	Potential Solution
Staff reluctant to give up using fax and/or phone	Provide technical support to clinicians and administrative staff
Protocol for routine use of HIE not institutionalized	Create standardized protocol, train staff on its use, solicit and incorporate feedback Attend MeHI's Process Improvement Workshop for guidance on developing new protocols
Content of Consolidated Clinical Document Architecture (CCD-A) not refined	Develop short term project team to design, review and adopt CCD-A
Some personnel are on board with HIE, some are not	Acquire high level endorsement within practice

Potential Problems and Solutions

HIE Workflow Issues – Receiver

Potential Problem	Potential Solution
Unclear whom to contact at trading partner	Use other contacts at partner; contact MeHI for help
Trading partner will not accept electronic transmission	Get to know key HIE personnel at trading partner
Correct handling of Summary of Care Record unreliable	Create test environment parallel to existing communication channel; customize content to conform both to CMS requirements & specs of receiving party; learn their workflow
Hard to ascertain receipt	Include vendors in problem solving
Receiving specialist not interested in Summary of Care Record	Emphasize regulatory trend is mandating increased interoperability
No incentive for receiver to cooperate	Start by engaging with high volume trading partners

Entering Data Into MAPIR

Attestation Tab > Meaningful Use > Objective 7: Health Information Exchange (HIE)

- In MAPIR, for each exclusion, indicate if the exclusion applies to you

Measure 1

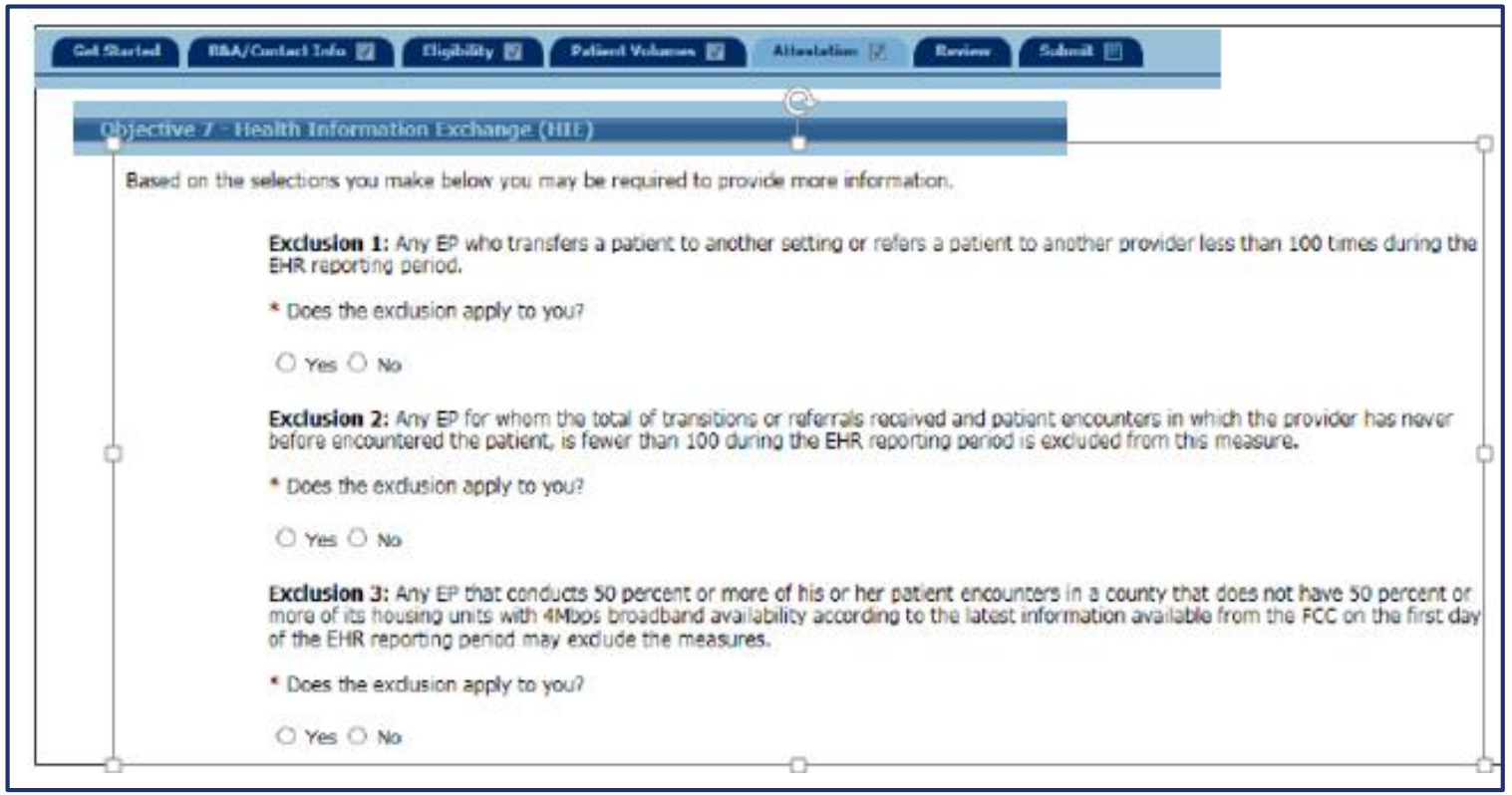
EP who transfers a patient to another setting less than 100 times during the EHR reporting period

Measure 2

EP with fewer than 100 total transitions received and first-time patient encounters during the EHR reporting period

Measure 3

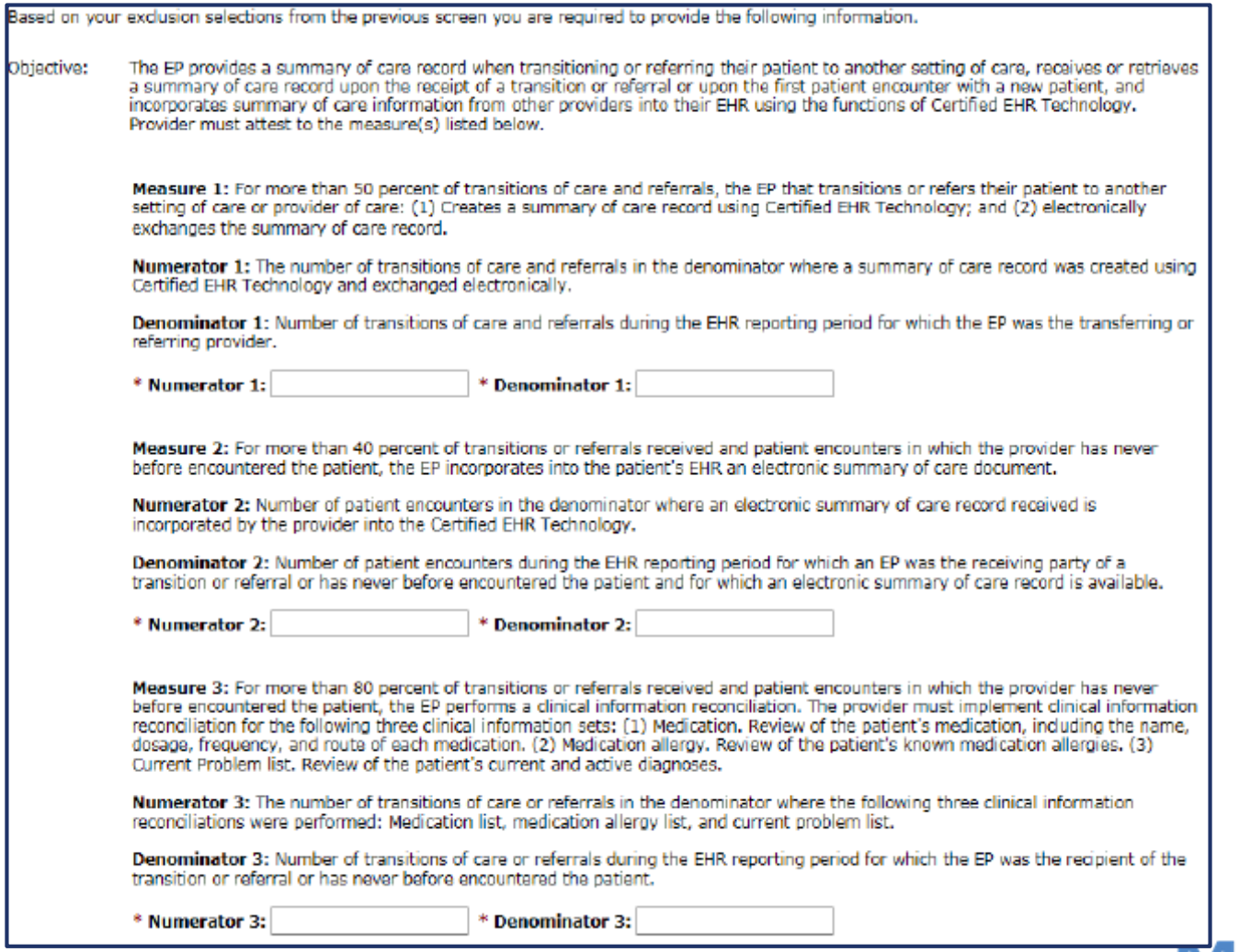
Same as Measure 2



Entering Data Into MAPIR, continued

Attestation Tab > Meaningful Use > Objective 7: Health Information Exchange (HIE)

- In MAPIR, enter the numerators and denominators lifted directly from the MU dashboard report to show that the EP met the required measure thresholds



Based on your exclusion selections from the previous screen you are required to provide the following information.

