MDLand
The Future of Digital Health

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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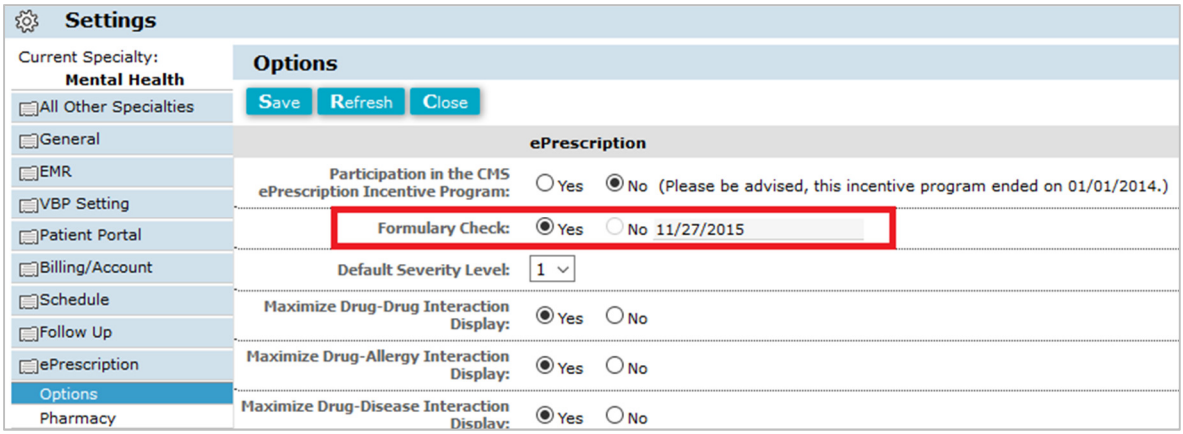
Objective 1: Protect Electronic Health Information

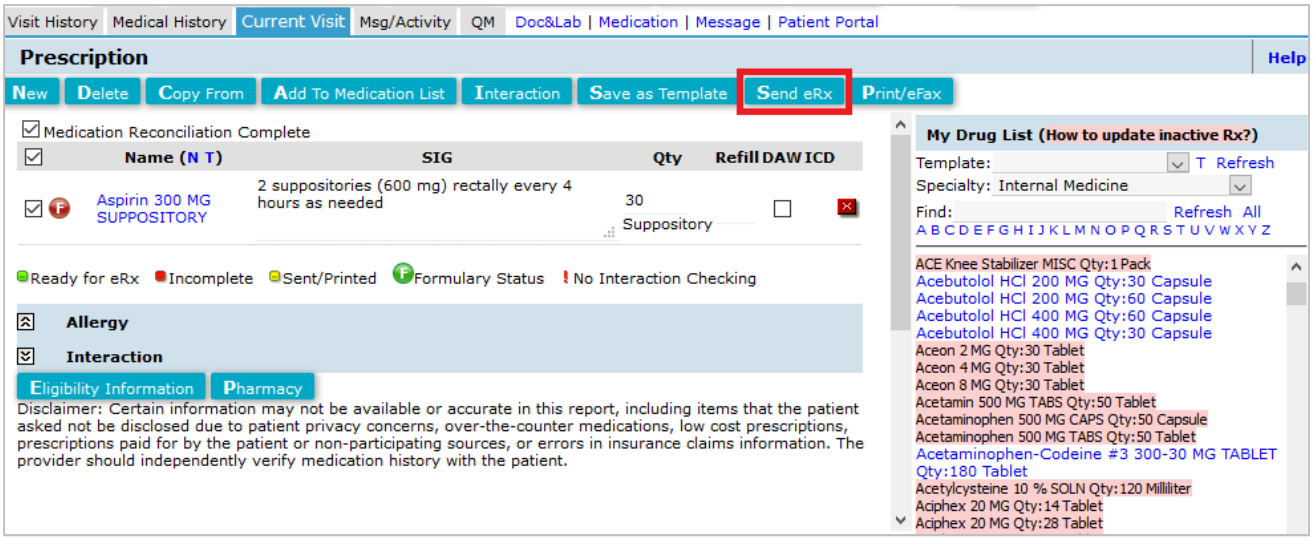
- Measure Description: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), 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.



(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.

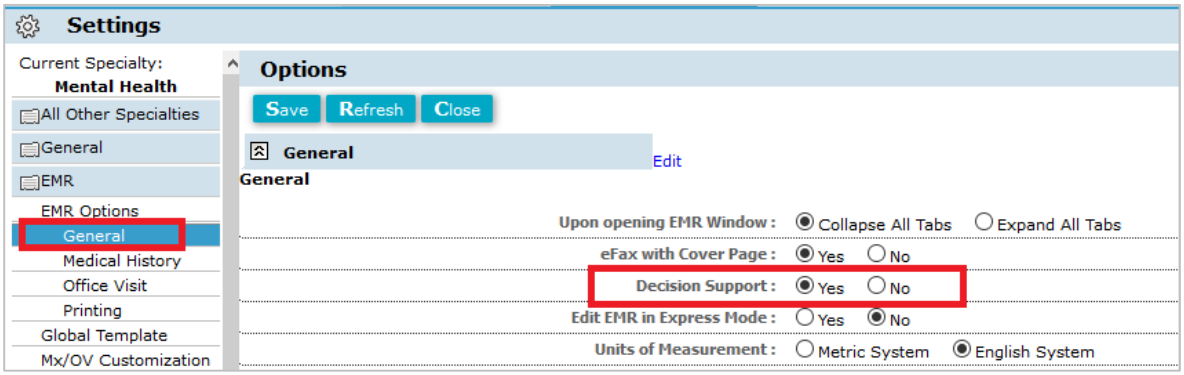


Objective 3: Clinical Decision Support

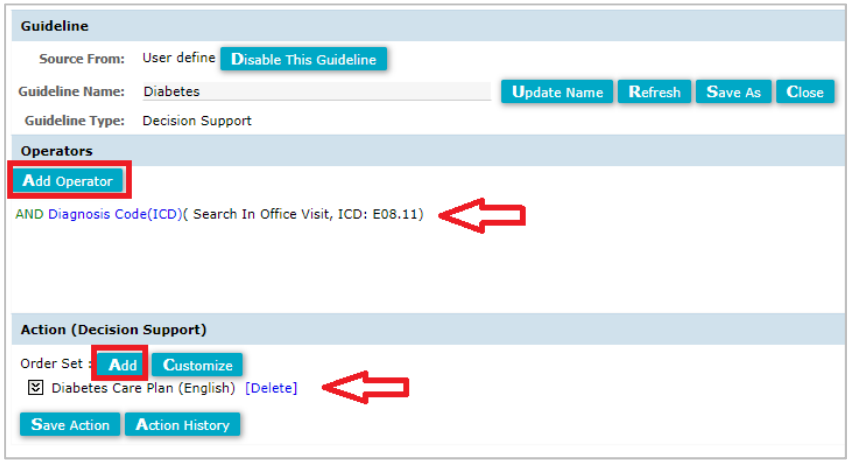
Eligible Professionals (EPs) must satisfy both of the following measures in order to meet the objective.

Measure 1 – Clinical Decision Interventions related to CQMs

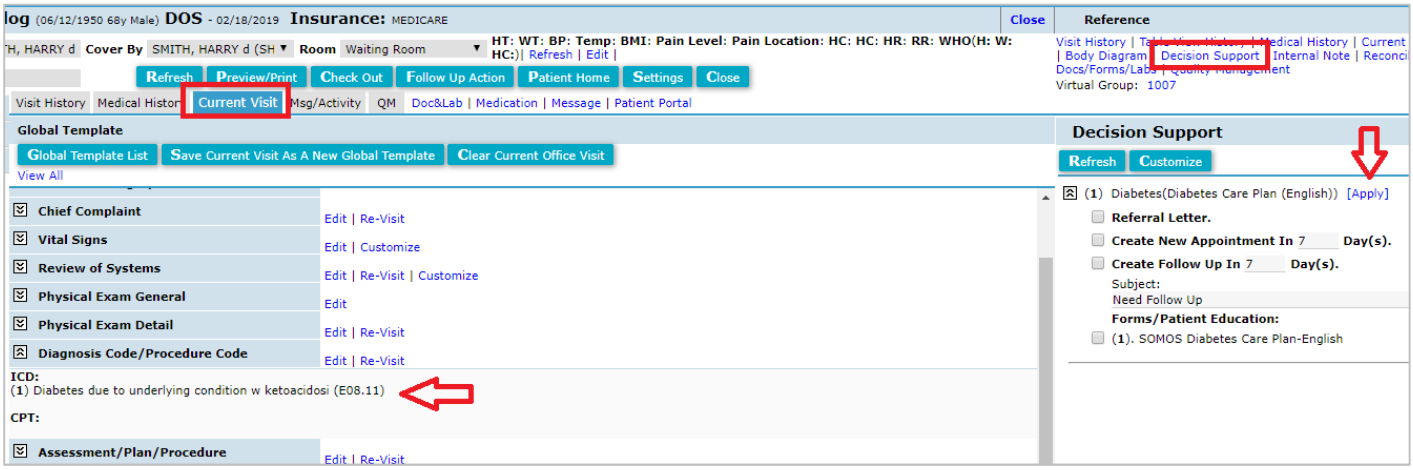
- Measure Description: Implement five CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire Promoting Interoperability (PI) reporting period. Absent four CQMs related to an EPs scope of practice or patient population, the CDS interventions 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.

