



Meaningful Use Stage 3 Report Manual

MDLand International, Inc.

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Preface



Purpose

This document describes 2019 Meaningful Use Stage 3 Report Objectives and its workflow.

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Software Development



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Objective 1: Protect Electronic Health Information

- Measure Description: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.
- Requirements: Yes/No
- Exclusions: NONE
- How-to: Download the Excel document "DIY HIT Security Risk Assessment Questionnaire". Once this questionnaire is completed, save it to your computer.

Objective 2: Electronic Prescribing

- **Measure Description:** More than 60 percent of all permissible prescriptions written by the eligible professional (EP) are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).
- **Requirements:** More than 60%
- **Exclusions:** Any EP who:
 - Writes fewer than 100 permissible prescriptions during the PI reporting period; or
 - Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her PI reporting period.
- **How-to:** (1) Turn on the formulary check by going to Settings > ePrescription > Options and select “Yes” for Formulary Check.

Settings

Current Specialty: **Mental Health**

Options

Save Refresh Close

ePrescription

Participation in the CMS ePrescription Incentive Program: Yes No (Please be advised, this incentive program ended on 01/01/2014.)

Formulary Check: Yes No 11/27/2015

Default Severity Level: 1

Maximize Drug-Drug Interaction Display: Yes No

Maximize Drug-Allergy Interaction Display: Yes No

Maximize Drug-Disease Interaction Display: Yes No

(2) After entering a patient's prescription within “Current Office Visit > Prescription” or “Medical History > Active Medication List”, click the SEND button to send out electronically.

Visit History Medical History Current Visit Msg/Activity QM Doc&Lab Medication Message Patient Portal

Prescription

New Delete Copy From Add To Medication List Interaction Save as Template **Send eRx** Print/eFax

Medication Reconciliation Complete

Name (N T) **SIG** **Qty** **Refill DAW ICD**

F Aspirin 300 MG SUPPOSITORY 2 suppositories (600 mg) rectally every 4 hours as needed 30 Suppository

Ready for eRx Incomplete Sent/Printed Formulary Status No Interaction Checking

Allergy

Interaction

Eligibility Information **Pharmacy**

Disclaimer: Certain information may not be available or accurate in this report, including items that the patient asked not be disclosed due to patient privacy concerns, over-the-counter medications, low cost prescriptions, prescriptions paid for by the patient or non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

My Drug List (How to update inactive Rx?)

Template: T Refresh

Specialty: Internal Medicine

Find: Refresh All

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

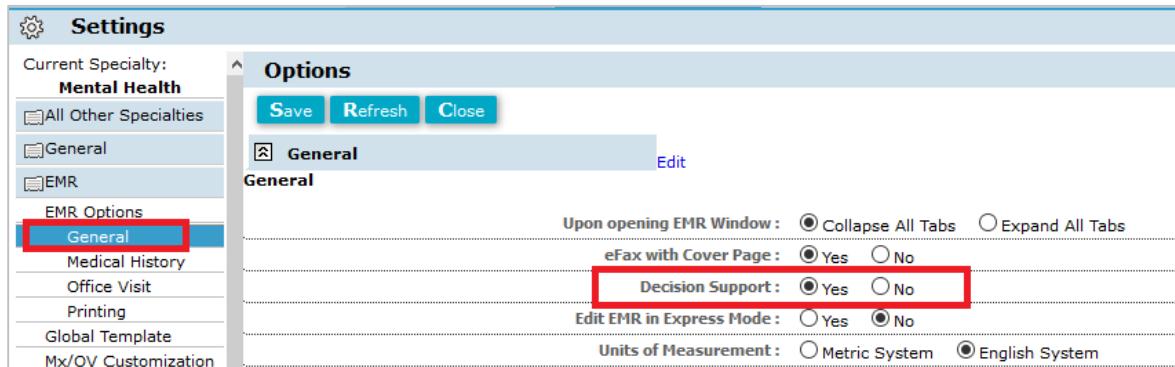
ACE Knee Stabilizer MISC Qty:1 Pack
 Acetabtolol HCI 200 MG Qty:30 Capsule
 Acetabtolol HCI 200 MG Qty:60 Capsule
 Acetabtolol HCI 400 MG Qty:60 Capsule
 Acetabtolol HCI 400 MG Qty:30 Capsule
 Aeon 2 MG Qty:30 Tablet
 Aeon 4 MG Qty:30 Tablet
 Aeon 8 MG Qty:30 Tablet
 Acetamin 500 MG TABS Qty:50 Tablet
 Acetaminophen 500 MG CAPS Qty:50 Capsule
 Acetaminophen 500 MG TABS Qty:50 Tablet
 Acetaminophen-Codeine #3 300-30 MG TABLET Qty:180 Tablet
 Acetylcysteine 10 % SOLN Qty:120 Milliliter
 Aiphex 20 MG Qty:14 Tablet
 Aiphex 20 MG Qty:28 Tablet

Objective 3: Clinical Decision Support

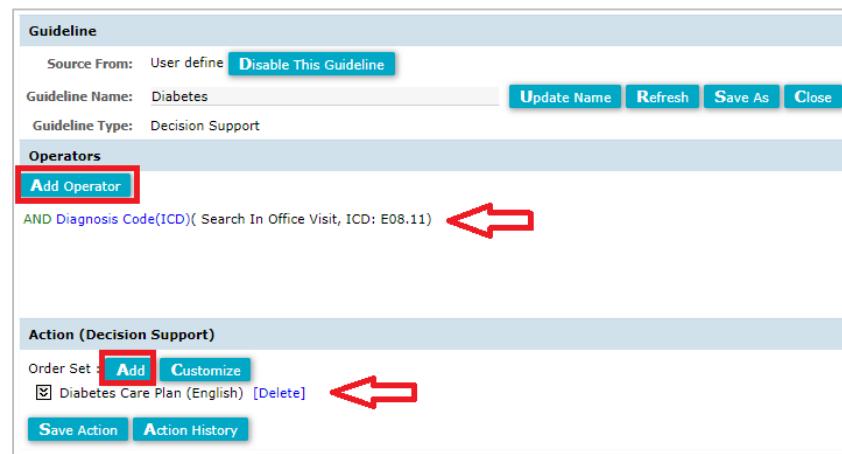
Eligible Professionals (EPs) must satisfy both of the following measures in order to meet the objective.

Measure 1 – Clinical Decision Interventions related to CQMs

- Measure Description: Implement five CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire Promoting Interoperability (PI) reporting period. Absent four CQMs related to an EPs scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.
- Requirements: Yes/No
- Exclusions: NONE
- How-to: Enable Decision Support from Settings > EMR > General.



Create Clinical Decision Support interventions by going to Settings > EMR > Decision Support or Health Registry > New and selecting “Decision Support” from the Guideline Type drop down box. A decision support AND order set must be created and connected to get credit for this measure.



Apply the Decision Support to an office visit that meets the criteria from Current Visit > Decision Support (under Reference) > select the items > click Apply.

Global Template

Global Template List | Save Current Visit As A New Global Template | Clear Current Office Visit | View All

Chief Complaint: Chief Complaint | Edit | Re-Visit

Vital Signs: Vital Signs | Edit | Customize

Review of Systems: Review of Systems | Edit | Re-Visit | Customize

Physical Exam General: Physical Exam General | Edit

Physical Exam Detail: Physical Exam Detail | Edit | Re-Visit

Diagnosis Code/Procedure Code: Diagnosis Code/Procedure Code | Edit | Re-Visit

ICD: (1) Diabetes due to underlying condition w ketoacidosis (E08.11)

CPT: Assessment/Plan/Procedure | Edit | Re-Visit

Decision Support

Refresh | Customize |

(1) Diabetes(Diabetes Care Plan (English))

Referral Letter.

Create New Appointment In 7 Day(s).

Create Follow Up In 7 Day(s).