Objective: The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of Certified EHR Technology. Provider must attest to the measure(s) listed below.

Measure 1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using Certified EHR Technology; and (2) electronically exchanges the summary of care record.

Numerator 1: The number of transitions of care and referrals in the denominator where a summary of care record was created using Certified EHR Technology and exchanged electronically.

Denominator 1: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

* **Numerator 1:** * **Denominator 1:**

Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.

Numerator 2: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the Certified EHR Technology.

Denominator 2: Number of patient encounters during the EHR reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.

* **Numerator 2:** * **Denominator 2:**

Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies. (3) Current Problem list. Review of the patient's current and active diagnoses.

Numerator 3: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: Medication list, medication allergy list, and current problem list.

Denominator 3: Number of transitions of care or referrals during the EHR reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient.

* **Numerator 3:** * **Denominator 3:**

MU Supporting Documentation: HIE

Upload Supporting Documentation

Measure 1: Referrals and transitions of care electronically exchanged

- EHR-generated MU Dashboard or report
- Copy of one unique Summary of Care Record created by the EP
- Confirmation of receipt or proof that the receiving provider made a query of this one Summary of Care Record

Measure 2: Electronic summary of care records received and incorporated**

- EHR-generated MU Dashboard or report

Measure 3: Clinical information reconciliation

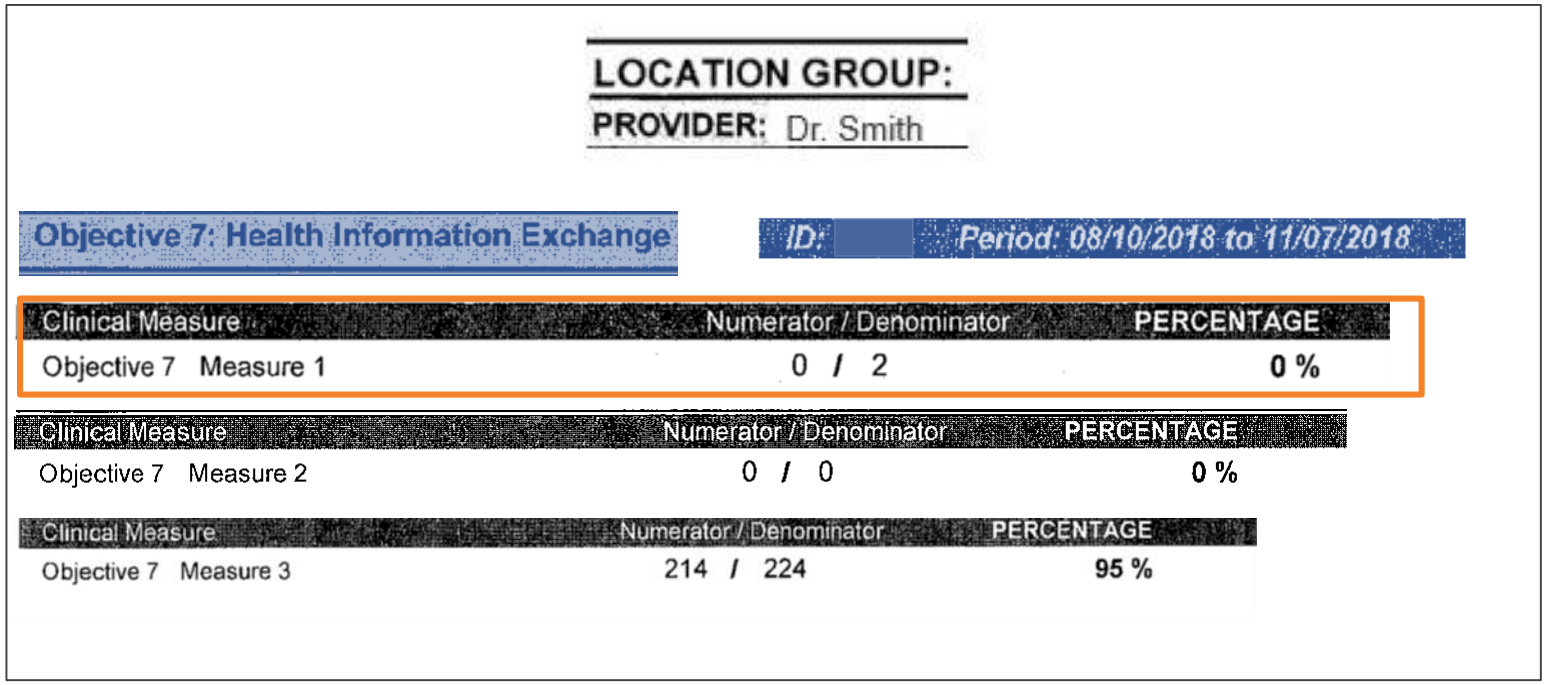
- EHR-generated MU Dashboard or report covering clinical reconciliation of medication, medication allergies and current problem list

** If EP receives insufficient electronic Summary of Care records to meet Measure 2, the EP can use ***Requests and Query HIE*** to obtain additional records. See Supporting Documentation Guide.

Measure 1: Referrals and transitions of care electronically exchanged

EHR-generated MU Dashboard or report

- Selected MU reporting period
- Attesting EP's name
- Recorded numerator, denominator and percentages for this measure



LOCATION GROUP:
PROVIDER: Dr. Smith

Objective 7: Health Information Exchange | **ID:** | **Period: 08/10/2018 to 11/07/2018**

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 1	0 / 2	0 %

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 2	0 / 0	0 %

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 3	214 / 224	95 %

Measure 1: Confirmation of Receipt

Measure 1: Confirmation of Receipt of the Summary of Care record

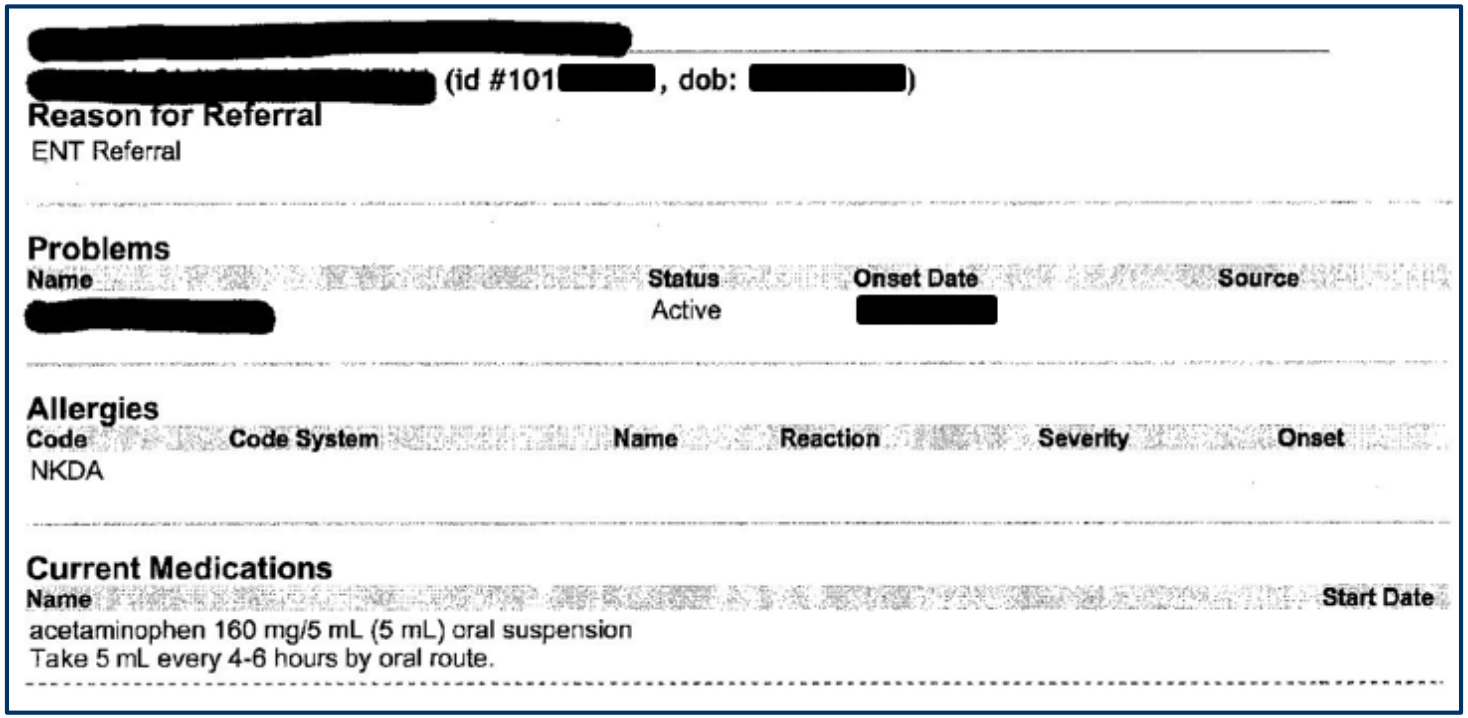
- Referring EP must have reasonable certainty of receipt of the Summary of Care record
- EPs must be able to provide additional supporting documentation to confirm the receiving provider queried the Summary of Care records counted in the numerator*
- See examples on slides 41-45