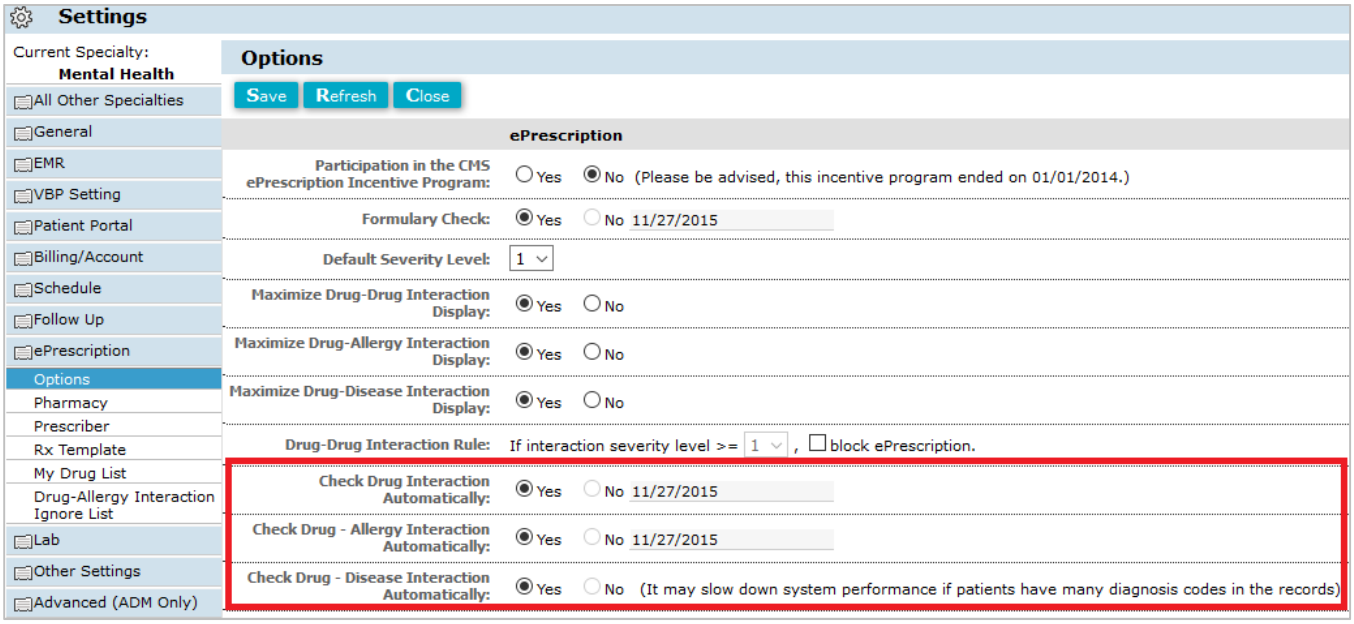


Apply the Decision Support to an office visit that meets the criteria from Current Visit > Decision Support (under Reference) > select the items > click Apply.



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.”

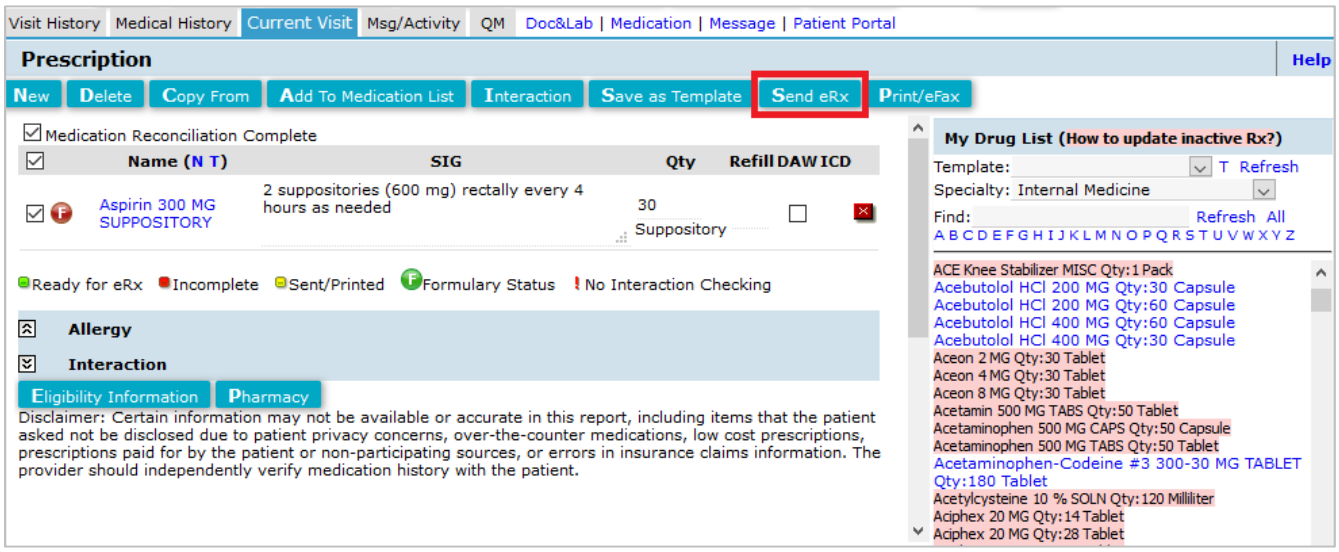


Objective 4: Computerized Provider Order Entry

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

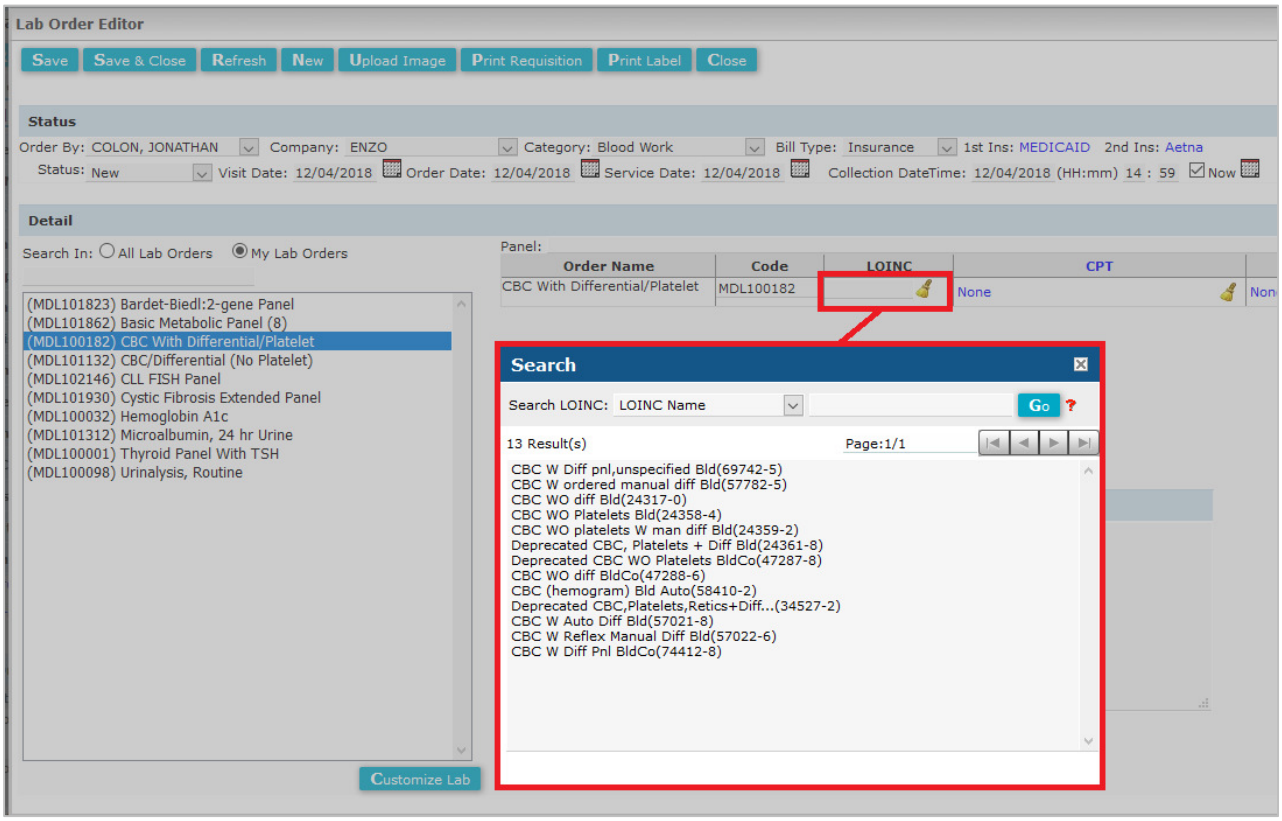
Measure 1 – Medication

- 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.