Subject: Need Follow Up

Forms/Patient Education: (1). SOMOS Diabetes Care Plan-English

Measure 2 – Drug-drug and drug-allergy interaction checks

- Measure Description:** The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period.
- Requirements:** Yes/No
- Exclusions:** Any EP who writes fewer than 100 medication orders during the PI reporting period.
- How-to:** Enable the drug-drug and drug allergy interaction checks by going to Settings > ePrescription > Options and selecting “Yes” for “Check Drug Interaction Automatically”, “Check Drug - Allergy Interaction Automatically”, and “Check Drug - Disease Interaction Automatically.”

Settings

Current Specialty: Mental Health

Options

Save | Refresh | Close

ePrescription

Participation in the CMS ePrescription Incentive Program: Yes No (Please be advised, this incentive program ended on 01/01/2014.)

Formulary Check: Yes No 11/27/2015

Default Severity Level: 1

Maximize Drug-Drug Interaction Display: Yes No

Maximize Drug-Allergy Interaction Display: Yes No

Maximize Drug-Disease Interaction Display: Yes No

Drug-Drug Interaction Rule: If interaction severity level >= 1, block ePrescription.

Check Drug Interaction Automatically: Yes No 11/27/2015

Check Drug - Allergy Interaction Automatically: Yes No 11/27/2015

Check Drug - Disease Interaction Automatically: Yes No (It may slow down system performance if patients have many diagnosis codes in the records)

Objective 4: Computerized Provider Order Entry

An eligible professional (EP), through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.

Measure 1 – Medication

- Measure Description: More than 60 percent of medication orders created by the EP during the Promoting Interoperability (PI) reporting period are recorded using computerized provider order entry.
- Requirements: More than 60%
- Exclusions: Any EP who writes fewer than 100 medication orders during the EHR reporting period.
- How-to: Create medication orders from within Prescription in an Office Visit or Active Medication List in Medical History. It's advised to send medication order electronically by selecting SEND.

Visit History | Medical History | Current Visit | Msg/Activity | QM | Doc&Lab | Medication | Message | Patient Portal

Prescription Help

New | Delete | Copy From | Add To Medication List | Interaction | Save as Template | **Send eRx** (highlighted with a red box) | Print/eFax

Medication Reconciliation Complete

Name (N T) SIG Qty Refill DAW ICD

Aspirin 300 MG SUPPOSITORY 2 suppositories (600 mg) rectally every 4 hours as needed 30 Suppository

■ Ready for eRx ■ Incomplete ■ Sent/Printed ■ Formulary Status ! No Interaction Checking

■ Allergy ■ Interaction

Eligibility Information **Pharmacy**

Disclaimer: Certain information may not be available or accurate in this report, including items that the patient asked not be disclosed due to patient privacy concerns, over-the-counter medications, low cost prescriptions, prescriptions paid for by the patient or non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

My Drug List (How to update inactive Rx?)

Template: Refresh

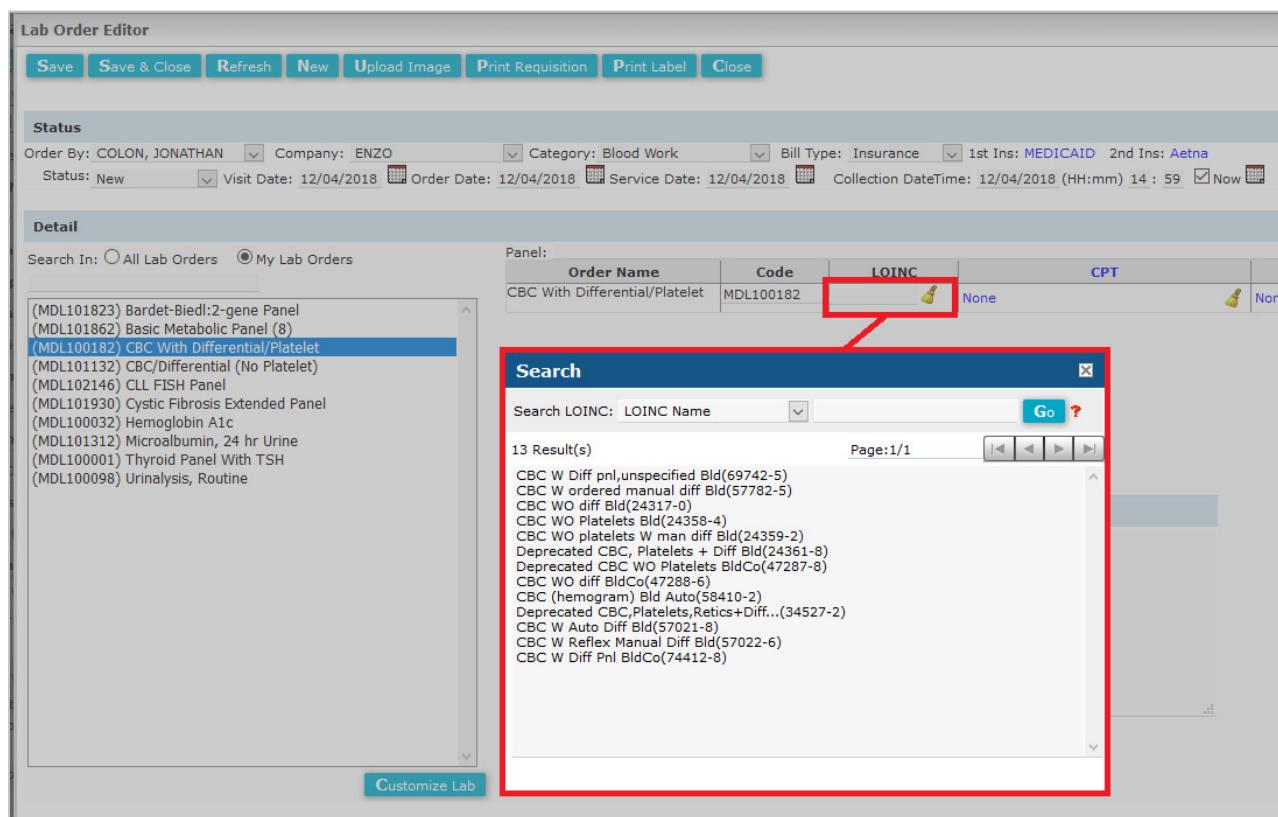
Specialty: Internal Medicine

Find: Refresh All ABCDEFGHIJKLMNOPQRSTUVWXYZ

ACE Knee Stabilizer MISC Qty:1 Pack
 Acebutolol HCl 200 MG Qty:30 Capsule
 Acebutolol HCl 200 MG Qty:60 Capsule
 Acebutolol HCl 400 MG Qty:60 Capsule
 Acebutolol HCl 400 MG Qty:30 Capsule
 Aceon 2 MG Qty:30 Tablet
 Aceon 4 MG Qty:30 Tablet
 Aceon 8 MG Qty:30 Tablet
 Acetamin 500 MG TABS Qty:50 Tablet
 Acetaminophen 500 MG CAPS Qty:50 Capsule
 Acetaminophen 500 MG TABS Qty:50 Tablet
 Acetaminophen-Codeine #3 300-30 MG TABLET Qty:180 Tablet
 Acetylcysteine 10 % SOLN Qty:120 Milliliter
 Aciphen 20 MG Qty:14 Tablet
 Aciphen 20 MG Qty:28 Tablet

Measure 2 – Laboratory

- **Measure Description:** More than 60 percent of laboratory orders created by the EP during the PI reporting period are recorded using computerized provider order entry.
- **Requirements:** More than 60%
- **Exclusions:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.
- **How-to:** Create a New Lab Order from within a patient's Current Office Visit or from their Medical History. It's advised to include the LOINC code with the lab order and send out electronically. The results will arrive in the Inbox and must be checked in.