* eFax is not considered HIE and is not an acceptable form of proof

Example 1:
Summary of Care Record for "Patient 101"

Measure 1: Copy of one unique Summary of Care record

- Occurred within the same calendar year as the MU reporting period
- At minimum, includes current problem list, current medication list, and current medication allergy list
- Is in human readable format and is not a test record



[redacted] (id #101[redacted], dob: [redacted])

Reason for Referral
ENT Referral

Problems

Name	Status	Onset Date	Source
[redacted]	Active	[redacted]	

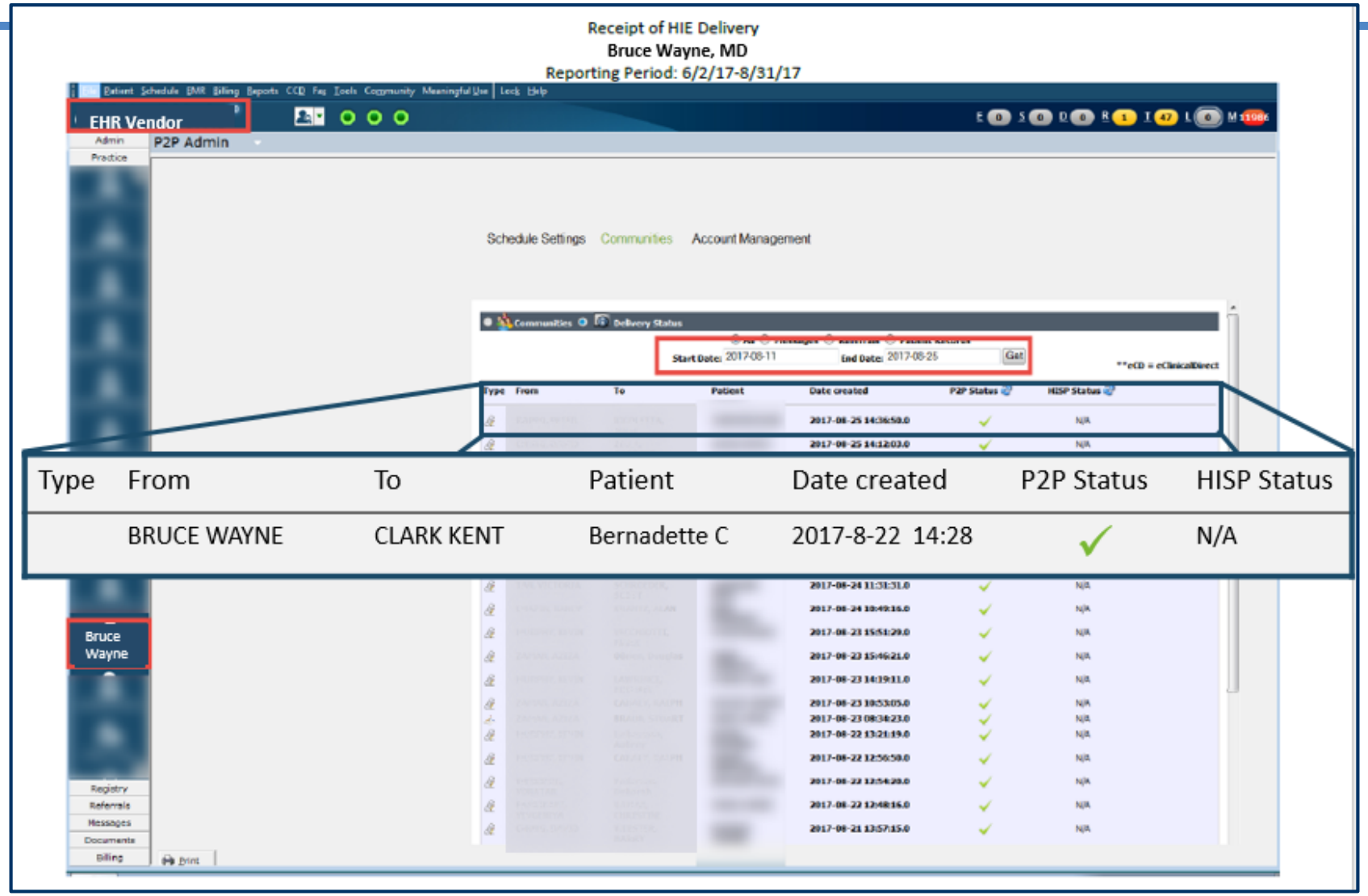
Allergies

Code	Code System	Name	Reaction	Severity	Onset
NKDA					

Current Medications

Name	Start Date
acetaminophen 160 mg/5 mL (5 mL) oral suspension Take 5 mL every 4-6 hours by oral route.	

Example 1: Confirmation of Receipt (part 1 of 2)
Log showing SOC was sent to receiving provider for "Patient 101"



*Note: This is a fictional patient record

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Example 1: Confirmation of Receipt (part 2 of 2)
Progress note confirming "Patient 101" was seen by receiving provider

EYE AND EAR SPECIALISTS
CLARK KENT, MD
100 NORTH DRIVE
WESTBOROUGH, MA 01581

3/3/2018

RE: PATIENT ID #101[redacted], Bernadette C., DOB: 1/1/2016

Dr. Bruce Wayne
20 West Street
Hudson, MA 01749

Dear Dr. Bruce Wayne,

Your patient, Bernadette C. was seen today for evaluation of her right ear that has been draining on and off with an odor for the past two weeks. She had tubes placed in 15 months ago.

Upon examination the right tube is in place. The left tube has extruded. Perforation is present in the central portion of the left drum. She said she has been using Cipro Drops. I switched her to TobraDex drops today and I will see her back in two weeks for follow.

Thank you for referring your patient, Bernadette, to our office for evaluation.

Clark Kent, MD

Clark Kent, MD (Electronically signed by Clark Kent, MD)

EYE AND EAR SPECIALISTS (ID #101[redacted]) Bernadette C. DOB: 1/1/2016

*Note: This is a fictional patient record

Example 2:
Summary of Care Record for "Patient 12345"

[redacted] (id # 12345 [redacted]

Problems

Name	Status	Onset Date	Source
Lactose Intolerance	Active	[redacted]	
Gluten Sensitivity	Active	[redacted]	
Hyperlipidemia	Active		History
Anxiety	Active		History
Hemorrhoids	Active		History
Palpitations	Active		History
Non-cardiac Chest Pain	Active		Encounter

Allergies

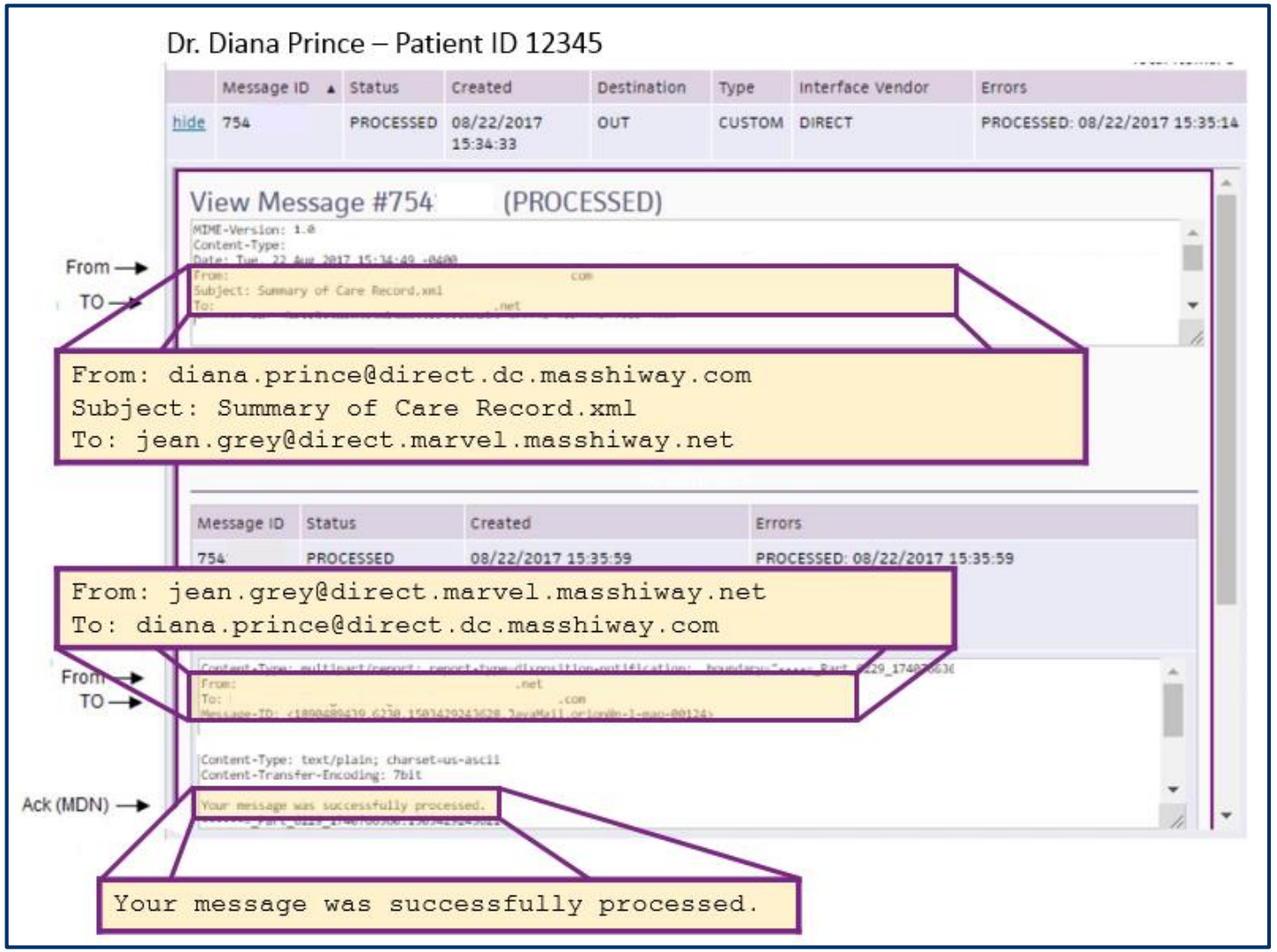
Code	Code System	Name	Reaction	Severity	Onset
NKDA					