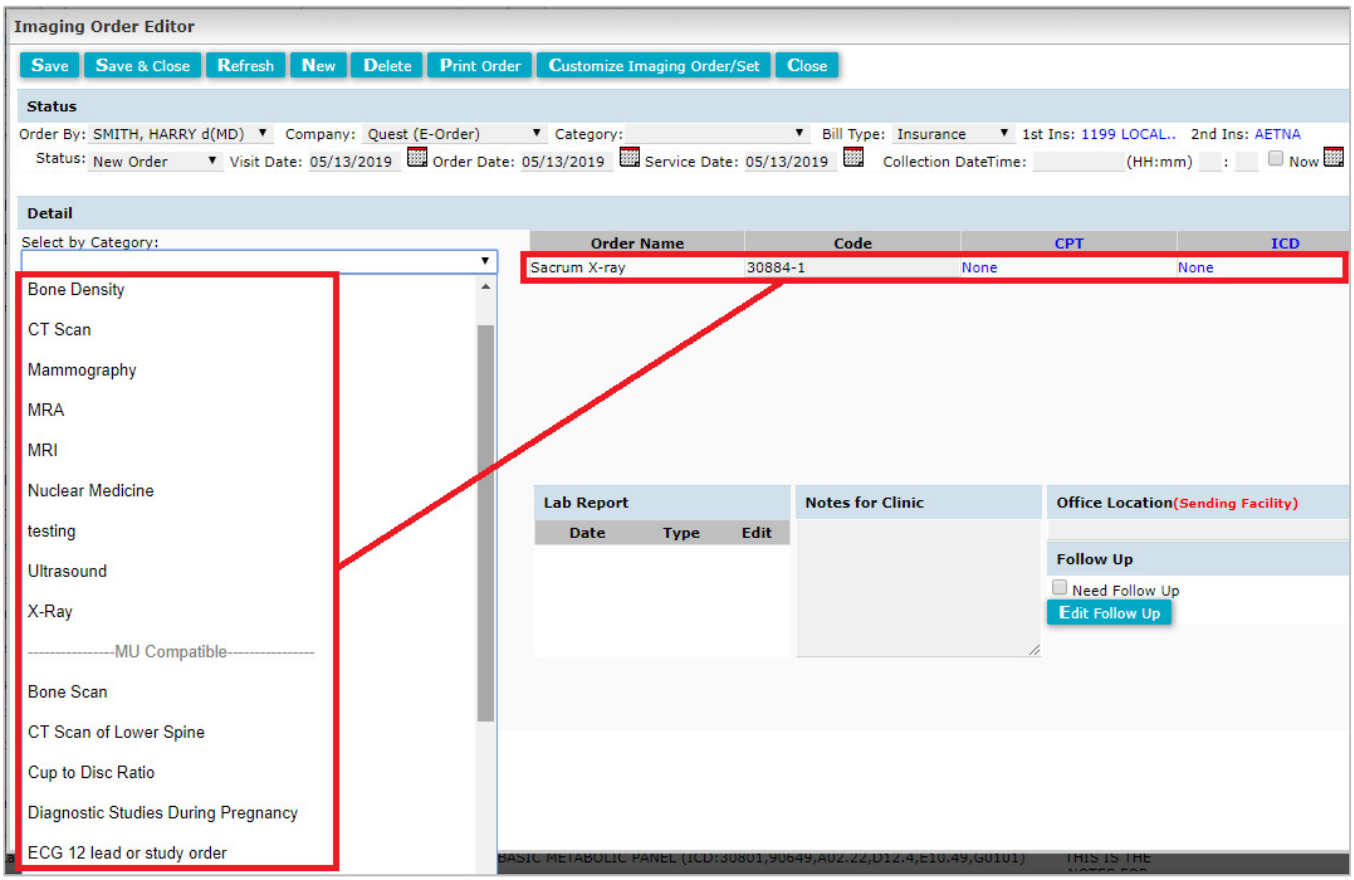
Measure 2 – Laboratory

- 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.

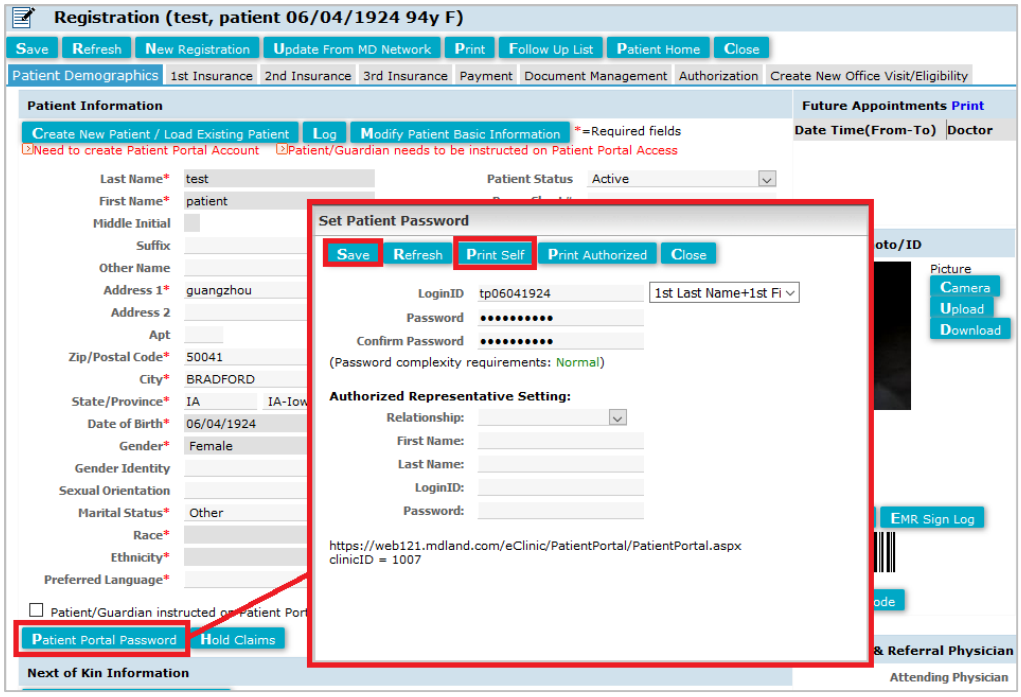


Objective 5: Patient Electronic Access

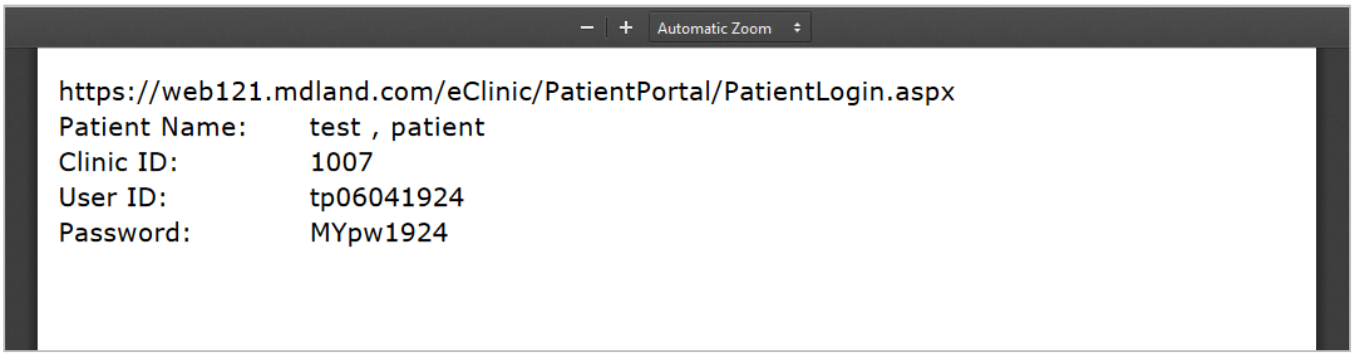
EPs must satisfy both measures in order to meet this objective.

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

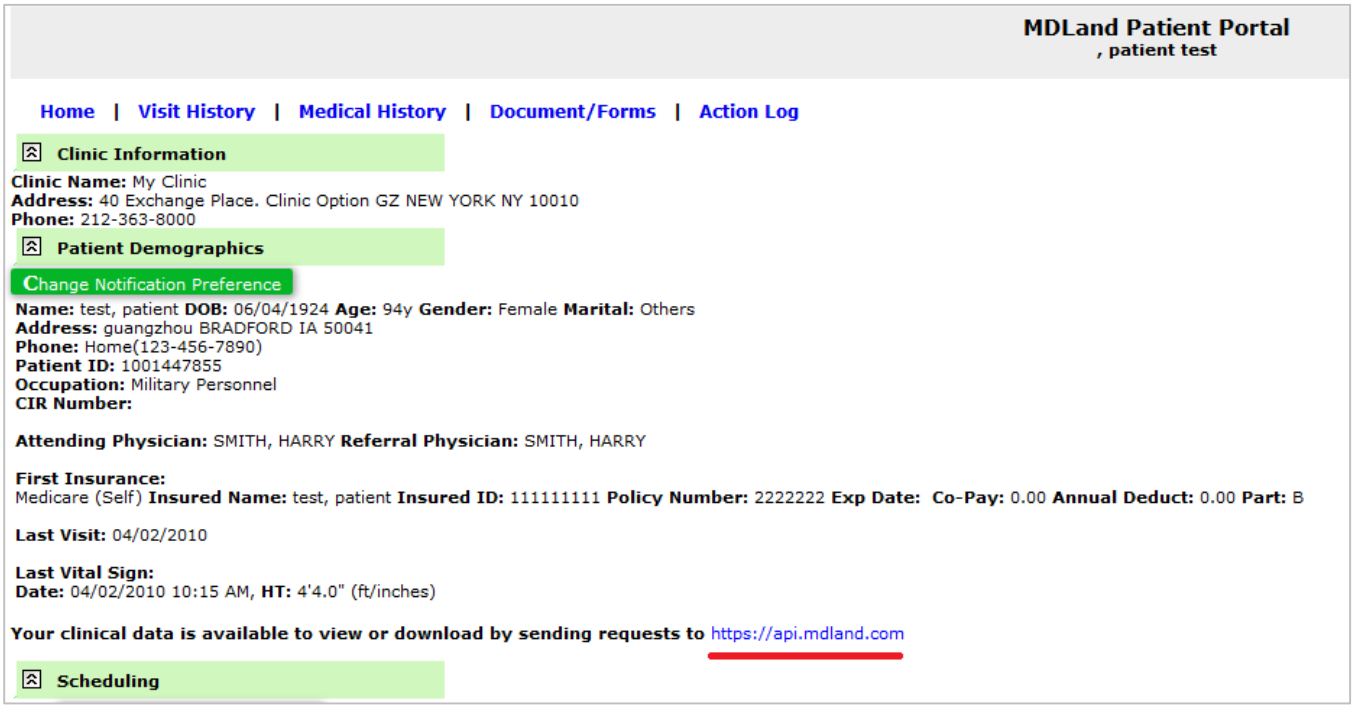
- Measure Description: For more than 80 percent of all unique patients seen by the EP:
  - (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and
  - (2) The provider ensures the patient's health information 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.