Measure 3 – Diagnostic Imaging

- Measure Description: More than 60 percent of diagnostic imaging orders created by the EP during the PI reporting period are recorded using computerized provider order entry.
- Requirements: More than 60%
- Exclusions: Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.
- How-to: Create a New Imaging Order from within a patient's Current Office Visit or from their Medical History. It's advised to select an order from an "MU Compatible" category. If the clinic does not have a bi-directional interface with an imaging company, the order can be printed out and given to the patient.

Imaging Order Editor

Save Save & Close Refresh New Delete Print Order Customize Imaging Order/Set Close

Status Order By: SMITH, HARRY d(MD) Company: Quest (E-Order) Category: Bill Type: Insurance 1st Ins: 1199 LOCAL.. 2nd Ins: AETNA

Status: New Order Visit Date: 05/13/2019 Order Date: 05/13/2019 Service Date: 05/13/2019 Collection DateTime: (HH:mm) Now

Detail

Select by Category:

Order Name	Code	CPT	ICD
Sacrum X-ray	30884-1	None	None

Lab Report

Date	Type	Edit	Notes for Clinic	Office Location(Sending Facility)
------	------	------	------------------	-----------------------------------

Follow Up

Need Follow Up **Edit Follow Up**

-----MU Compatible-----

Bone Density
CT Scan
Mammography
MRA
MRI
Nuclear Medicine
testing
Ultrasound
X-Ray
-----MU Compatible-----
Bone Scan
CT Scan of Lower Spine
Cup to Disc Ratio
Diagnostic Studies During Pregnancy
ECG 12 lead or study order

BASIC METABOLIC PANEL (ICD:90801,90549,A02.22,O12.4,E10.49,G0101) THIS IS THE NOTES FOR

Objective 5: Patient Electronic Access

EPs must satisfy both measures in order to meet this objective.

Measure 1 – Patients' access to view, download and transmit health info

- Measure Description: For more than 80 percent of all unique patients seen by the EP:
 - (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and
 - (2) The provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's certified electronic health record technology (CEHRT).
- Requirements: More than 80%
- Exclusions: A provider may exclude the measures if one of the following applies:
 - An EP may exclude from the measure if they have no office visits during the PI reporting period.
 - 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 PI reporting period may exclude the measure.
- How-to: (1) Create the patient portal by going to patient's Registration and clicking the Patient Portal Password button. Create a custom loginID, password, save, and print the handout for the patient by clicking on Print Self. Then check the box "Patient/Guardian instructed on Patient Portal Access" which is above Patient Portal Password.

Registration (test, patient 06/04/1924 94 F)

Patient Demographics 1st Insurance 2nd Insurance 3rd Insurance Payment Document Management Authorization Create New Office Visit/Eligibility

Patient Information

Create New Patient / Load Existing Patient Log Modify Patient Basic Information *=Required fields

Need to create Patient Portal Account Patient/Guardian needs to be instructed on Patient Portal Access

Last Name* test Patient Status Active

First Name* patient

Middle Initial

Other Name

Address 1* guangzhou

Address 2

Apt

Zip/Postal Code* 50041

City* BRADFORD

State/Province* IA IA-Iow

Date of Birth* 06/04/1924

Gender* Female

Gender Identity

Sexual Orientation

Marital Status* Other

Race*

Ethnicity*

Preferred Language*

Patient/Guardian instructed on Patient Portal Access

Patient Portal Password Hold Claims

Next of Kin Information

Set Patient Password

Save Refresh Print Self Print Authorized Close

LoginID tp06041924 1st Last Name+1st Fi

Password Confirm Password

(Password complexity requirements: Normal)

Authorized Representative Setting:

Relationship:

First Name:

Last Name:

LoginID:

Password:

https://web121.mdland.com/eClinic/PatientPortal/PatientPortal.aspx

clinicID = 1007

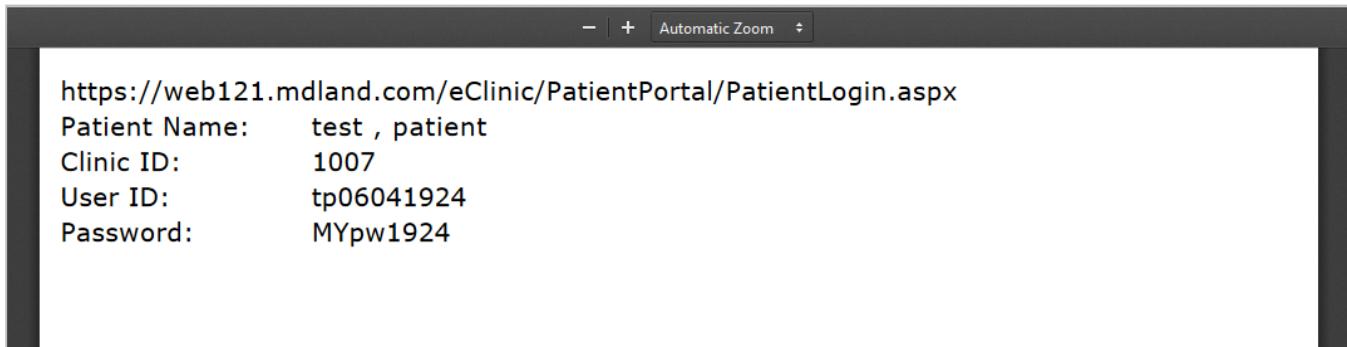
EMR Sign Log

Code

& Referral Physician

Attending Physician

Print and provide the portal credentials to the patient.



(2) The system is configured and has an API available. API can be request from Patient Portal > clicking on the link and submitting the API request form.

The screenshot shows the MDLand Patient Portal interface with the following details:

MDLand Patient Portal
, patient test

[Home](#) | [Visit History](#) | [Medical History](#) | [Document/Forms](#) | [Action Log](#)

Clinic Information

Clinic Name: My Clinic
Address: 40 Exchange Place. Clinic Option GZ NEW YORK NY 10010
Phone: 212-363-8000

Patient Demographics

Change Notification Preference

Name: test, patient **DOB:** 06/04/1924 **Age:** 94y **Gender:** Female **Marital:** Others
Address: guangzhou BRADFORD IA 50041
Phone: Home(123-456-7890)
Patient ID: 1001447855
Occupation: Military Personnel
CIR Number:

Attending Physician: SMITH, HARRY **Referral Physician:** SMITH, HARRY

First Insurance:
Medicare (Self) **Insured Name:** test, patient **Insured ID:** 11111111 **Policy Number:** 2222222 **Exp Date:** **Co-Pay:** 0.00 **Annual Deduct:** 0.00 **Part:** B

Last Visit: 04/02/2010

Last Vital Sign:
Date: 04/02/2010 10:15 AM, **HT:** 4'4.0" (ft/inches)

Your clinical data is available to view or download by sending requests to <https://api.mdland.com>

Scheduling

Measure 2 – Patient Specific Education

- **Measure Description:** The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the Promoting Interoperability (PI) reporting period.
- **Requirements:** More than 35%
- **Exclusions:** A provider may exclude the measures if one of the following applies:
 - An EP may exclude from the measure if they have no office visits during the PI reporting period.
 - 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 PI reporting period may exclude the measure.
- **How-to:** After an ICD Code was added to the office visit, for some ICD Codes user has the option to click on the name of the educational material or “*Send all education link to patient portal*” under “**Alert/Reminder**” module to send the material to patient portal.

Visit History | Medical History | **Current Visit** | Msg/Activity | QM | Doc&Lab | Medication | Message |

Global Template

Global Template List | Save Current Visit As A New Global Template | Re-Visit From Last Visit | View All

Alert/Reminder

Re-Generate Alert/Reminder | Re-Generate PQRS

Alert/Reminder Test Only
Please take a look at document/lab/imaging
This patient has 1 un-finished message(s) in inbox. Click [here](#) to view them in inbox.