Current Medications

Name	Start Date
cyclobenzaprine 10 mg tablet Take 1 tablet as needed by oral route at bedtime for 30 days.	
multivitamin one tablet daily	

Example 2: Confirmation of Receipt

Log confirming SOC for "Patient 12345" was sent to receiving provider and receiving provider acknowledged receipt

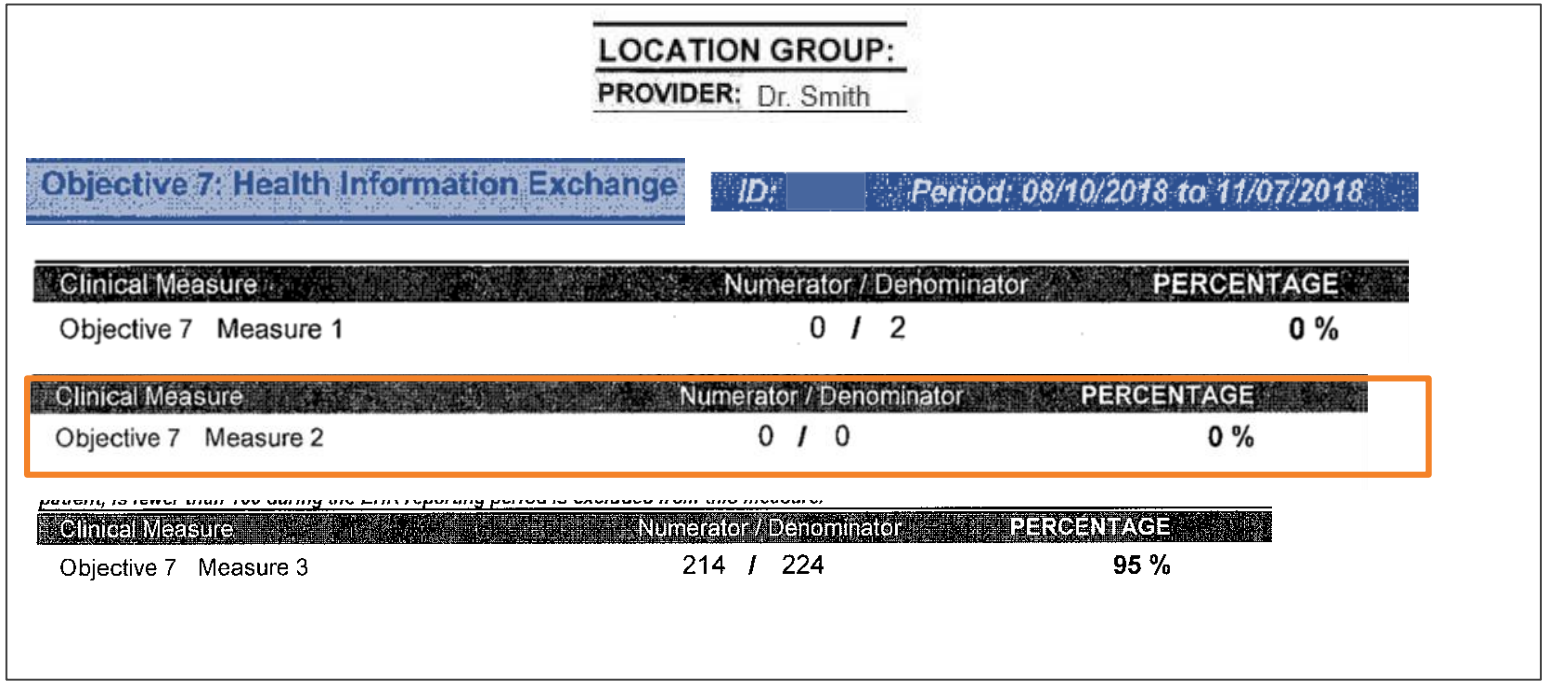


*Note: This is a fictional record

Measure 2: Summary of Care Records Received and Incorporated

EHR-generated MU Dashboard or report

- Selected MU reporting period
- Attesting provider's name
- Recorded numerator, denominator and percentages for this measure



LOCATION GROUP:
PROVIDER: Dr. Smith

Objective 7: Health Information Exchange | **ID:** | **Period: 08/10/2018 to 11/07/2018**

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 1	0 / 2	0 %

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 2	0 / 0	0 %

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 3	214 / 224	95 %

Measure 2: Summary of Care Records Received and Incorporated
Requests and Query HIE

Query-based HIE is not an MU requirement, but EPs who receive insufficient electronic Summary of Care records to meet Measure 2 can use Requests and Query HIE to obtain additional records.

Conditional supporting documentation applies to EPs who, in order to meet Measure 2:

- Used Requests and Query HIE to obtain electronic Summary of Care records, and
- Manually deducted patients from the Measure 2 Denominator, because the EP's MU Dashboard did not automatically exclude these patients from the denominator

Objective 7: Health Information Exchange – Using Requests & Query HIE

What is Query HIE?

Expanded CEHRT functionality that allows EPs to conduct searches for Summary of Care records

- If your dashboard shows that you are meeting Measure 2, query-based HIE is not required
- If you receive insufficient electronic Summary of Care records to meet Measure 2, you can use requests and Query HIE (if applicable) to try to obtain additional records

What is the difference between a request and a query?

- A “request” is a manual process through which you directly request an electronic summary of care from another provider. If you make a phone call, send a fax, or send a secure email to ask that a patient record be sent electronically, that counts as a request.
- A “query” is an automated process conducted by your EHR. The EHR system, usually via a platform like Commonwell/Carequality, conducts a search for records based on the patient’s name and DOB. You may have to click a button, or the system may be set up to automatically conduct a query whenever there is a new patient.

Objective 7: Health Information Exchange – Using Requests & Query HIE

How can requests and queries help me meet Measure 2?

- If you make a request* and/or conduct a query** and receive an electronic Summary of Care, and you incorporate this Summary of Care into your EHR:
  Your EHR will automatically add the patient to your denominator AND numerator, thereby helping you meet the measure. No further action is needed.

- If you have access to Query HIE, and you make a request and conduct a query but don't receive an electronic Summary of Care, the patient can be deducted from the measure 2 denominator:
  If your EHR does not deduct these patients from your denominator automatically, you can do so manually by following the documentation instructions on the next slides.

- If you don't have access to Query HIE, and you make a request but don't receive an electronic Summary of Care, the patient can be deducted from the measure 2 denominator:
  If your EHR does not deduct these patients from your denominator automatically, you can do so manually by following the documentation instructions on the next slides.