Print and provide the portal credentials to the patient.



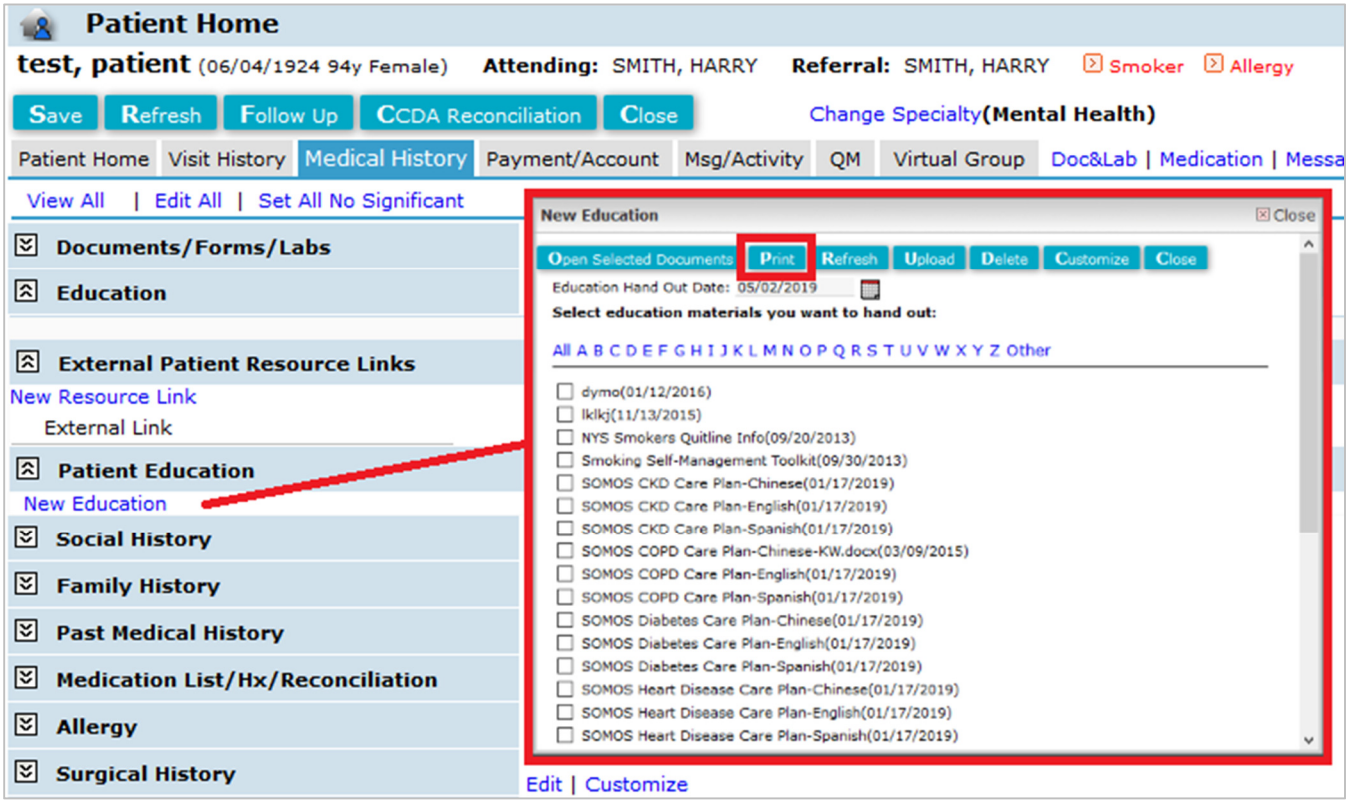
(2) The system is configured and has an API available. API can be request from Patient Portal > clicking on the link and submitting the API request form.



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.

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.

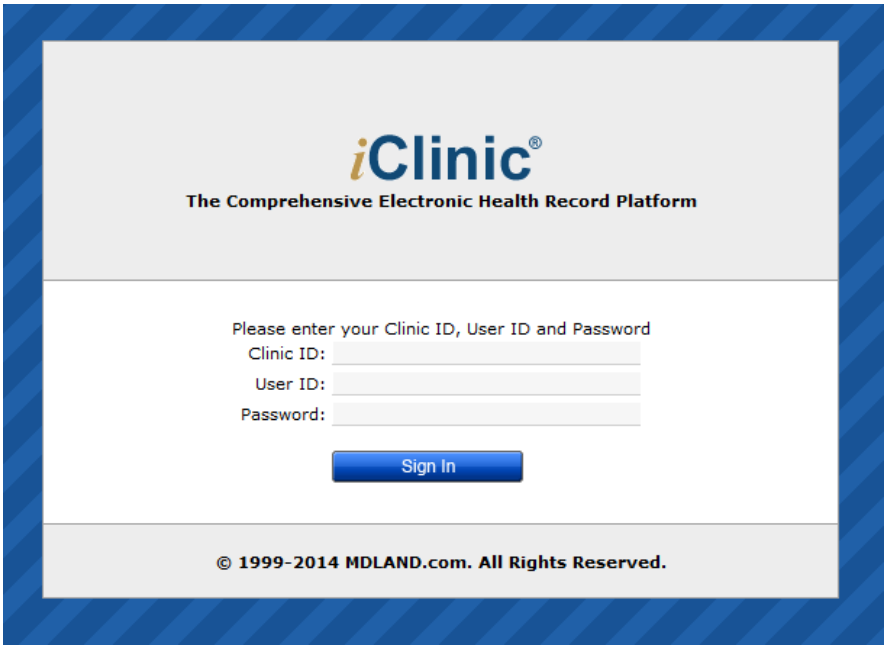


Objective 6: Coordination of Care

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.

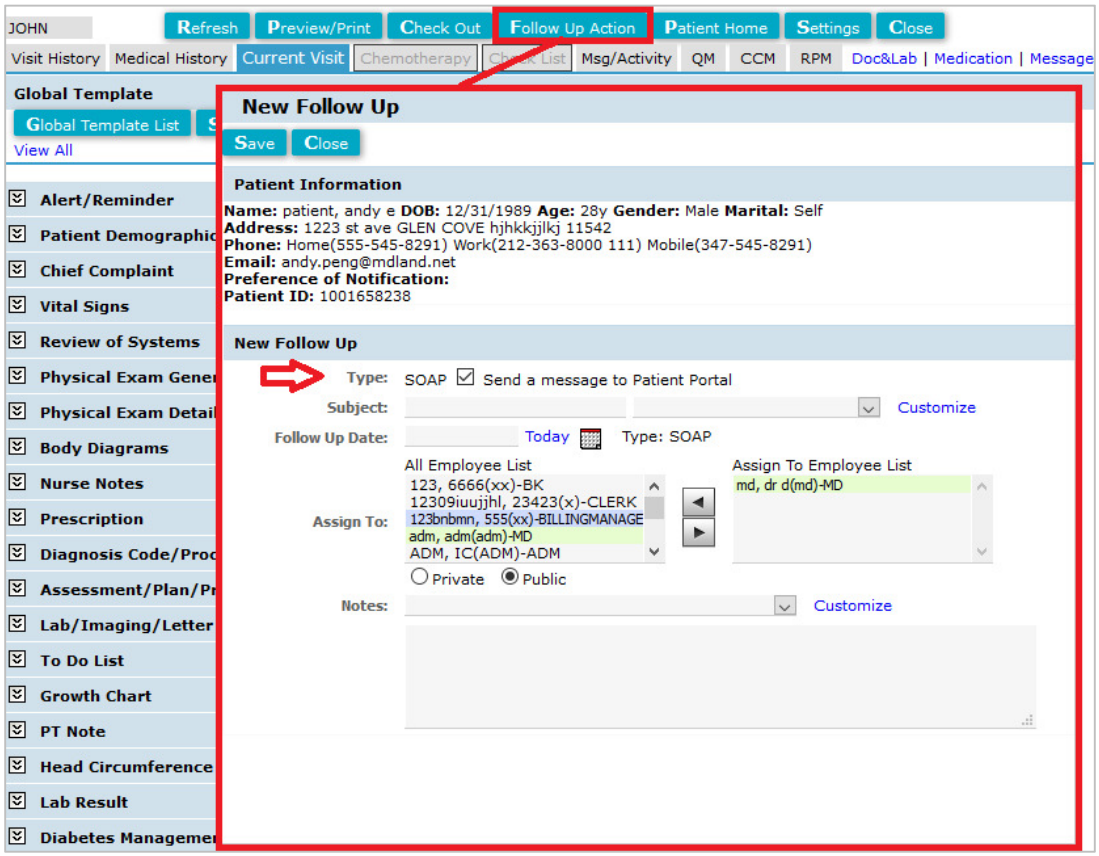


Patient portal login page.

