

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
<input checked="" type="checkbox"/> Aspirin 300 MG SUPPOSITORY	2 suppositories (600 mg) rectally every 4 hours as needed	30			

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

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

Aciphex 20 MG Qty:14 Tablet

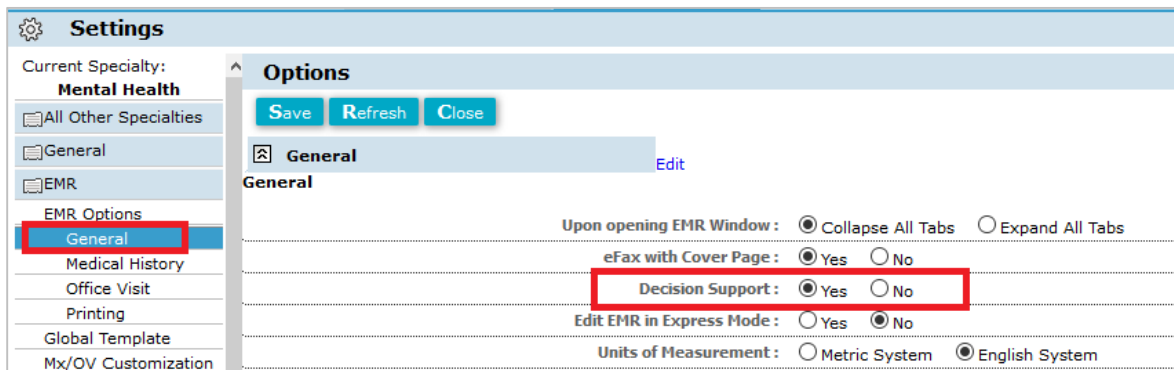
Aciphex 20 MG Qty:28 Tablet

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.



Settings

Current Specialty: **Mental Health**

Options: Save Refresh Close

General Edit

General

Upon opening EMR Window : ☒ Collapse All Tabs ☐ Expand All Tabs

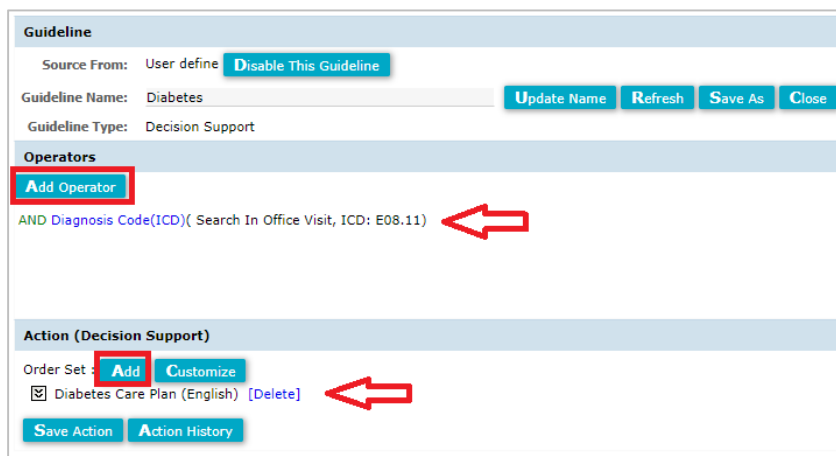
eFax with Cover Page : ☒ Yes ☐ No

Decision Support : ☒ Yes ☐ No

Edit EMR in Express Mode : ☐ Yes ☒ No

Units of Measurement : ☐ Metric System ☒ English System

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.



Guideline

Source From: User define Disable This Guideline

Guideline Name: Diabetes Update Name Refresh Save As Close

Guideline Type: Decision Support

Operators

Add Operator

AND Diagnosis Code(ICD) Search In Office Visit, ICD: E08.11

Action (Decision Support)

Order Set: Add Customize

☒ Diabetes Care Plan (English) Delete

Save Action Action History

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

The screenshot shows the MDSave interface for a patient named HARRY d. SMITH. The 'Current Visit' tab is selected. The 'Decision Support' panel on the right shows a list of items to be applied, including 'Diabetes(Diabetes Care Plan (English))'. A red arrow points to the 'Apply' button.