Education:

Asthma (J45.20) 
High Blood Pressure (I10) 

[Send all education link to patient portal](#)

Patient Demographics

Chief Complaint | [Edit](#) | [Re-Visit](#)

Alternatively, printing out educational materials will also enable those materials available in the Patient Portal to view. Accomplish this by going to Patient Home > Medical History > Education > New Education > in the pop-up window > select an educational material > Print.

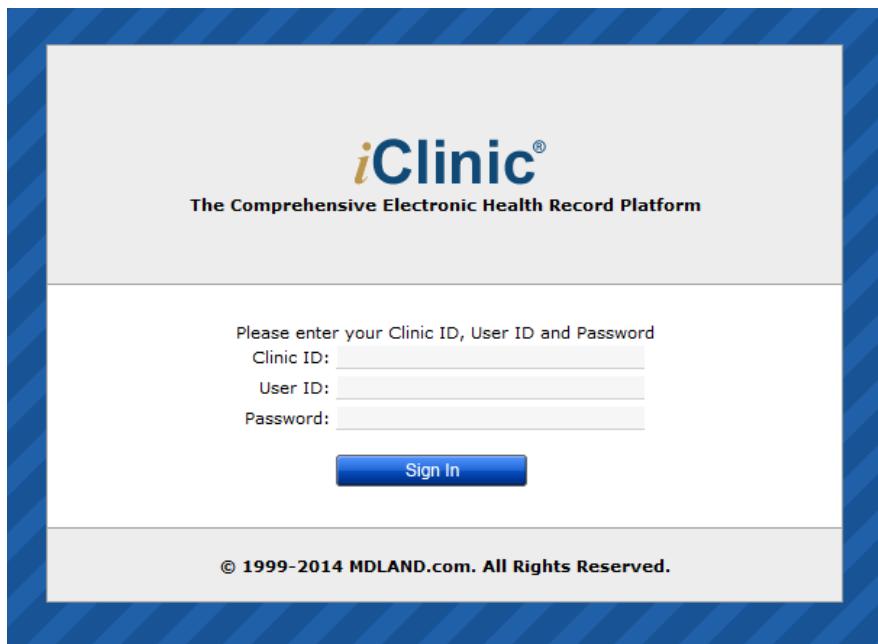
The screenshot shows the MDLand Patient Home interface. On the left, there is a sidebar with various patient history sections: Documents/Forms/Labs, Education, External Patient Resource Links, Patient Education (which is highlighted with a red arrow), Social History, Family History, Past Medical History, Medication List/Hx/Reconciliation, Allergy, and Surgical History. The 'Patient Education' section is expanded. At the top of the page, the patient information is displayed: test, patient (06/04/1924 94y Female), Attending: SMITH, HARRY, Referral: SMITH, HARRY, and status: Smoker, Allergy. Below the patient info, there are buttons for Save, Refresh, Follow Up, CCDA Reconciliation, Close, and Change Specialty (Mental Health). The 'Medical History' tab is selected. A 'New Education' pop-up window is open, showing a list of educational materials with checkboxes. The 'Print' button in the pop-up window is highlighted with a red box. The list includes items like 'dymo(01/12/2016)', 'IkIkj(11/13/2015)', 'NYS Smokers Quitline Info(09/20/2013)', and various SOMOS care plans in English, Chinese, and Spanish for conditions like CKD, COPD, and Diabetes.

Objective 6: Coordination of Care

Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.

Measure 1 – Patients' engagement with electronic health record

- **Measure Description:** 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 CEHRT; **or**
 - 3. A combination of (1) and (2)
- **Requirements:** More than 5%
- **Exclusions:** A provider may exclude the measures if one of the following applies:
 - An EP may exclude from the measure if they have no office visits during the PI reporting period.
 - 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 PI reporting period may exclude the measure.
- **How-to:** Patient logs into their patient portal during the reporting period.



Patient portal login page.

Provide patient their portal login credentials by going to Registration > click “Patient Portal Password” button > click “Print Self” button. Refer to Objective 5 Measure 1 for full details.

Measure 2 – Secure messages to patients

- **Measure Description:** More than 5 percent of all unique patients seen by the EP during the PI reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative.
- **Requirements:** More than 5%
- **Exclusions:** A provider may exclude the measures if one of the following applies:
 - An EP may exclude from the measure if they have no office visits during the PI reporting period.
 - 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 PI reporting period may exclude the measure.
- **How-to:** Provider sends a message to patient portal or responds to patient portal message.

The screenshot shows the MDLand EMR interface. The top navigation bar includes buttons for Refresh, Preview/Print, Check Out, Follow Up Action (which is highlighted with a red box), Patient Home, Settings, and Close. Below the navigation bar is a Global Template sidebar with various dropdown menus like Alert/Reminder, Patient Demographic, Chief Complaint, Vital Signs, etc. The main window is titled 'New Follow Up' and contains a 'Patient Information' section with patient details: Name: patient, andy e DOB: 12/31/1989 Age: 28y Gender: Male Marital: Self. Address: 1223 st ave GLEN COVE hjhjkjlkj 11542. Phone: Home(555-545-8291) Work(212-363-8000 111) Mobile(347-545-8291). Email: andy.peng@mdland.net. Preference of Notification: Patient ID: 1001658238. The 'New Follow Up' section has a red arrow pointing to the 'Type: SOAP' field and the 'Send a message to Patient Portal' checkbox. Other fields include Subject, Follow Up Date (set to Today), Type (SOAP), Assign To Employee List (with a dropdown menu showing 'md, dr d(md)-MD'), and Notes.

Go to office visit > click on “Follow Up Action” > check “Send a message to Patient Portal” > complete the rest of the boxes > Save > This will send a message to patient portal.

Follow Up

Options & Filters

Follow Up Date

1 7 30 90
From 12/04/2018 To 12/05/2018

Patient

One Patient All Patients

Create By

One Creator All Creators

Subject

All Subject

Status

Pending and Working

Follow Up Type

Patient Portal

Assign to Employee

All

Subject: Lab result request

Patient: TEST, TESTER

Follow Up Date: 12/04/2018

#Phone: 212-555-1212

Create: 12/04/2018

By: SH

To: Pending

Total: 1 Goto: 1

Follow Up Action

Save Re-Assign Open Patient Home Patient Portal Close

Patient Information

Name: TEST, TESTER DOB: 01/01/1950 Age: 68y Gender: Female Marital: Married
Address: 123 MAIN STREET NEW YORK NY 10013
Phone: Home(212-555-1212) Work() Mobile()
Email:
Preference of Notification:
Patient ID: 1001662194

Action

Follow Up Subject: Lab result request

Action Taken: Customize

Action Date: 12/04/2018 Time: 17 : 26 (HH:MM) Now Transportation: Customize

Note:

Status: Pending Add to Patient Communications Log as Permanent Document

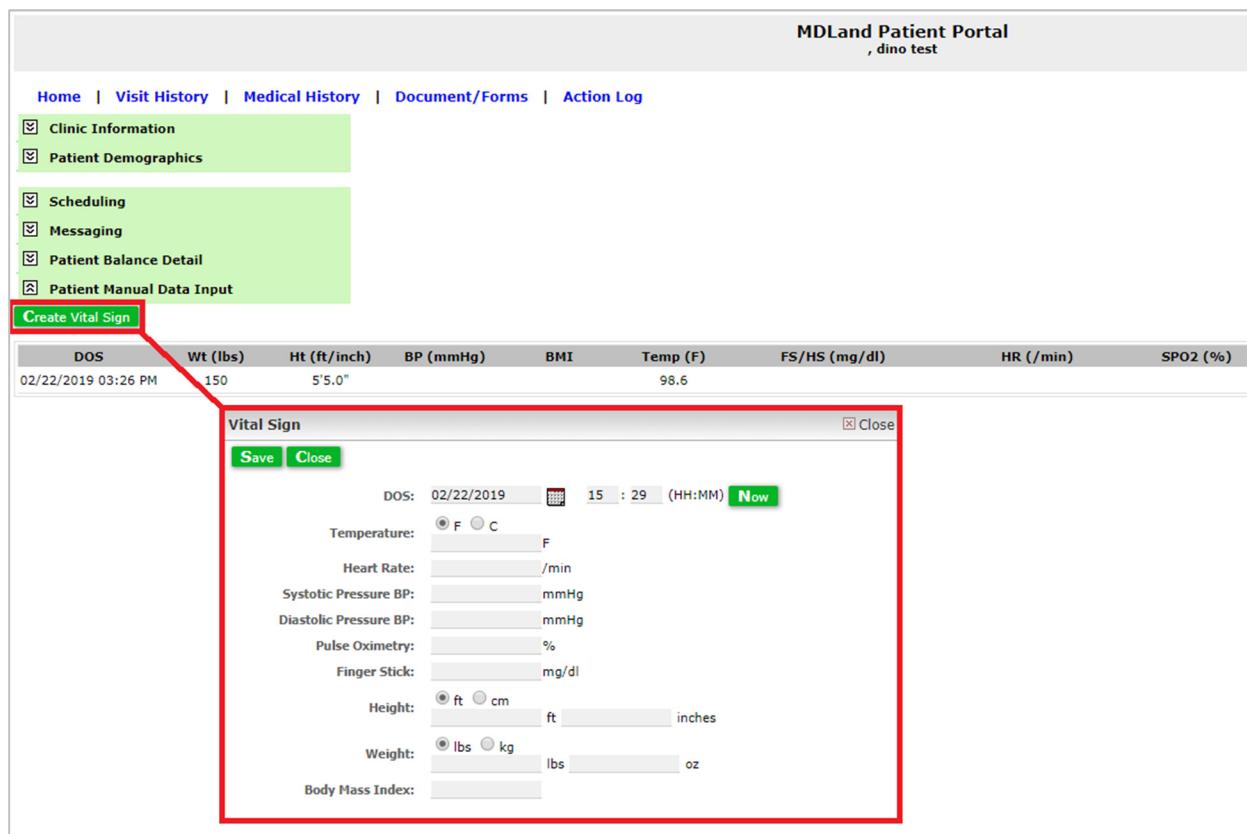
Follow Up Action History

[12/04/2018 05:25:43 PM] [Create] by TEST, TESTER
Is my lab results ready? [Created From Patient Portal]

Messages from patient portal are located in “Follow Up”. To respond to a message from patient portal, go to Follow up > click on the message > enter in your response/message into the notes > Save

Measure 3 – Patient generated health data

- **Measure Description:** Patient generated health data or data from a non-clinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the PI reporting period.
- **Requirements:** More than 5%
- **Exclusions:** A provider may exclude the measures if one of the following applies:
 - An EP may exclude from the measure if they have no office visits during the PI reporting period, or;
 - 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 PI reporting period may exclude the measure.
- **How-to:** Patient has the option to send health data from their Patient Portal or VIP Health App such as vital signs or messages. After which adds to patient record.



The screenshot shows the MDLand Patient Portal interface. The top navigation bar includes links for Home, Visit History, Medical History, Document/Forms, and Action Log. Below this, a sidebar on the left lists Clinic Information, Patient Demographics, Scheduling, Messaging, Patient Balance Detail, and Patient Manual Data Input. A red box highlights the 'Create Vital Sign' button under Patient Manual Data Input. The main content area displays a table of vital signs: DOS (02/22/2019 03:26 PM), Wt (lbs) (150), Ht (ft/inch) (5'5.0"), BP (mmHg) (98.6), BMI, Temp (F) (98.6), FS/HS (mg/dl), HR (/min), and SPO2 (%). A modal dialog box titled 'Vital Sign' is open, also highlighted with a red border. It contains fields for DOS (02/22/2019 15 : 29 (HH:MM) Now), Temperature (F), Heart Rate (min), Systolic Pressure BP (mmHg), Diastolic Pressure BP (mmHg), Pulse Oximetry (%), Finger Stick (mg/dl), Height (ft, cm), Weight (lbs, kg), and Body Mass Index.

Patient signs into their Patient Portal > Click on Create Vital Sign (under Patient Manual Data Input) > Enter in vital signs > Save

Save Refresh Follow Up CCDA Reconciliation Close Change Specialty(Internal Medicine) RPM VIP-H

Patient Home Visit History Medical History Payment/Account Msg/Activity QM Virtual Group RPM Doc&Lab Medication

View All | Edit All | Set All No Significant

Vital Sign History Edit | Customize

New Vital Signs **Patient Generated Vital Signs** Show All

Date	Wt (lbs/oz)	Ht (inch)	HC (inch)	BP (mmHg)	BMI	Temp (F)	BHT (inch)	BWT (lbs/oz)	BSA	FS/HS (mg/dl)	HR (min)	Others
05/15/2019 10:07 AM	90.700	175.3		119/70	29.5	37.2			2.1	2.8		99
05/15/2019 10:07 AM	91.600	175.3		130/100	29.8	36.7			2.1	2.5		99

Active Medication List Edit | Settings

Allergy Edit | Settings

Vital signs from Patient Portal or VIP are stored in Patient Home > Medical History > Vital Sign History > Patient Generated Vital Signs.

Patient Generated Vital Signs

Refresh **Retrieve Selected Record(s) to VitalSign History** Close

Vital Sign Date In: 1 day 7 days 30 days 90 days From 05/08/2019 To 05/15/2019 Source All

Upload Date	Source	Device HT(ft/inches/cm)	WT(lbs/oz/kg)	BMI	BSA	BP(mmHg)	Temp(F/C)	FS(mg/dl)	HR(/min)	Pulse(/min)	SP02(%)	Status
05/13/2019 16:16:32	myMonitor	5'9.0"/175.3	201/15.1/91.6	29.8	2.1	130/100	98.1/36.7	2.5		70	99	New
05/13/2019 16:15:58	myMonitor	5'9.0"/175.3	199/15.3/90.7	29.5	2.1	119/70	99.0/37.2	2.8		76	99	New
05/14/2019 02:54:00	Patient Portal	5'7.0"	125	19.58		135/85	97					New
05/14/2019 01:06:00	Patient Portal	5'4.0"	136	23.34		117/74	98.5	74	65		10	New

Select the vital signs and click "Retrieve Selected Record(s) to Vital Sign History"

Save Refresh Follow Up CCDA Reconciliation Close Change Specialty(Internal Medicine) RPM VIP-H

Patient Home Visit History Medical History Payment/Account Msg/Activity QM Virtual Group RPM Doc&Lab Medication Message Patient Portal

View All | Edit All | Set All No Significant

Vital Sign History Edit | Customize

New Vital Signs | Patient Generated Vital Signs | Show All

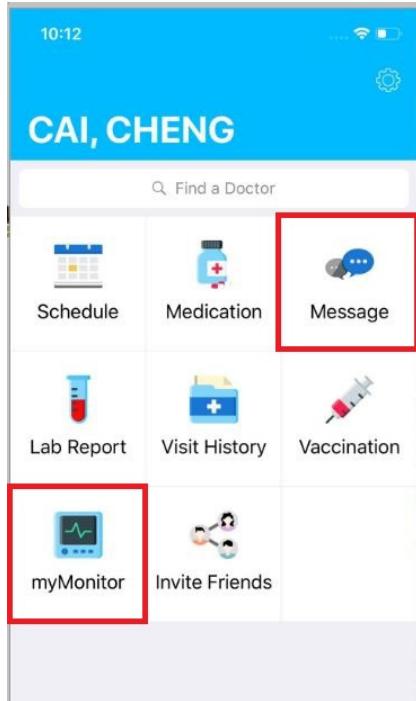
Date	Wt (kg)	Ht (cm)	HC (cm)	BP (mmHg)	BMI	Temp (iæ)	BHT (inch)	BWT (kg)	BSA	FS/HS (mg/dl)	HR (min)	Others	RR (/min)	SPO2 (%)	P	ASB
05/15/2019 10:07 AM	90.700	175.3		119/70	29.5	37.2			2.1	2.8				99	76	
05/15/2019 10:07 AM	91.600	175.3		130/100	29.8	36.7			2.1	2.5				99	70	