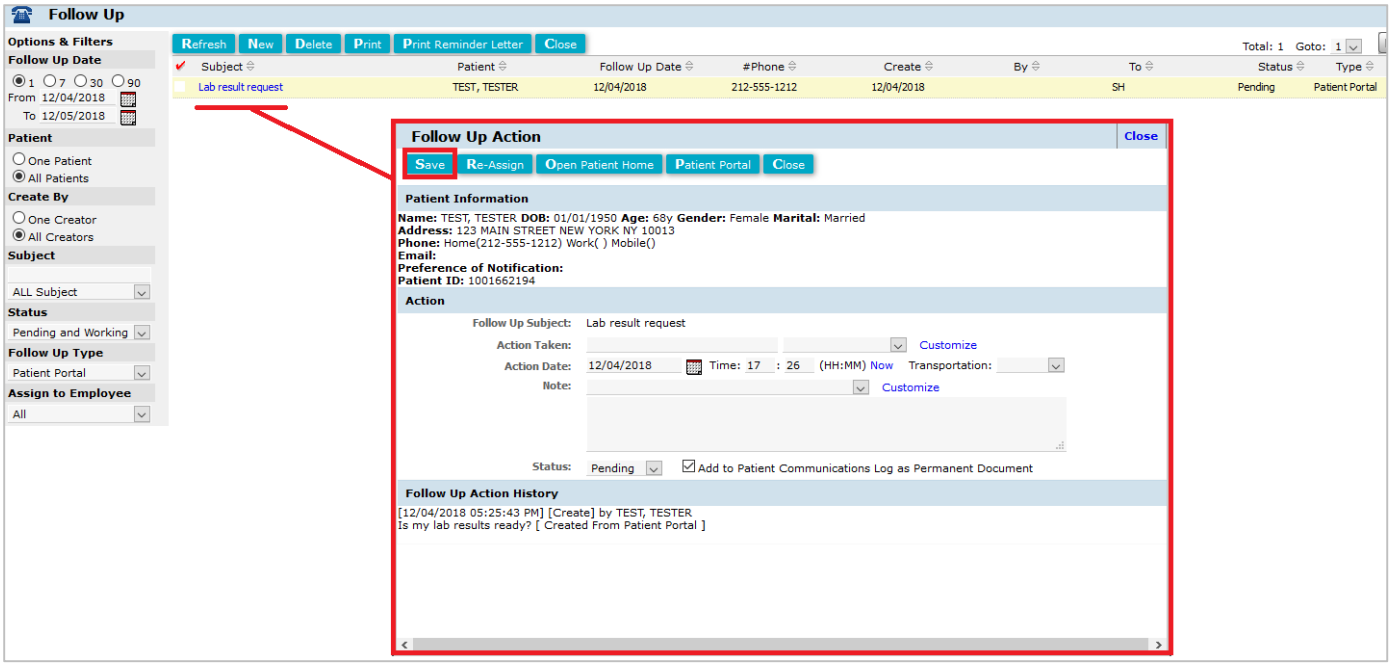
Provide patient their portal login credentials by going to Registration > click "Patient Portal Password" button > click "Print Self" button. Refer to Objective 5 Measure 1 for full details.

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.



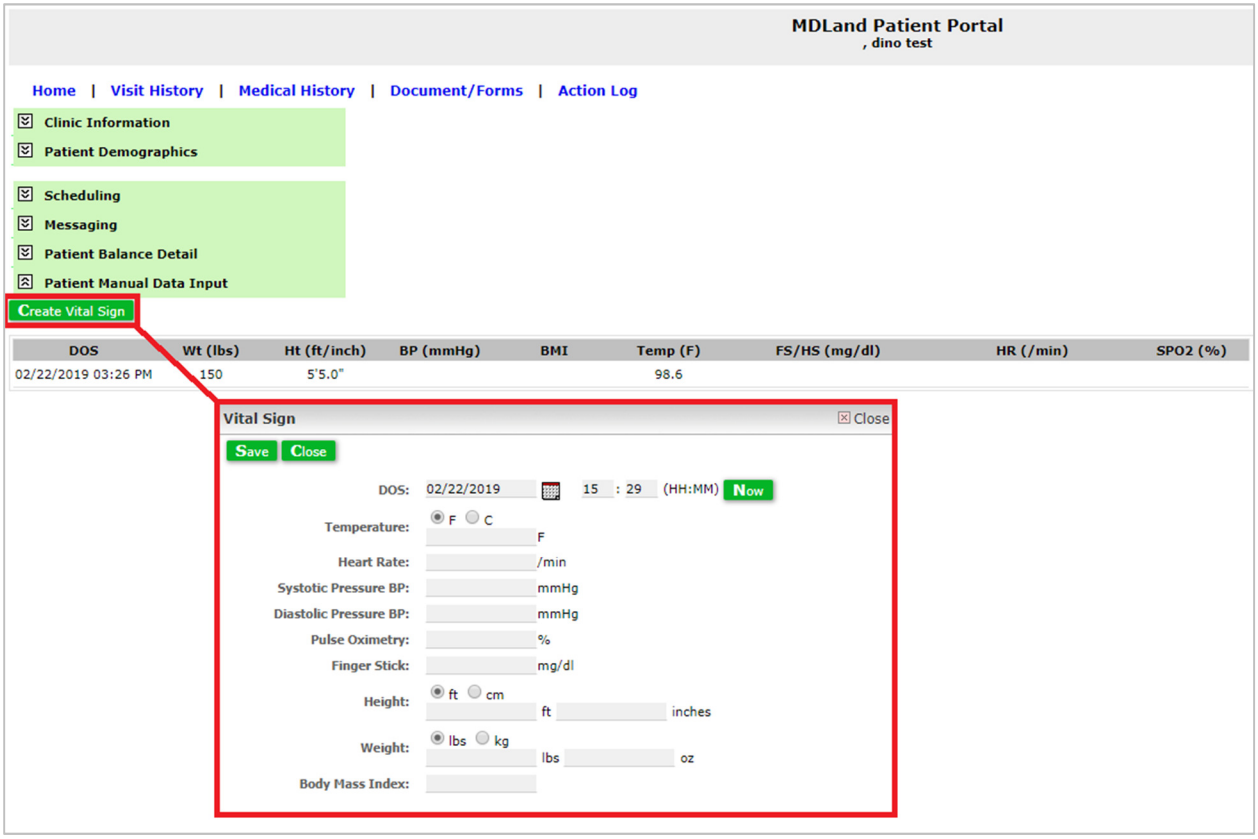
Go to office visit > click on "Follow Up Action" > check "Send a message to Patient Portal" > complete the rest of the boxes > Save > This will send a message to patient portal.



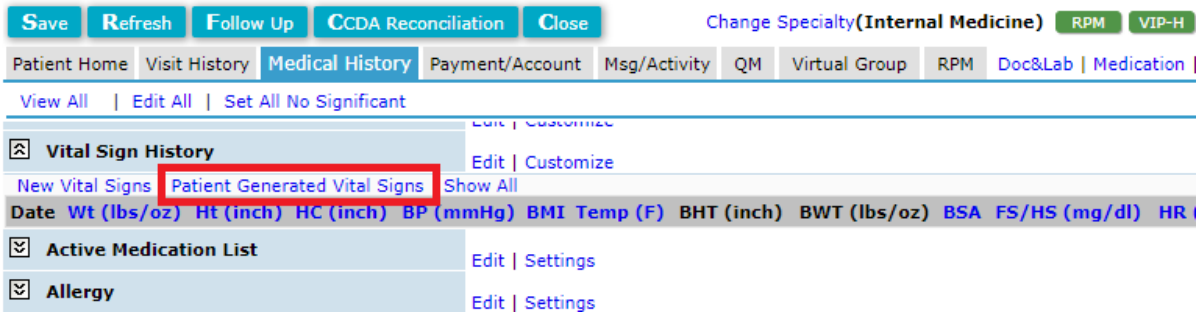
Messages from patient portal are located in “Follow Up”. To respond to a message from patient portal, go to Follow up > click on the message > enter in your response/message into the notes > Save

Measure 3 – Patient generated health data

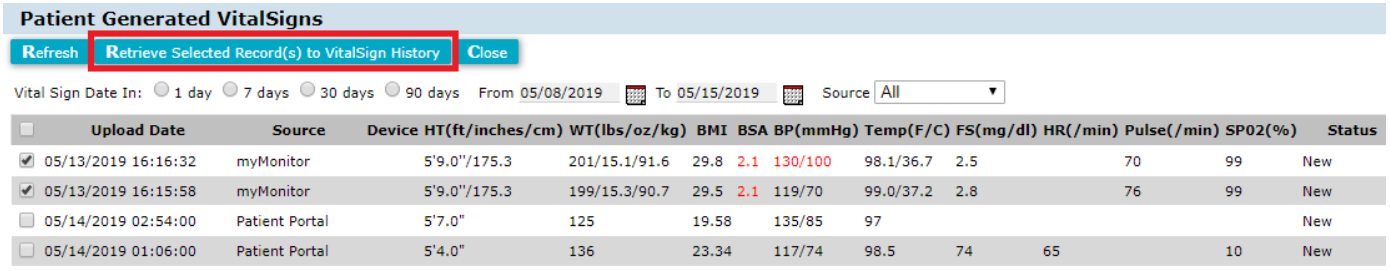
- Measure Description: Patient generated health data or data from a non-clinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the PI reporting period.
- Requirements: More than 5%
- Exclusions: A provider may exclude the measures if one of 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.