* The request can be made by phone, fax, or email, but the Summary of Care must be received electronically via Health Information Exchange (HIE)

** The query must be made and the Summary of Care must be received via HIE

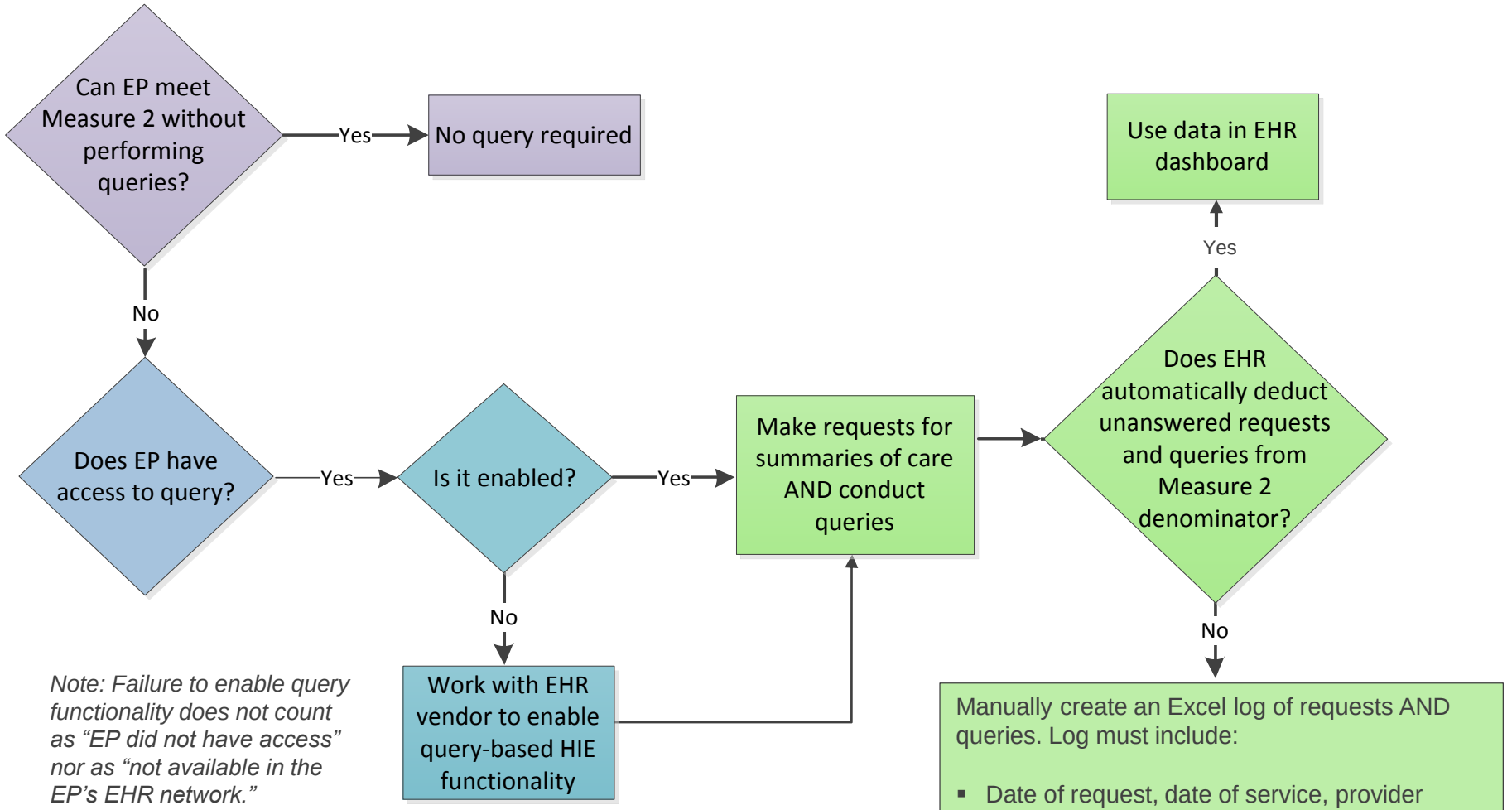
Objective 7: Health Information Exchange – Using Requests & Query HIE

Does my EHR vendor support Query HIE?

- Many 2015 Edition CEHRTs support Query HIE, either via vendor functionality or via integration of Query HIE platforms such as Commonwell or Carequality
- Not enabling the functionality does not count as “EP did not have access” nor as “not available in the EP’s EHR network”
- Ask your vendor whether query HIE functionality is available and how to enable it
- Some vendors may charge a fee to enable query HIE functionality

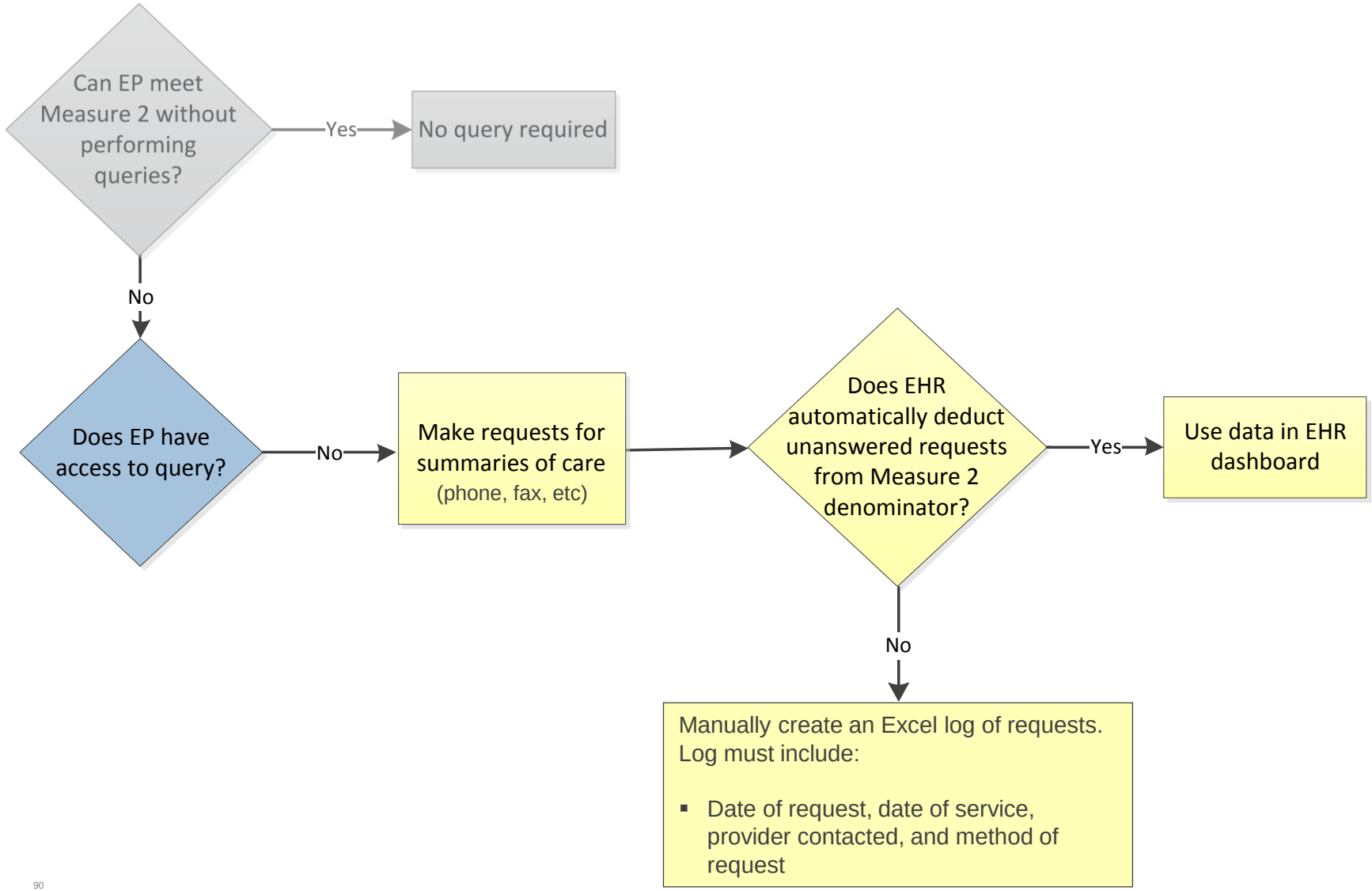
Do you have access to query-based HIE?	
No	**Yes**
Make requests (by phone, fax, or secure email) to try to obtain electronic Summary of Care records for transitions, referrals, and first-time patients	Make requests AND use query HIE to try to obtain electronic Summary of Care records for transitions, referrals, and first-time patients

Step-by-Step: Before and During MU Reporting Period – if EP has query access



Note: Failure to enable query functionality does not count as "EP did not have access" nor as "not available in the EP's EHR network."