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.”

The screenshot shows the 'Settings' page for 'Mental Health'. The 'Options' section under 'ePrescription' is expanded. The following options are highlighted with a red box:

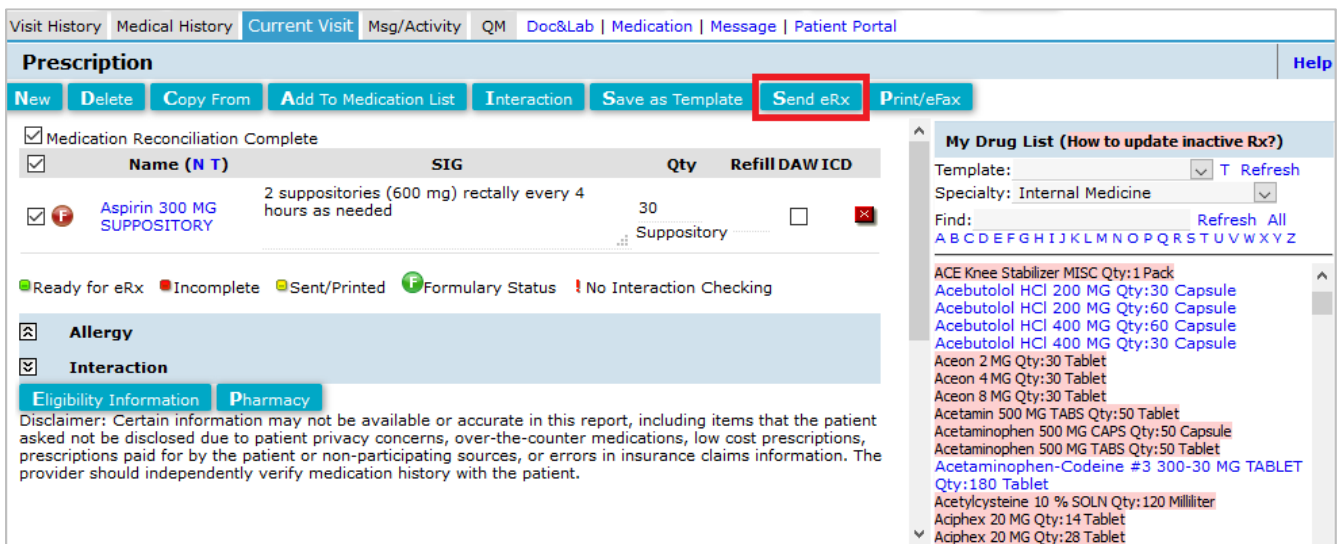
- Check Drug Interaction Automatically: ☒ Yes ☐ No 11/27/2015
- Check Drug - Allergy Interaction Automatically: ☒ Yes ☐ No 11/27/2015
- Check Drug - Disease Interaction Automatically: ☒ Yes ☐ No (It may slow down system performance if patients have many diagnosis codes in the records)

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** | Print/fax

☒ Medication Reconciliation Complete

Name (N T)	SIG	Qty	Refill DAW ICD
<input checked="" type="checkbox"/>  Aspirin 300 MG SUPPOSITORY	2 suppositories (600 mg) rectally every 4 hours as needed	30 Suppository	<input type="checkbox"/> 