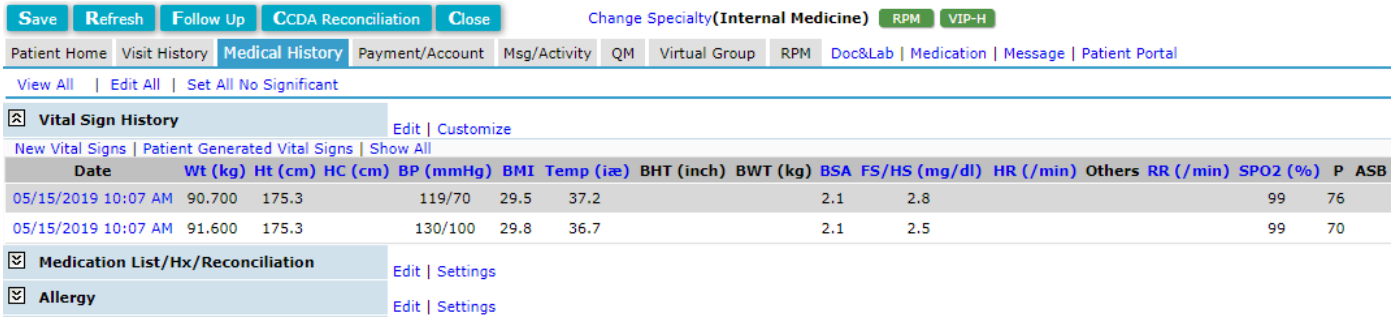
Patient signs into their Patient Portal > Click on Create Vital Sign (under Patient Manual Data Input) > Enter in vital signs > Save



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

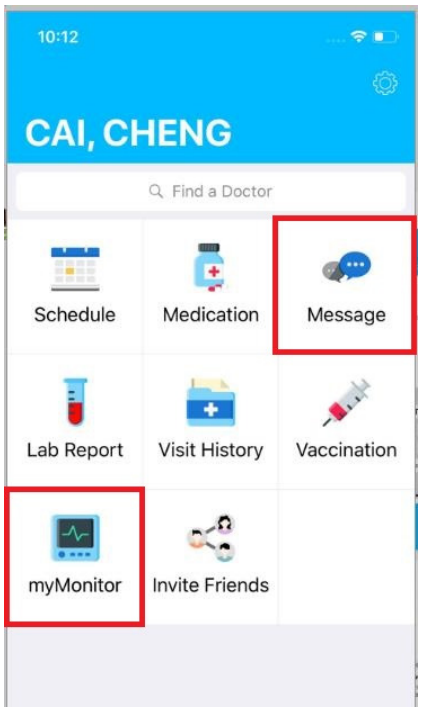


Select the vital signs and click “Retrieve Selected Record(s) to Vital Sign History”

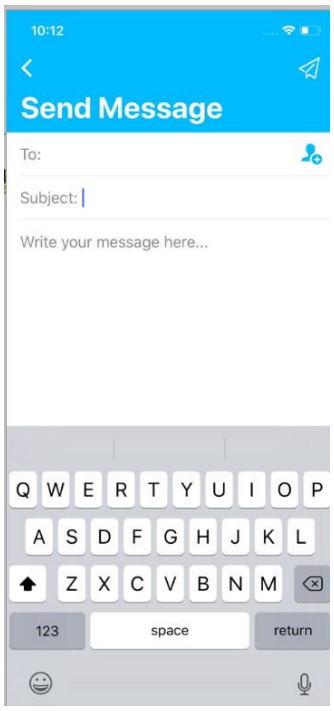


Records added to Vital Sign History

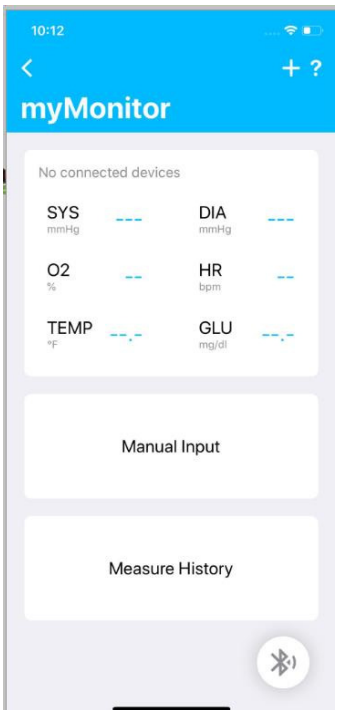
Patient can send health data using VIP Health App. Once within the app, patient has the option to send message or vital signs.



App > click Message or myMonitor



Send Message



Send Vital Signs

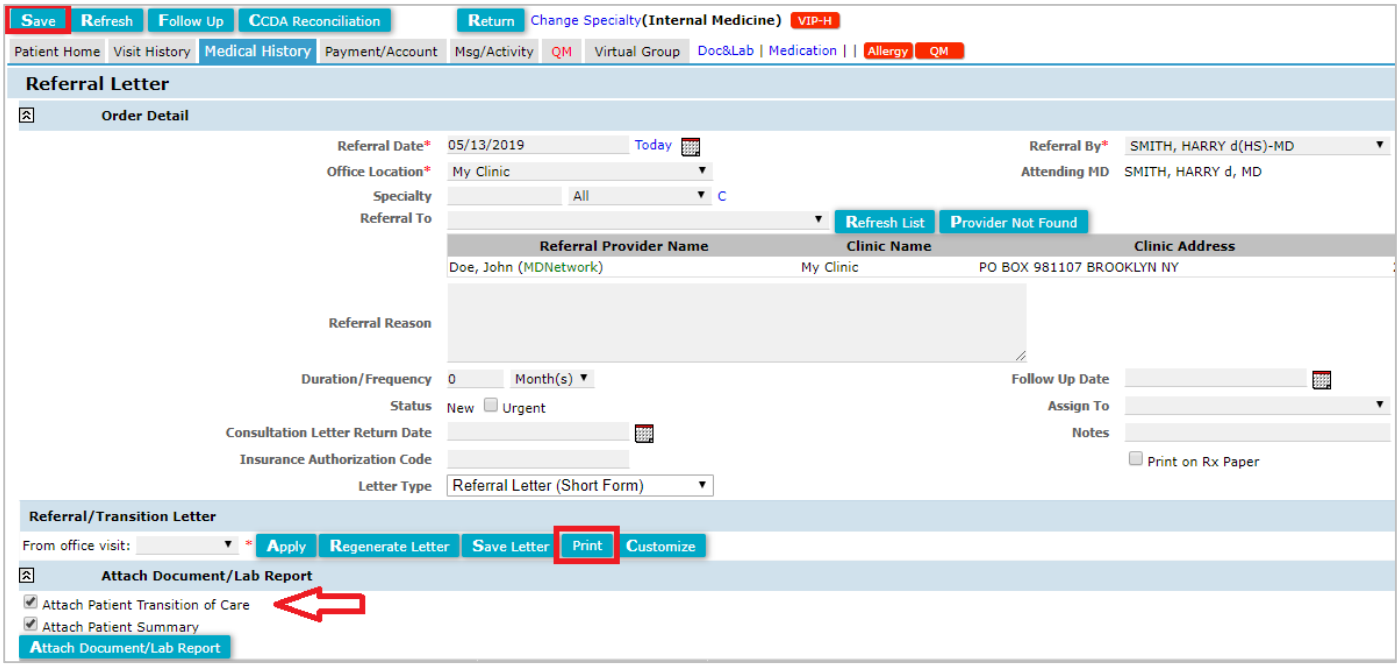
Health data arrives in system.

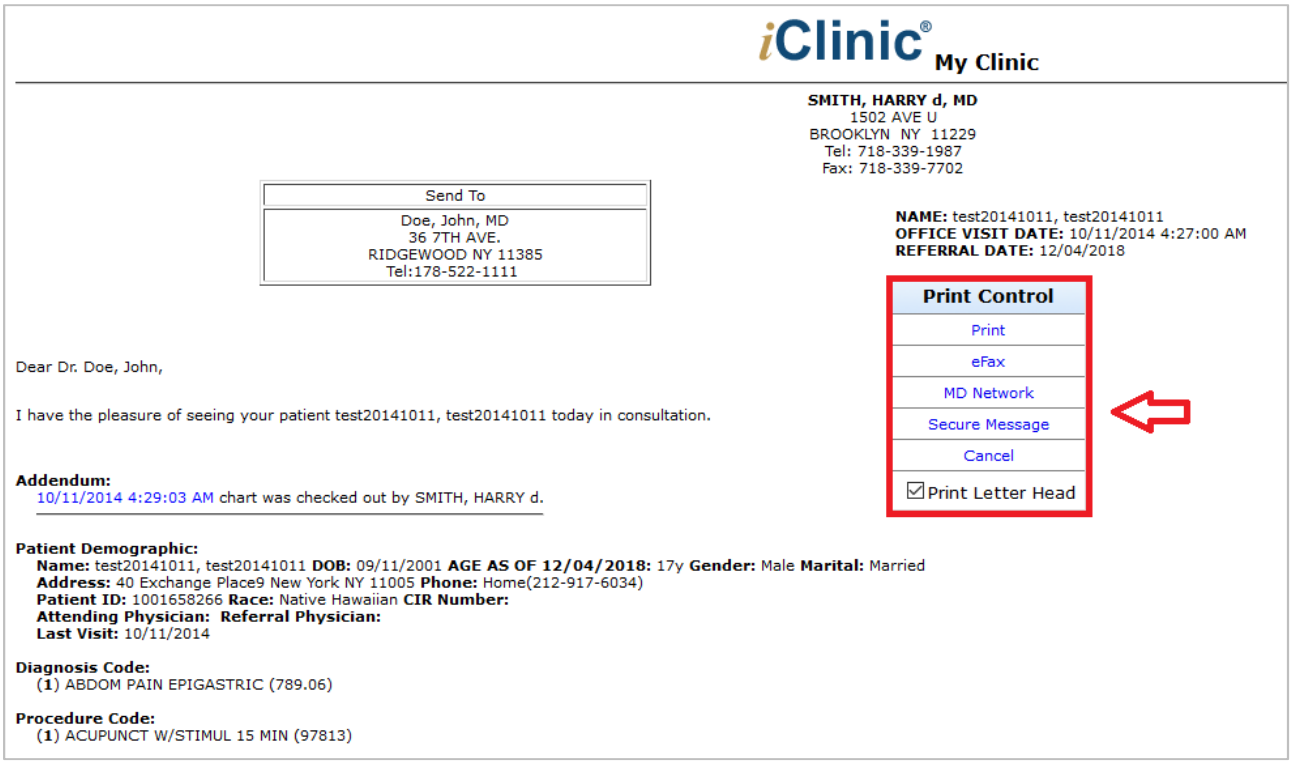
Objective 7: Health Information Exchange

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).