Medication List/Hx/Reconciliation Edit | Settings

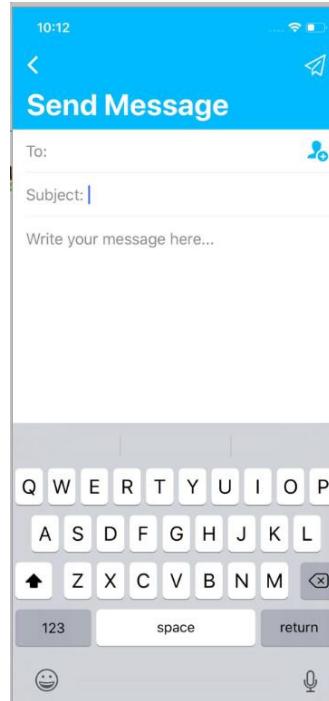
Allergy Edit | Settings

Records added to Vital Sign History

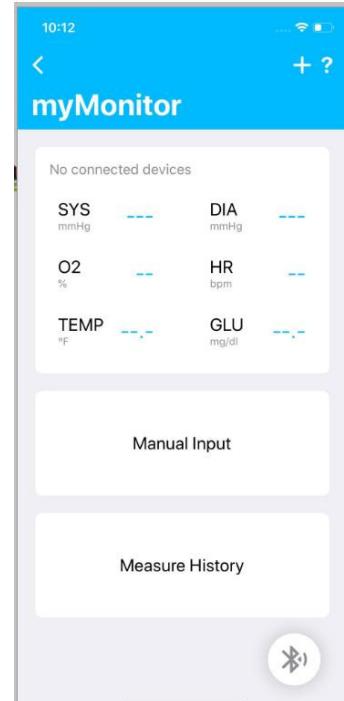
Patient can send health data using VIP Health App. Once within the app, patient has the option to send message or vital signs.



App > click Message or myMonitor



Send Message



Send Vital Signs

Health data arrives in system.

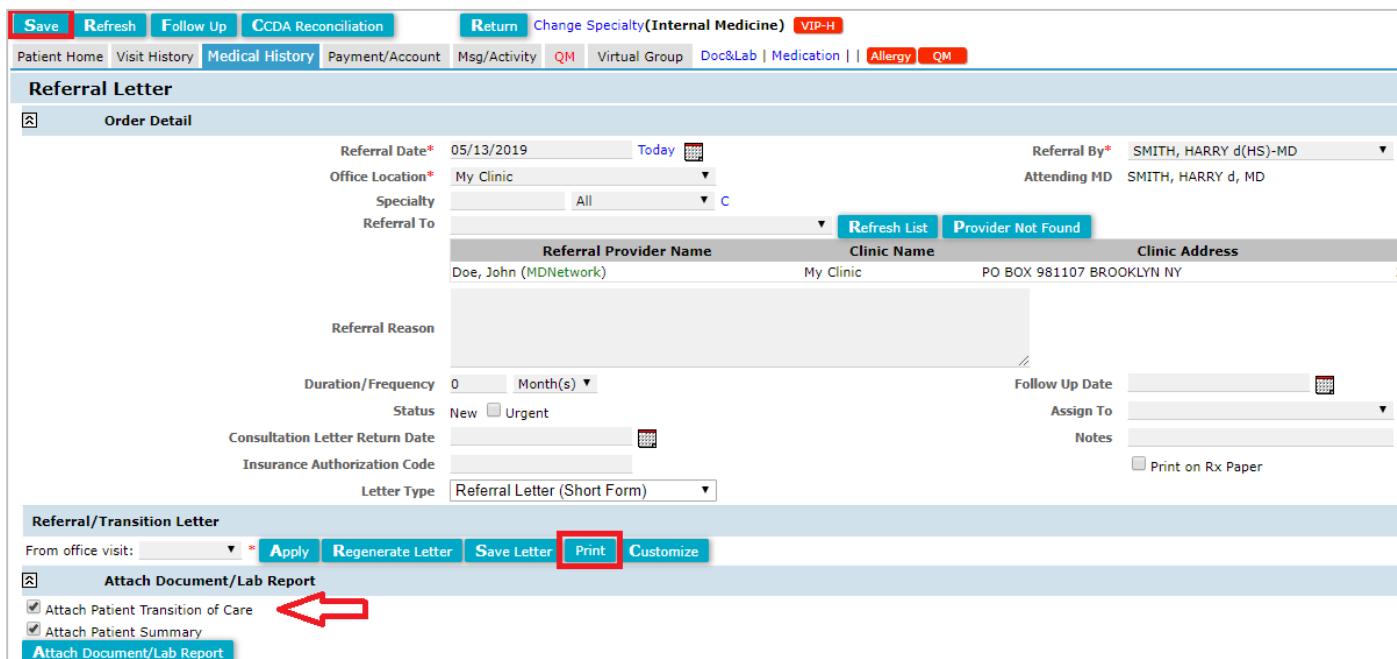
Subject	Type	From	To	DOS	Patient	Total: 3	Page: 05/1
Test	Patient Message	Cai, Weiming	RX	05/15/2019	Cai, Weiming		05/1
Quest Lab Report - XU,RICHARD Final ABN	Quest Lab Report		RX	03/21/2019	CAI, WEIMING(05/30/1947, M)		03/2
Quest Lab Report - XU,RICHARD Final ABN	Quest Lab Report		RX	03/21/2019	CAI, WEIMING(05/30/1947, M)		03/2

Objective 7: Health Information Exchange

Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.

Measure 1 – Create and exchange summary of care record

- **Measure Description:** 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
- **Requirements:** More than 50%
- **Exclusions:** A provider may exclude from the measure if any of the following apply:
 - Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the PI reporting period.
 - 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 PI reporting period may exclude the measures.
- **How-to:** Create a Referral/Consultation letter from within a patient's Current Office Visit or Medical History by going to Lab/Imaging/Letter Order (History) and selecting "New Referral Letter" or "New Consultation Letter". Select the referral/consultation provider and select an office visit to connect to the new letter. Check "Attach Patient Transition of Care". Save the letter. When on the print preview screen, click on *MD Network* (to send to MDLand Provider) or *Secure Message* (Provider who uses another EHR System).



The screenshot shows the MDLand EHR software interface for creating a Referral Letter. The top navigation bar includes buttons for Save, Refresh, Follow Up, CCDA Reconciliation, Return, Change Specialty (Internal Medicine), and VIP-H. Below the navigation is a toolbar with Patient Home, Visit History, Medical History, Payment/Account, Msg/Activity, QM, Virtual Group, Doc&Lab, Medication, Allergy, and another QM button. The main window is titled 'Referral Letter' and contains a 'Order Detail' section. It includes fields for Referral Date (05/13/2019), Office Location (My Clinic), Referral To (Specialty: All, Referral Provider Name: Doe, John (MDNetwork), Clinic Name: My Clinic, Clinic Address: PO BOX 981107 BROOKLYN NY), Referral Reason (Duration/Frequency: 0 Month(s)), Status (New, Urgent), and Follow Up Date. Below this is a 'Referral/Transition Letter' toolbar with buttons for Apply, Regenerate Letter, Save Letter, Print (highlighted with a red box), and Customize. The 'Print' button is highlighted with a red box. At the bottom is a section titled 'Attach Document/Lab Report' with checkboxes for 'Attach Patient Transition of Care' (highlighted with a red box and a red arrow) and 'Attach Patient Summary'. The 'Attach Document/Lab Report' button is also highlighted with a red box.