Step-by-Step: Before and During MU Reporting Period – if EP has no access to query



MU Supporting Documentation: Requests and Query HIE – if EP has query access

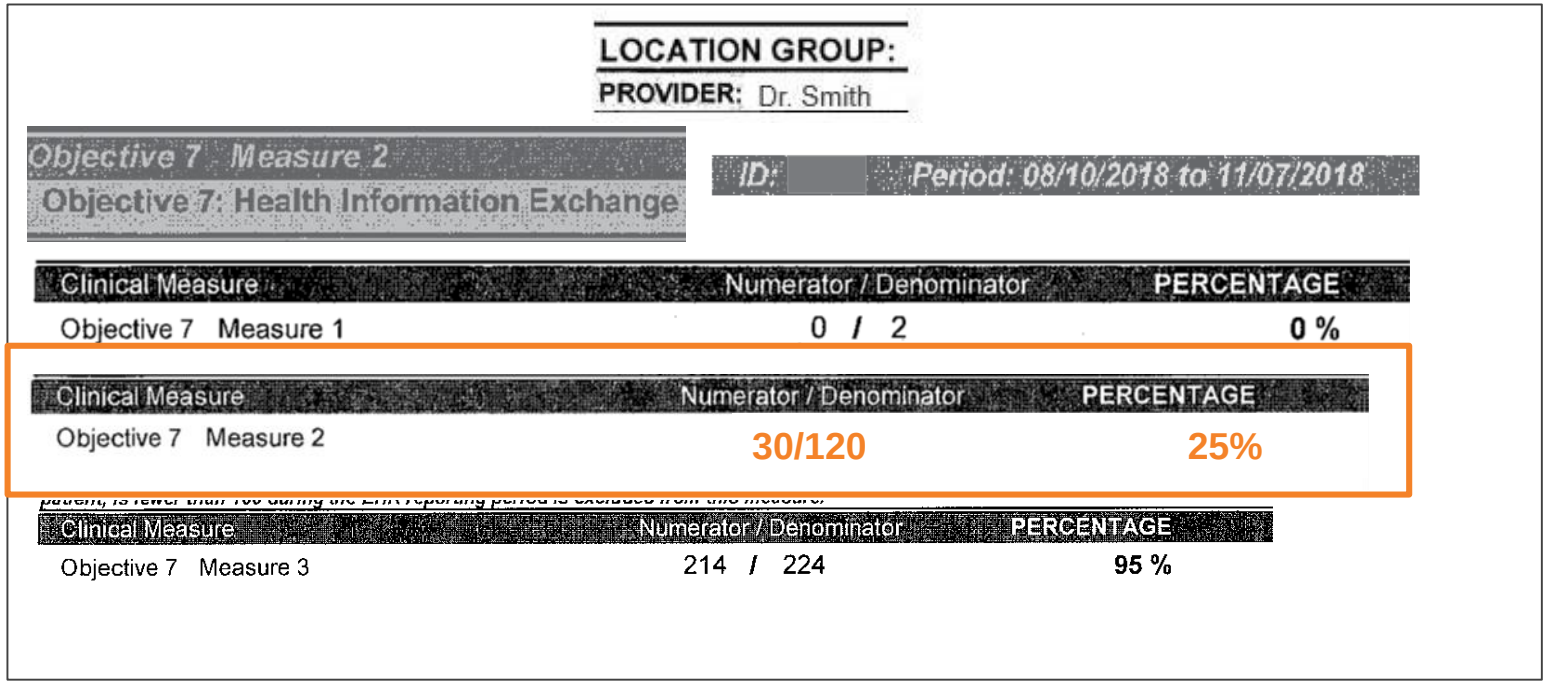
If the EP had access to Query HIE functionality, the EP must upload:

- EHR-generated MU Dashboard
- Letter signed by an authorized official (EP, Designee, Clinical/Medical Director) confirming that:
  - EP had access to Query HIE functionality that supports a query of external sources, and
  - EP's MU dashboard did not account for the patients that can be excluded
- Request and Query Audit Log in Excel format with unique IDs of patients deducted from the denominator, including:
  - For requests: the date the EP requested an electronic Summary of Care record, date of service, the provider contacted, and the method used to make the request (phone, secure email, secure messaging, or other method)
  - For query HIE: the date the EP used Query HIE to query at least one external source in which the EP did not locate a Summary of Care record for the patient, date of service, and the name or description of the external source(s)

MU Supporting Documentation: Requests and Query HIE – if EP has query access

EHR-generated MU Dashboard or report

- Selected MU reporting period
- Attesting provider's name
- Recorded numerator, denominator and percentages for this measure



LOCATION GROUP:
PROVIDER: Dr. Smith

Objective 7 Measure 2
Objective 7: Health Information Exchange

ID: *Period: 08/10/2018 to 11/07/2018*

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 1	0 / 2	0 %

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 2	30/120	25%

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 3	214 / 224	95 %

MU Supporting Documentation: Requests and Query HIE – if EP has query access

- Letter signed by an authorized official at the location where the electronic Summary of Care records were unavailable (EP, Designee, Clinical or Medical Director) confirming the EP had access to Query HIE functionality that supports a query of external sources, and that the EP's MU dashboard did not account for the patients that can be excluded.

Central Massachusetts Internal Medicine
100 North Drive
Westborough, MA 01581
508-000-0000

04/24/2019

To Whom It May Concern:

Letter confirming the EP had access to Query HIE functionality that supports a query of external sources, and that the EP's MU dashboard did not account for the patients that can be excluded.

Sincerely,

Clark Kent, MD

Clark Kent, MD

Medical Director

MU Supporting Documentation: Requests and Query HIE – if EP has query access

- Request and Query Audit Log in Excel format with the unique IDs of the patients deducted from the denominator (redact any PHI information, such as patient name), including:
  - The date the EP requested an electronic Summary of Care record, date of service, the provider contacted in the request, and the method used to make the request, e.g. phone, secure email, secure messaging, or other method
  - The date the EP used Query HIE functionality to query at least one external source in which the EP did not locate a Summary of Care record for the patient, date of service, and the name or description of the external source(s)

1	2	3	4	5	6	7	8
					NO SOC RECEIVED FOR PATIENT SEEN IN 90 DAY MU RP 5/1/2019-7/30/2019		
		REQUESTED (via MANUALLY P2P)				QUERY HIE (via system query)	
PROVIDER	DOS	UNIQUE PT ID	DATE REQUESTED E-SOC	PROVIDER CONTACTED	REQUEST METHOD	DATE EP USED QUERY HIE FUNCTIONALITY	NAME/DESCRIPTION OF EXTERNAL SOURCE
DR. KENT	5/2/2019	11111	4/1/2019	DR. OZ	FAX	4/4/2019	Hospital ABC
DR. KENT	5/20/2019	22222	4/2/2019	DR. ABC	PHONE	4/4/2019	State Repository
DR. KENT	5/30/2019	33333	4/10/2019	DR. DOE	SECURE EMAIL	4/12/2019	MetroWest Ear, nose, throat

- These patients can be deducted from the Measure 2 denominator on your EHR dashboard
- Every row in the report must document **both** a request and a query attempt
  - If you receive an SOC in response to either, the patient should not appear on this report

MU Supporting Documentation: Requests and Query HIE – if EP does NOT have query access

If the EP had no access to Query HIE functionality, the EP must upload:

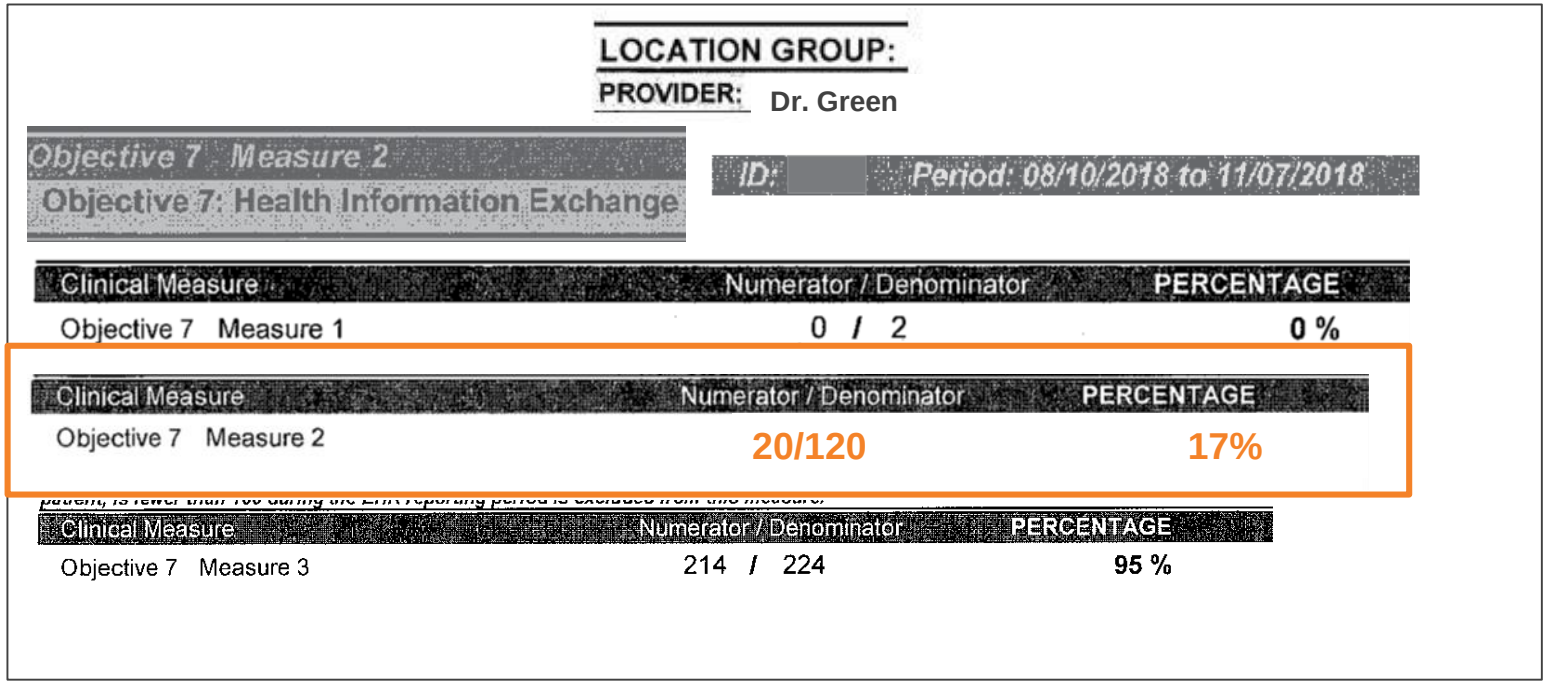
- EHR-generated MU Dashboard
- Letter signed by an authorized official (EP, Designee, Clinical/Medical Director) confirming that either
  - EP did not have access to Query HIE functionality that supports a query of external sources or
  - Query HIE functionality that supports query of external sources was not operational in the EP's geographic area and not available in the EP's EHR network*
- Request Audit Log in Excel format with the unique IDs of the patients deducted from the denominator including:
  - date the EP requested an electronic Summary of Care record, date of service, provider contacted, and the method used to make the request (phone, secure email, secure messaging, other)