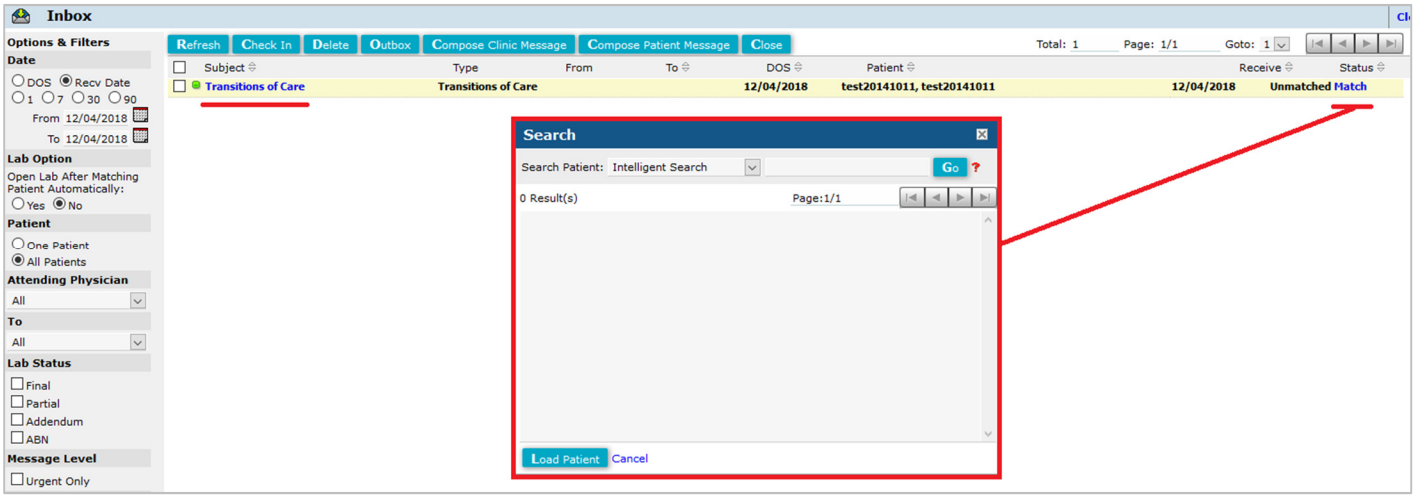


On print preview page, click on *MD Network* or *Secure Message* to send referral or consultation letter electronically.

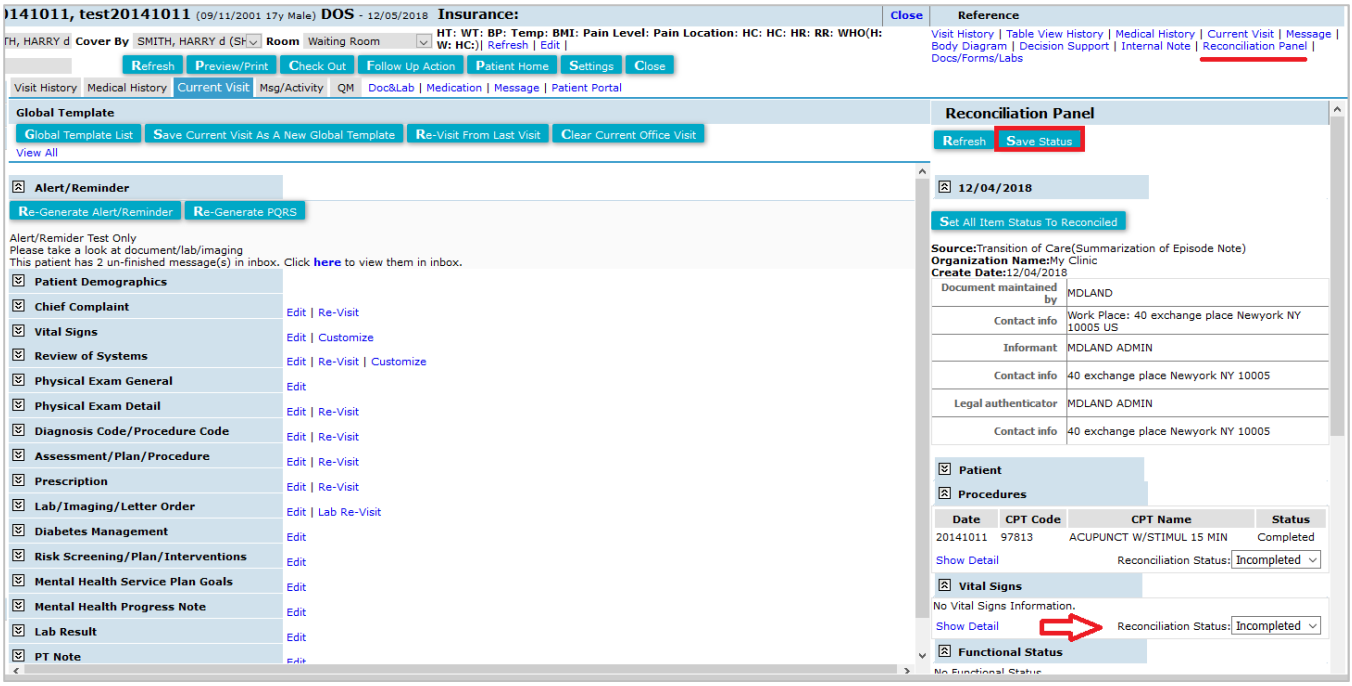
Measure 2 – Incorporate new patients' summary of care into HER

- 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.

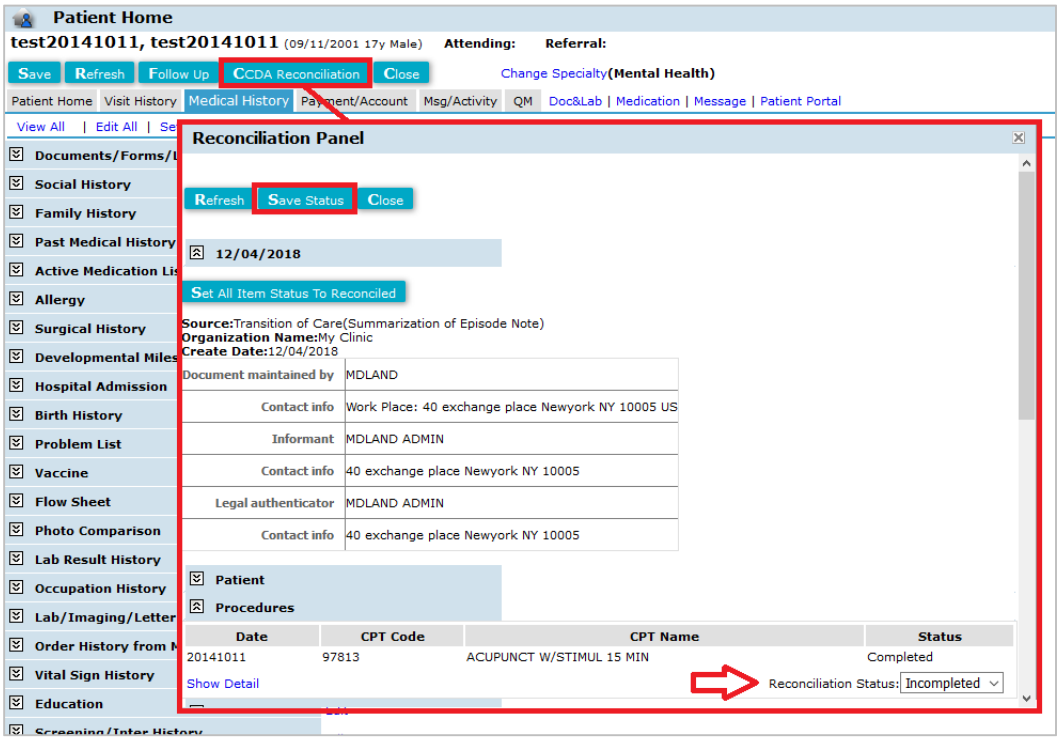
Patient came in for an office visit.



Match the "Transitions of Care" document to a patient.



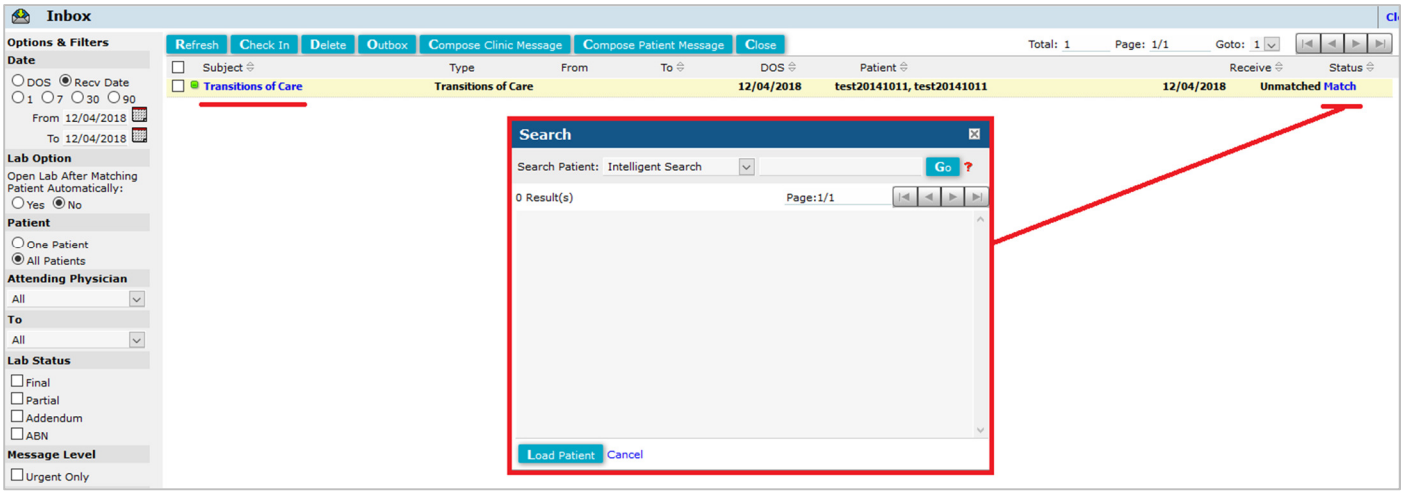
In office visit > click “Reconciliation Panel” (under Reference on the right) to load “Transitions of Care” > reconcile at least one of the items by changing the Reconciliation Status to “Reconciled” > click “Save Status” to document the work.