SMITH, HARRY d, MD
 1502 AVE U
 BROOKLYN NY 11229
 Tel: 718-339-1987
 Fax: 718-339-7702

Send To
Doe, John, MD 36 7TH AVE. RIDGEWOOD NY 11385 Tel:178-522-1111

NAME: test20141011, test20141011
 OFFICE VISIT DATE: 10/11/2014 4:27:00 AM
 REFERRAL DATE: 12/04/2018

Print Control
Print
eFax
MD Network
Secure Message
Cancel
<input checked="" type="checkbox"/> Print Letter Head



Dear Dr. Doe, John,

I have the pleasure of seeing your patient test20141011, test20141011 today in consultation.

Addendum:
 10/11/2014 4:29:03 AM chart was checked out by SMITH, HARRY d.

Patient Demographic:
 Name: test20141011, test20141011 DOB: 09/11/2001 AGE AS OF 12/04/2018: 17y Gender: Male Marital: Married
 Address: 40 Exchange Place9 New York NY 11005 Phone: Home(212-917-6034)
 Patient ID: 1001658266 Race: Native Hawaiian CIR Number:
 Attending Physician: Referral Physician:
 Last Visit: 10/11/2014

Diagnosis Code:
 (1) ABDOM PAIN EPIGASTRIC (789.06)

Procedure Code:
 (1) ACUPUNCT W/STIMUL 15 MIN (97813)

On print preview page, click on *MD Network* or *Secure Message* to send referral or consultation letter electronically.

Measure 2 – Incorporate new patients' summary of care into HER

- **Measure Description:** 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.
- **Requirements:** More than 40%
- **Exclusions:** A provider may exclude from the measure if any of the following apply:
 - Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.
 - 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 PI reporting period may exclude the measures.
- **How-to:** Patient has to have an office visit during the reporting period. For the “Transitions of Care” documents from the inbox, match the TOC document to the patient. Then, reconcile at least one of the items in either the office visit or patient home.

Patient came in for an office visit.

Match the “Transitions of Care” document to a patient.

0141011, test20141011 (09/11/2001 17y Male) DOS - 12/05/2018 Insurance: Close

TH, HARRY d Cover By SMITH, HARRY d (SH✓) Room Waiting Room HT: WT: BP: Temp: BMI: Pain Level: Pain Location: HC: HC: HR: RR: WHO(H: W: HC:)) Refresh | Edit |

Refresh | Preview/Print | Check Out | Follow Up Action | Patient Home | Settings | Close

Visit History | Medical History | Current Visit | Msg/Activity | QM | Doc&Lab | Medication | Message | Patient Portal

Global Template

Global Template List | Save Current Visit As A New Global Template | Re-Visit From Last Visit | Clear Current Office Visit | View All

Alert/Reminder

Re-Generate Alert/Reminder | Re-Generate PQRS

Alert/Reminder Test Only
Please take a look at document/lab/imaging
This patient has 2 un-finished message(s) in inbox. Click [here](#) to view them in inbox.

Patient Demographics

Chief Complaint

Vital Signs

Review of Systems

Physical Exam General

Physical Exam Detail

Diagnosis Code/Procedure Code

Assessment/Plan/Procedure

Prescription

Lab/Imaging/Letter Order

Diabetes Management

Risk Screening/Plan/Interventions

Mental Health Service Plan Goals

Mental Health Progress Note

Lab Result

PT Note

Reconciliation Panel

Refresh | Save Status

12/04/2018

Set All Item Status To Reconciled

Source:Transition of Care(Summarization of Episode Note)
Organization Name:My Clinic
Create Date:12/04/2018

Document maintained by MDLAND

Contact info Work Place: 40 exchange place Newyork NY 10005 US

Informant MDLAND ADMIN

Contact info 40 exchange place Newyork NY 10005

Legal authenticator MDLAND ADMIN

Contact info 40 exchange place Newyork NY 10005

Patient

Procedures

Date	CPT Code	CPT Name	Status
20141011	97813	ACUPUNCT W/STIMUL 15 MIN	Completed

Show Detail Reconciliation Status: Incompleted

Vital Signs

No Vital Signs Information.

Show Detail Reconciliation Status: Incompleted

Functional Status

No Functional Status

In office visit > click “Reconciliation Panel” (under Reference on the right) to load “Transitions of Care” > reconcile at least one of the items by changing the Reconciliation Status to “Reconciled” > click “Save Status” to document the work.

Patient Home
test20141011, test20141011 (09/11/2001 17y Male) Attending: Referral:

Save | Refresh | Follow Up | **CCDA Reconciliation** | Close | Change Specialty(Mental Health)

Patient Home | Visit History | Medical History | Payment/Account | Msg/Activity | QM | Doc&Lab | Medication | Message | Patient Portal

View All | Edit All | Set

Reconciliation Panel

Refresh | **Save Status** | Close

12/04/2018

Set All Item Status To Reconciled

Source:Transition of Care(Summarization of Episode Note)
Organization Name:My Clinic
Create Date:12/04/2018

Document maintained by MDLAND

Contact info Work Place: 40 exchange place Newyork NY 10005 US

Informant MDLAND ADMIN

Contact info 40 exchange place Newyork NY 10005

Legal authenticator MDLAND ADMIN

Contact info 40 exchange place Newyork NY 10005

Patient

Procedures

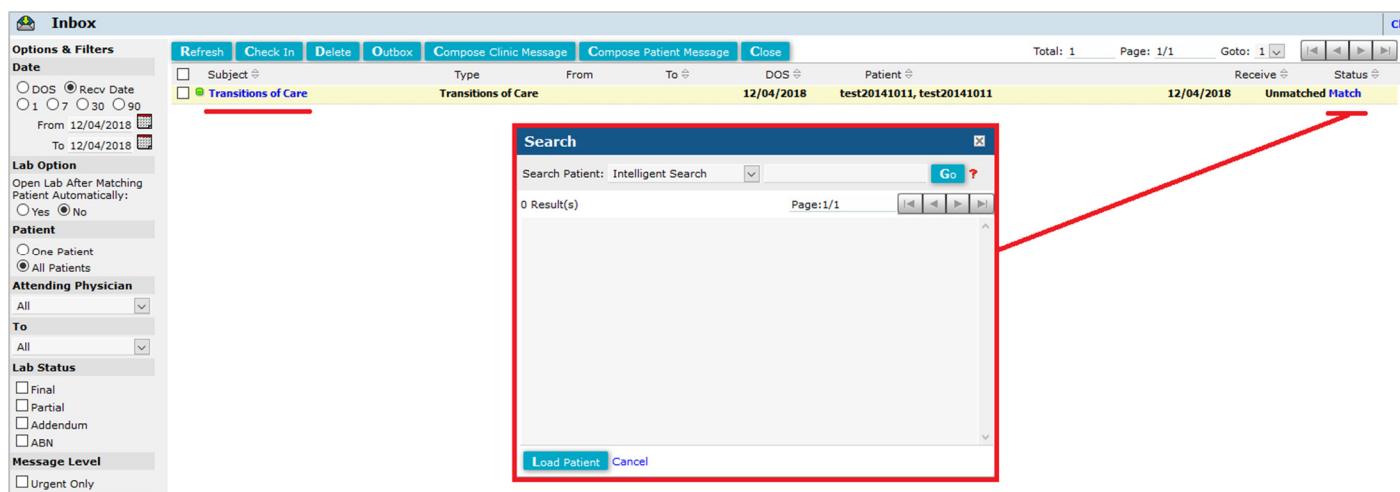
Date	CPT Code	CPT Name	Status
20141011	97813	ACUPUNCT W/STIMUL 15 MIN	Completed

Show Detail Reconciliation Status: Incompleted

An alternative option to reconcile is through Patient Home. Click “CCDA Reconciliation” to load “Transitions of Care”. Then reconcile at least one of the items.

Measure 3 – Clinical information reconciliation for new patients

- **Measure Description:** 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.
- **Requirements:** More than 80%
- **Exclusions:** Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.
- **How-to:** For the “Transitions of Care” documents in the inbox, match the TOC document to the patient. Then, reconcile *Medication*, *Medication Allergy*, **and** *Problem List* items in either the office visit, patient home, or inbox. The person who complete these actions gets the credit.