* *Many 2015 Edition CEHRTs support Query HIE, either via vendor functionality or via integration of Query HIE platforms, such as Commonwell or Carequality. Not enabling the functionality does not count as "EP did not have access", nor as "not available in the EP's EHR network." Check with your vendor whether Query HIE functionality is available and how to enable it.*

MU Supporting Documentation: Requests and Query HIE – if EP does NOT have query access

EHR-generated MU Dashboard or report

- Selected MU reporting period
- Attesting provider's name
- Recorded numerator, denominator and percentages for this measure



LOCATION GROUP:

PROVIDER: Dr. Green

Objective 7 Measure 2

Objective 7: Health Information Exchange

ID: [redacted] Period: 08/10/2018 to 11/07/2018

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 1	0 / 2	0 %
Objective 7 Measure 2	20/120	17%
Objective 7 Measure 3	214 / 224	95 %

MU Supporting Documentation: Requests and Query HIE – if EP does NOT have query access

- Letter signed by an authorized official at the location where the electronic Summary of Care records were unavailable (EP, Designee, Clinical or Medical Director) confirming either
  - EP did not have access to Query HIE functionality that supports a query of external sources or
  - Query HIE functionality that supports query of external sources was not operational in the EP's geographic area and not available in the EP's EHR network, as of the start of the EHR Reporting Period

Central Massachusetts Internal Medicine
100 North Drive
Westborough, MA 01581
508-000-0000

04/24/2019

To Whom It May Concern

Letter confirming that either "the EP did not have access to Query HIE functionality that supports a query of external sources", or "the Query HIE functionality that supports query of external sources was not operational in the EP's geographic area and not available in the EP's EHR network, as of the start of the EHR Reporting Period".

Sincerely,
Clark Kent, MD
Clark Kent, MD
Medical Director

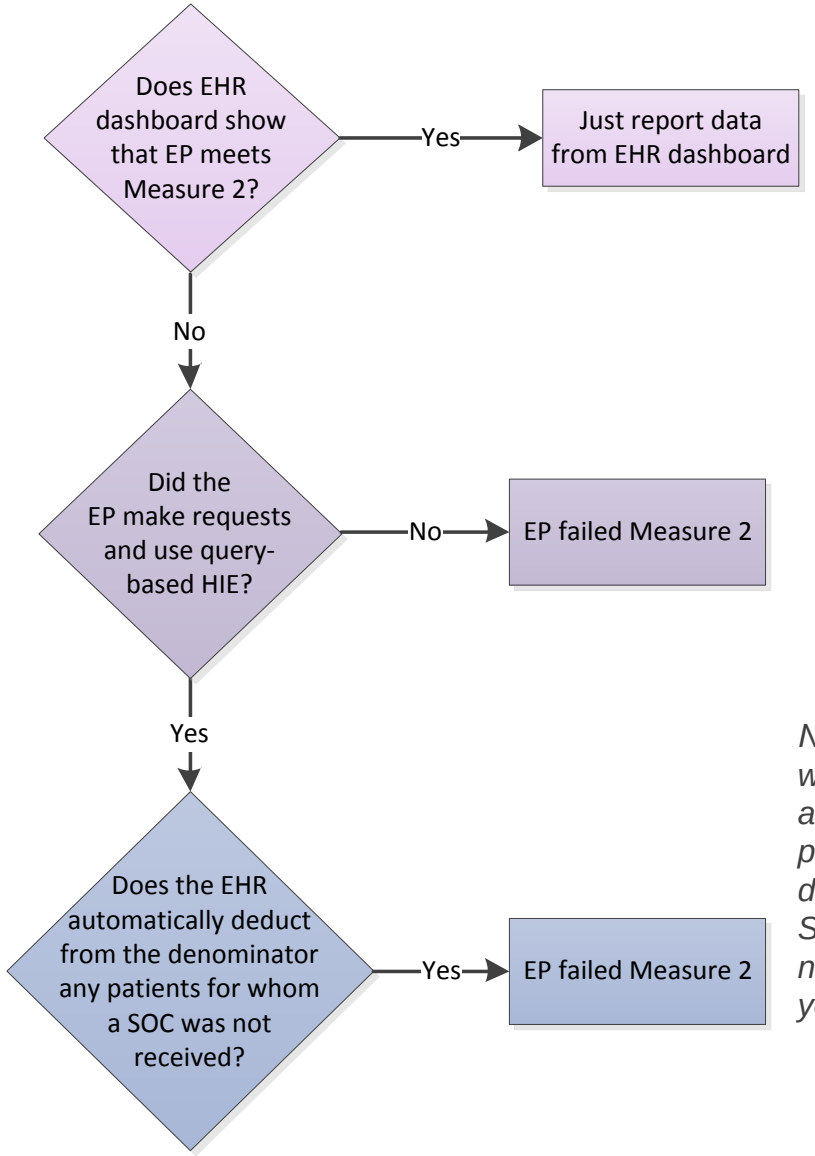
MU Supporting Documentation: Requests and Query HIE – if EP does NOT have query access

- Request Audit Log provided in Excel format with the unique IDs of the patients deducted from the denominator (redact any PHI information) including:
  - The date the EP requested an electronic Summary of Care record, the date of service, the provider contacted in the request, and the method used to make the request (phone, secure email, secure messaging, or other method)

			NO SOC RECEIVED FOR PATIENT SEEN IN 90 DAY MU RP 5/1/2019-7/30/2019		
			REQUESTED (via MANUALLY P2P)		
PROVIDER	DOS	UNIQUE PT ID	DATE REQUESTED E-SOC	PROVIDER CONTACTED	REQUEST METHOD
DR. KENT	5/2/2019	11111	4/1/2019	DR. OZ	SECURE EMAIL
DR. KENT	5/20/2019	22222	4/2/2019	DR. ABC	FAX
DR. KENT	5/30/2019	33333	4/10/2019	DR. DOE	PHONE