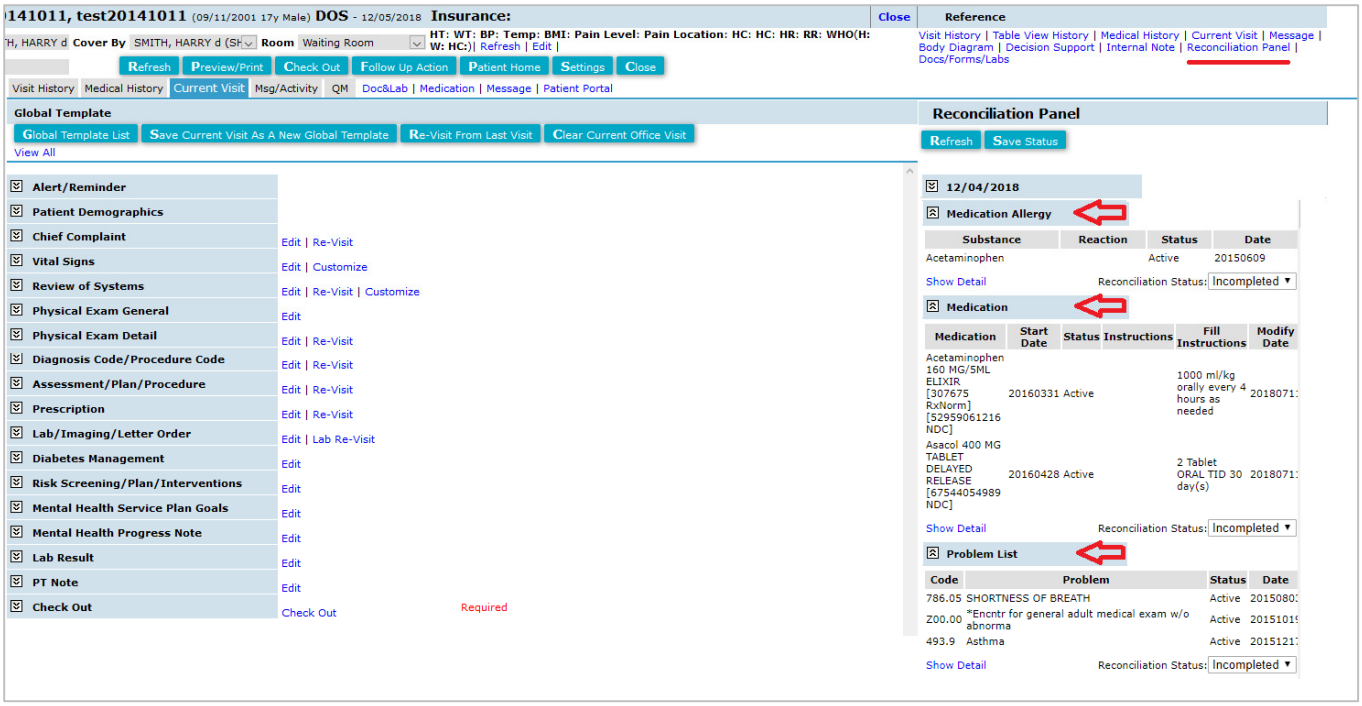
An alternative option to reconcile is through Patient Home. Click “CCDA Reconciliation” to load “Transitions of Care”. Then reconcile at least one of the items.

Measure 3 – Clinical information reconciliation for new patients

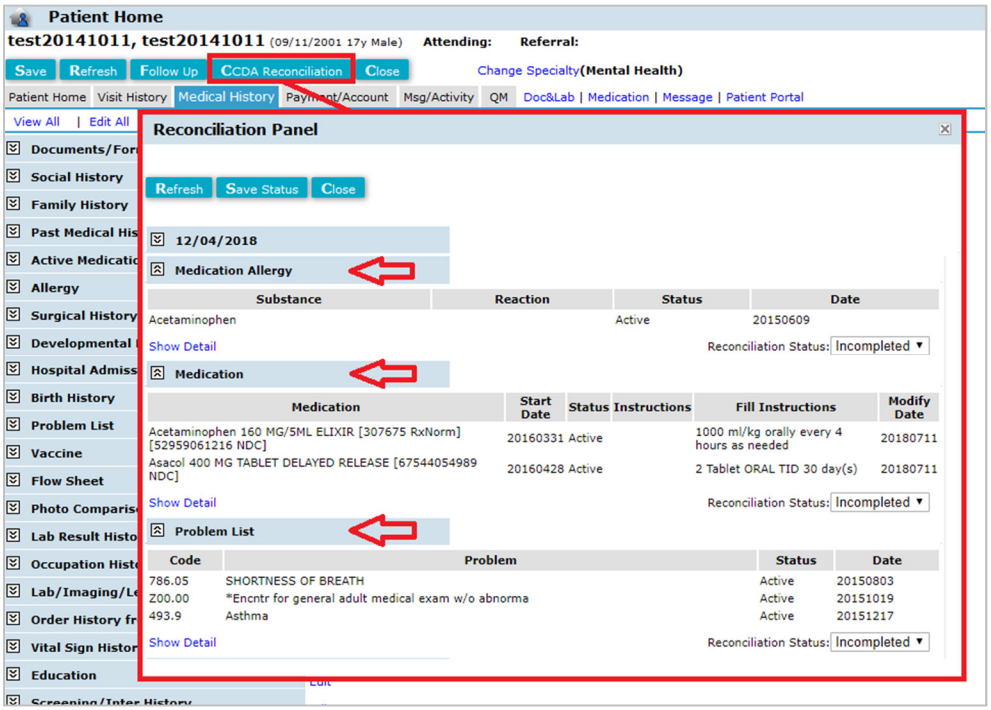
- Measure Description: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following 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.

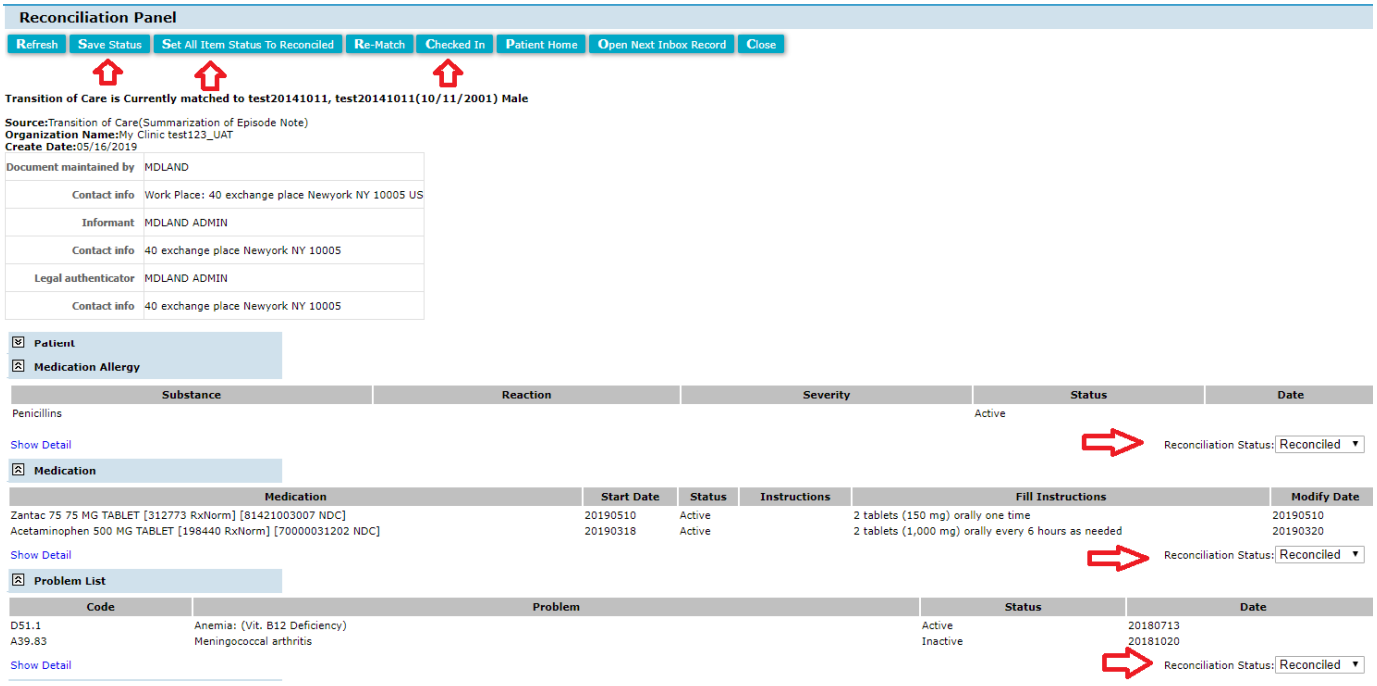


In office visit > click “Reconciliation Panel” (under Reference on the right) to load “Transitions of Care” > reconcile *Medication*, *Medication Allergy*, **and** *Problem List* items by changing the Reconciliation Status to “Reconciled” > click “Save Status” to document the work.



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”.



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