Match the “Transitions of Care” document to a patient.

141011, test20141011 (09/11/2001 17y Male) DOS - 12/05/2018 Insurance: Close Reference

H, HARRY d Cover By: SMITH, HARRY d (S) Room: Waiting Room HT: Wt: BP: Temp: BMI: Pain Level: Pain Location: HC: HC: HR: RR: WHO(H: W: HCS): Refresh | Edit | Visit History | Medical History | Current Visit | Msg/Activity | QM | Doc&Lab | Medication | Message | Patient Portal

Refresh | Preview/Print | Check Out | Follow Up Action | Patient Home | Settings | Close | Re-Visit From Last Visit | Clear Current Office Visit | View All

Global Template

Global Template List | Save Current Visit As A New Global Template | Re-Visit From Last Visit | Clear Current Office Visit | View All

Reconciliation Panel

Refresh | Save Status

12/04/2018

Medication Allergy (arrow)

Substance	Reaction	Status	Date
Acetaminophen		Active	20150609

Show Detail | Reconciliation Status: Incompleted ▾

Medication (arrow)

Medication	Start Date	Status	Instructions	Fill Instructions	Modify Date
Acetaminophen 160 MG/5ML ELIXIR [307675 RxNorm] (52959061216 NDC)	20160331	Active	1000 ml/kg orally every 4 hours as needed	20180711	
Asacol 400 MG TABLET DELAYED RELEASE [67544054989 NDC]	20160428	Active	2 Tablet ORAL TID 30 day(s)	20180711	

Show Detail | Reconciliation Status: Incompleted ▾

Problem List (arrow)

Code	Problem	Status	Date
786.05	SHORTNESS OF BREATH	Active	20150803
Z00.00	"Encntr for general adult medical exam w/o abnorma	Active	20151019
493.9	Asthma	Active	20151217

Show Detail | Reconciliation Status: Incompleted ▾

In office visit > click “Reconciliation Panel” (under Reference on the right) to load “Transitions of Care” > reconcile **Medication**, **Medication Allergy**, and **Problem List** items by changing the Reconciliation Status to “Reconciled” > click “Save Status” to document the work.

Patient Home
test20141011, test20141011 (09/11/2001 17y Male) Attending: Referrals: Change Specialty(Mental Health)

Save | Refresh | Follow Up | **CCDA Reconciliation** | Close | View All | Edit All

Reconciliation Panel

Refresh | Save Status | Close

12/04/2018

Medication Allergy (arrow)

Substance	Reaction	Status	Date
Acetaminophen		Active	20150609

Show Detail | Reconciliation Status: Incompleted ▾

Medication (arrow)

Medication	Start Date	Status	Instructions	Fill Instructions	Modify Date
Acetaminophen 160 MG/5ML ELIXIR [307675 RxNorm] (52959061216 NDC)	20160331	Active	1000 ml/kg orally every 4 hours as needed	20180711	
Asacol 400 MG TABLET DELAYED RELEASE [67544054989 NDC]	20160428	Active	2 Tablet ORAL TID 30 day(s)	20180711	

Show Detail | Reconciliation Status: Incompleted ▾

Problem List (arrow)

Code	Problem	Status	Date
786.05	SHORTNESS OF BREATH	Active	20150803
Z00.00	"Encntr for general adult medical exam w/o abnorma	Active	20151019
493.9	Asthma	Active	20151217

Show Detail | Reconciliation Status: Incompleted ▾

An alternative option to reconcile is through Patient Home. Click “CCDA Reconciliation” to load “Transitions of Care”. Then reconcile **Medication**, **Medication Allergy**, and **Problem List** items.

Reconcile “Transitions of Care” from inbox is possible as well. Go to inbox > open the “Transitions of Care” > Reconcile **Medication, Medication Allergy, and Problem List** items (or click “Set All item Status To Reconciled”) > click on “Save Status” > click “Checked In”.

Reconciliation Panel

Refresh Save Status Set All Item Status To Reconciled Re-Match Checked In Patient Home Open Next Inbox Record Close

Transition of Care is Currently matched to test20141011, test20141011(10/11/2001) Male

Source:Transition of Care(Summarization of Episode Note)
Organization Name:My Clinic test123_UAT
Create Date:05/16/2019

Document maintained by MDLAND

Contact info	Work Place: 40 exchange place Newyork NY 10005 US
Informant	MDLAND ADMIN
Contact info	40 exchange place Newyork NY 10005
Legal authenticator	MDLAND ADMIN
Contact info	40 exchange place Newyork NY 10005

Patient Medication Allergy

Substance	Reaction	Severity	Status	Date
Penicillins			Active	

Show Detail

Medication

Medication	Start Date	Status	Instructions	Fill Instructions	Modify Date
Zantac 75 75 MG TABLET [312773 RxNorm] [8142103007 NDC]	20190510	Active	2 tablets (150 mg) orally one time		20190510
Acetaminophen 500 MG TABLET [198440 RxNorm] [70000031200 NDC]	20190318	Active	2 tablets (1,000 mg) orally every 6 hours as needed		20190320

Show Detail

Problem List

Code	Problem	Status	Date
D51.1	Anemia: (Vit. B12 Deficiency)	Active	20180713
A39.83	Meningococcal arthritis	Inactive	20181020

Show Detail

Reconciliation Status: Reconciled

Reconciliation Status: Reconciled

Reconciliation Status: Reconciled

Objective 8: Public Health Reporting

EPs must attest to at *least two measures OR one measure and satisfy the exclusion for the other four measures* from the Public Health Reporting Objective, Measures 1 through 5.

An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP would need to meet two of the total number of measures available to them. *If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting all of the remaining measures available to them and claiming the applicable exclusions.* Available measures include ones for which the EP does not qualify for an exclusion.

Measure 1 – Immunization Registry Reporting

- Measure Description: Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).
- Requirements: Yes/No
- Exclusions: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP—
 - Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or IIS during the PI reporting period;
 - Operates in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of six months prior to the start of the PI reporting period.
- How-to: Contact your state's Immunization Registry to set up immunization data submission.

Measure 2 – Syndromic Surveillance Reporting

- Measure Description: Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.
- Requirements: Yes/No
- Exclusions: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP—
 - Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
 - Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs as of 6 months prior to the start of the PI reporting period.
- How-to: Contact your state's Health Department to know your state's status with Syndromic Surveillance Data.

Measure 3 – Electronic Case Reporting

- Measure Description: Electronic Case Reporting: The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.
- Requirements: Yes/No
- Exclusions: Any EP meeting one or more of the following criteria may be excluded from the case reporting measure if the EP—
 - Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the PI reporting period;
 - Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the PI reporting period.
- How-to: Contact your state's Health Department to know what public health agencies are available and whether or not you qualify to report.

Measure 4 – Public Health Registry Reporting

- Measure Description: Public Health Registry Reporting: The EP is in active engagement with a public health agency to submit data to public health registries.
- Requirements: Yes/No
- Exclusions: Any EP meeting at least one of the following criteria may be excluded from the public health registry reporting measure if the EP—
 - Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the PI reporting period;
 - Operates in a jurisdiction for which no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no public health registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the PI reporting period.
- How-to: Contact your state’s Health Department to know what public health agencies are available and whether or not you qualify to submit data.

Measure 5 – Clinical Data Registry Reporting

- Measure Description: Clinical Data Registry Reporting: The EP is in active engagement to submit data to a clinical data registry.
- Requirements: Yes/No
- Exclusions: Any EP meeting at least one of the following criteria may be excluded from the clinical data registry reporting measure if the EP—
 - Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the PI reporting period;
 - Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no clinical data registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the PI reporting period.
- How-to: Contact your state’s Health Department to know what clinical data registries are available and whether or not you qualify to submit data.

Resources

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2019ProgramRequirementsMedicaid.html>

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_2019.pdf