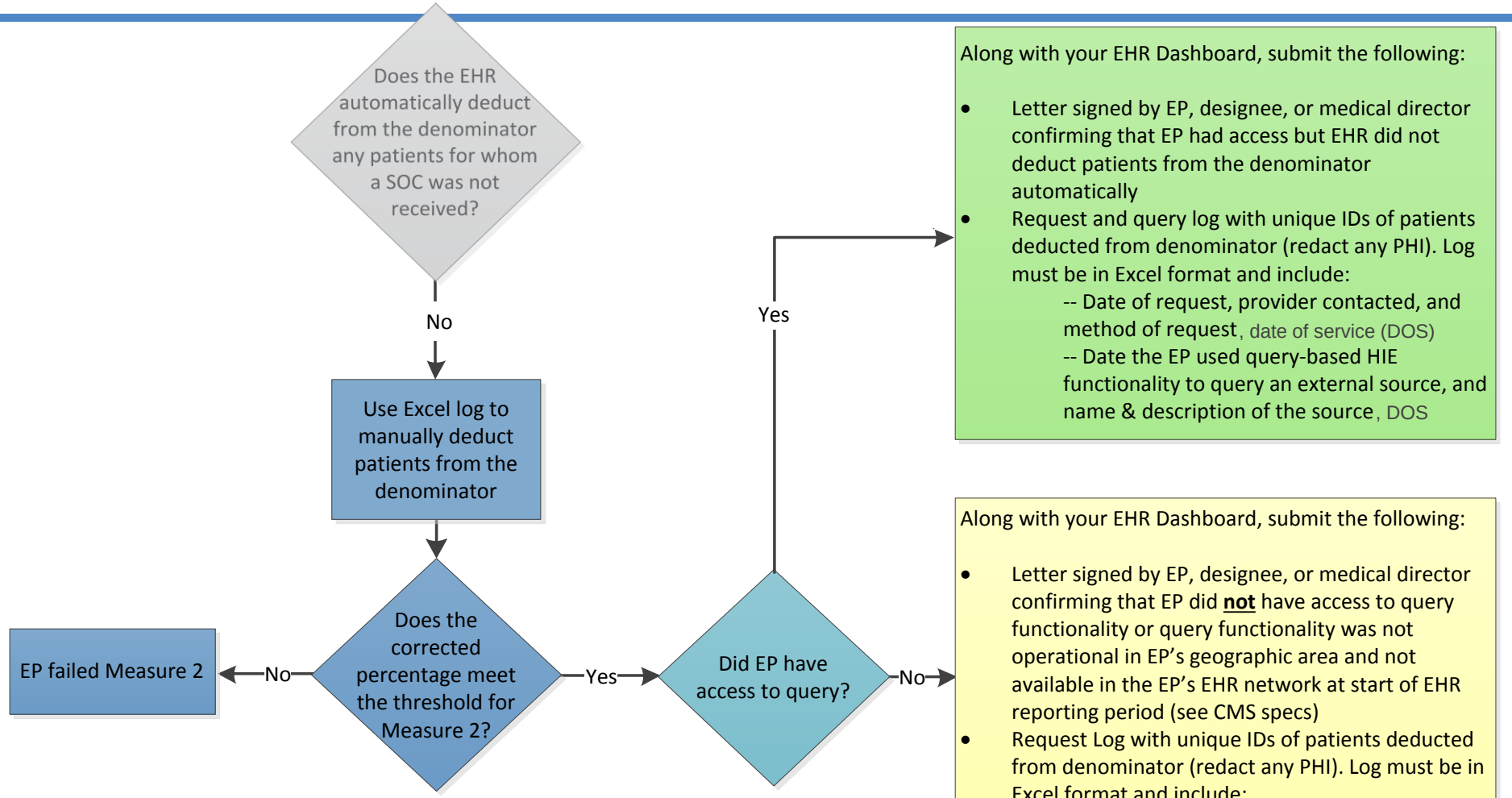
- These patients can be deducted from the Measure 2 denominator on your EHR dashboard
- If you receive an SOC in response to your request, the patient should not appear on this report

Step-by-Step: Upon Attestation



Note: If you're unsure whether your EHR automatically deducts patients from the denominator when a Summary of Care is not received, talk to your EHR vendor

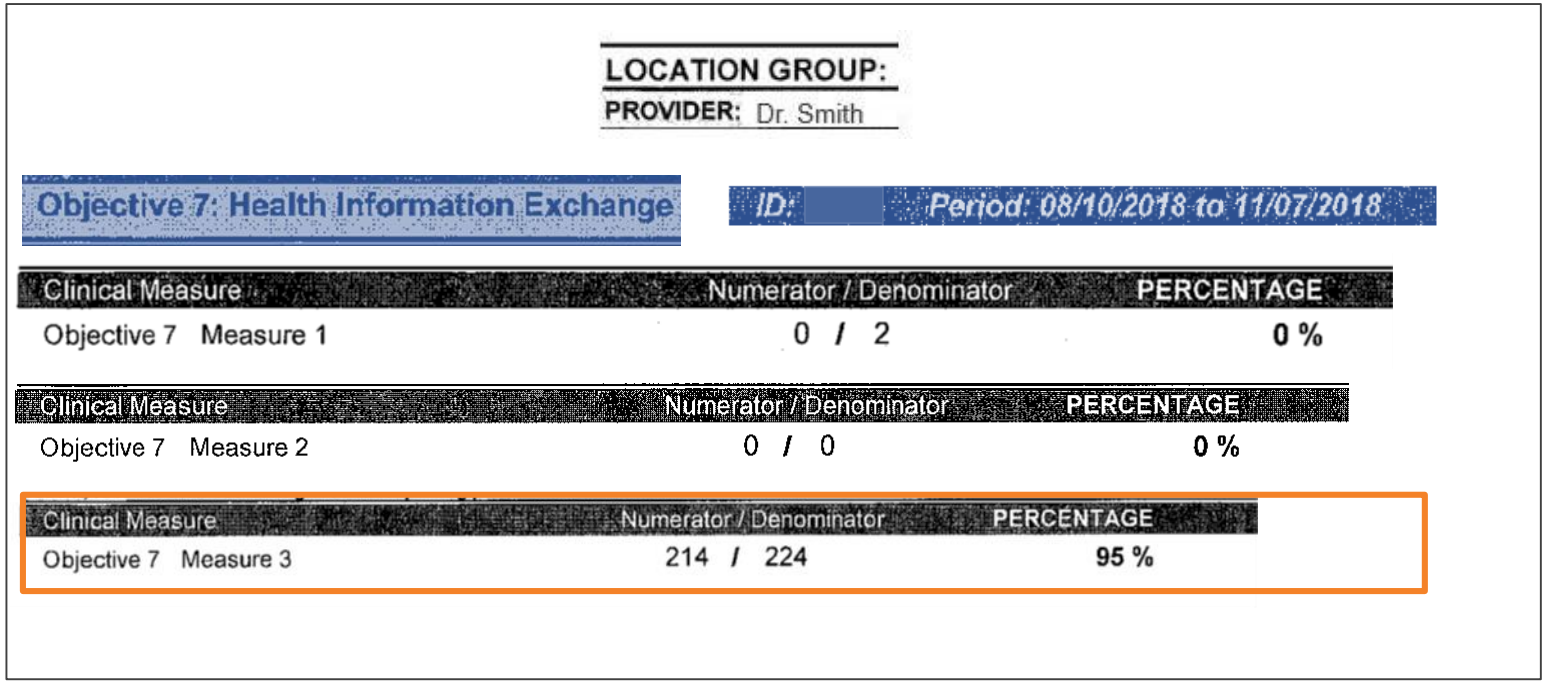
Step-by-Step: Upon Attestation



Measure 3: Clinical Information Reconciliation

EHR-generated MU Dashboard or report

- Selected MU reporting period
- Attesting provider's name
- Recorded numerator, denominator and percentages, covering the Clinical Reconciliation of Medication, Medication Allergy and Current Problem List



LOCATION GROUP:
PROVIDER: Dr. Smith

Objective 7: Health Information Exchange | **ID:** | **Period: 08/10/2018 to 11/07/2018**

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 1	0 / 2	0 %

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 2	0 / 0	0 %

Clinical Measure	Numerator / Denominator	PERCENTAGE
Objective 7 Measure 3	214 / 224	95 %

Strategies and Tips for Success

- Verify that the total number of referrals and transitions received during the MU reporting period is 100+
  - EP can claim exclusion for the measure if fewer than 100
  - If the EP claims an exclusion for 2 measures, they must meet the threshold for the remaining measure
- Ensure data is being entered correctly into the EHR
- Ensure EHR accurately captures all transitions when an SoC record is received
- Check with vendor to ensure Query HIE is enabled in CEHRT
  - Many EHRs now provide access to Query HIE functionality
- Regularly check EP's MU Dashboard or EHR Report to ensure the EP is on track to meet all MU objectives and measures
  - Consider selecting a different MU reporting period for EP's best performance

Strategies and Tips for Success (continued)

- Contact MeHI for technical assistance with MU
- Request HIway Adoption and Utilization Support (HAUS) Services

  HAUS Account Managers can assist your organization with incorporating HIE into your care coordination process:

  - Conduct technical assessment and develop HIE Technology and Workflow plan
  - Select project team and conduct project management
  - Develop HIE use cases and identify HIE trading partners
  - Implement the physical HIE connection
  - Provide workflow process improvement training and design new workflows

Reminders and Q & A

Reminder

The attestation deadline for Program Year 2019 is

March 31, 2020

Reminder: 2015 Edition CEHRT

- 2015 Edition CEHRT functionality is required to meet Stage 3 requirements
- The 2015 Edition CEHRT must be installed and used for the entirety of the EP's selected 90-day EHR reporting period

- If your EPs have not yet upgraded, start the process ASAP
  - If EPs don't upgrade to the 2015 CEHRT Edition before **October 3rd**, they won't be able to attest to Program Year 2019

Q & A


healthcare
providers
PVT
MAPIR
MeHI
query
Mass HIway
PY2019
Massachusetts
API
Attestation
EP
INFORMATION
Data
Security Risk Analysis
Eligible Professional
patient
Stage 3
Reporting Period
CPOE
Clinical Decision Support
CARE
Medication Reconciliation
Patient Encounter
CDS
Secure
Electronic
Messaging
CEHRT
MEANINGFUL USE
health
Informatics
MU
Public Health Reporting
Stage 3
HIE
Care Coordination
Medicaid
Electronic Prescribing
Electronic
Health
Record
PATIENT ENGAGEMENT
Massachusetts
eHealth Institute
SRA
Clinical Quality Measures
HEALTH IT
EHR
eRx
Patient Volume Threshold
Patient Portal
Patient Education
HEALTH INFORMATION EXCHANGE
Interoperability
people
documentation
Program Year 2019

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