● 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

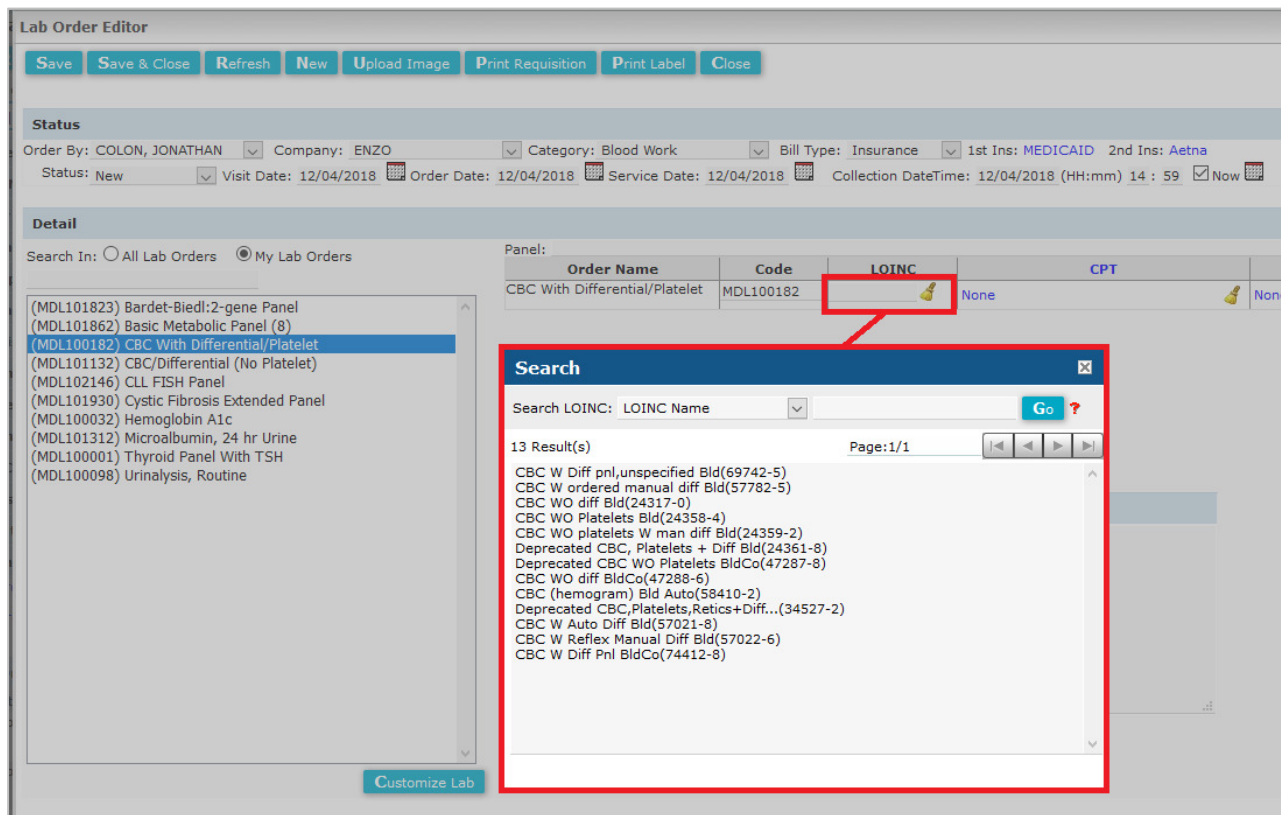
Find: Refresh All

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
- Aciphex 20 MG Qty:14 Tablet
- Aciphex 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.



The screenshot shows the 'Lab Order Editor' window. At the top, there are buttons: Save, Save & Close, Refresh, New, Upload Image, Print Requisition, Print Label, and Close. Below these are fields for Order By (COLON, JONATHAN), Company (ENZO), Category (Blood Work), Bill Type (Insurance), 1st Ins (MEDICAID), 2nd Ins (Aetna), Status (New), Visit Date (12/04/2018), Order Date (12/04/2018), Service Date (12/04/2018), Collection Date/Time (12/04/2018 14:59), and a 'Now' checkbox.

The 'Detail' section shows a search for 'All Lab Orders' and 'My Lab Orders'. A list of lab orders is displayed, with '(MDL100182) CBC With Differential/Platelet' selected. A 'Search' dialog box is open, showing 13 results for the search term 'CBC W Diff pnl,unspecified Bld(69742-5)'. The results include various CBC and platelet test codes and their descriptions.

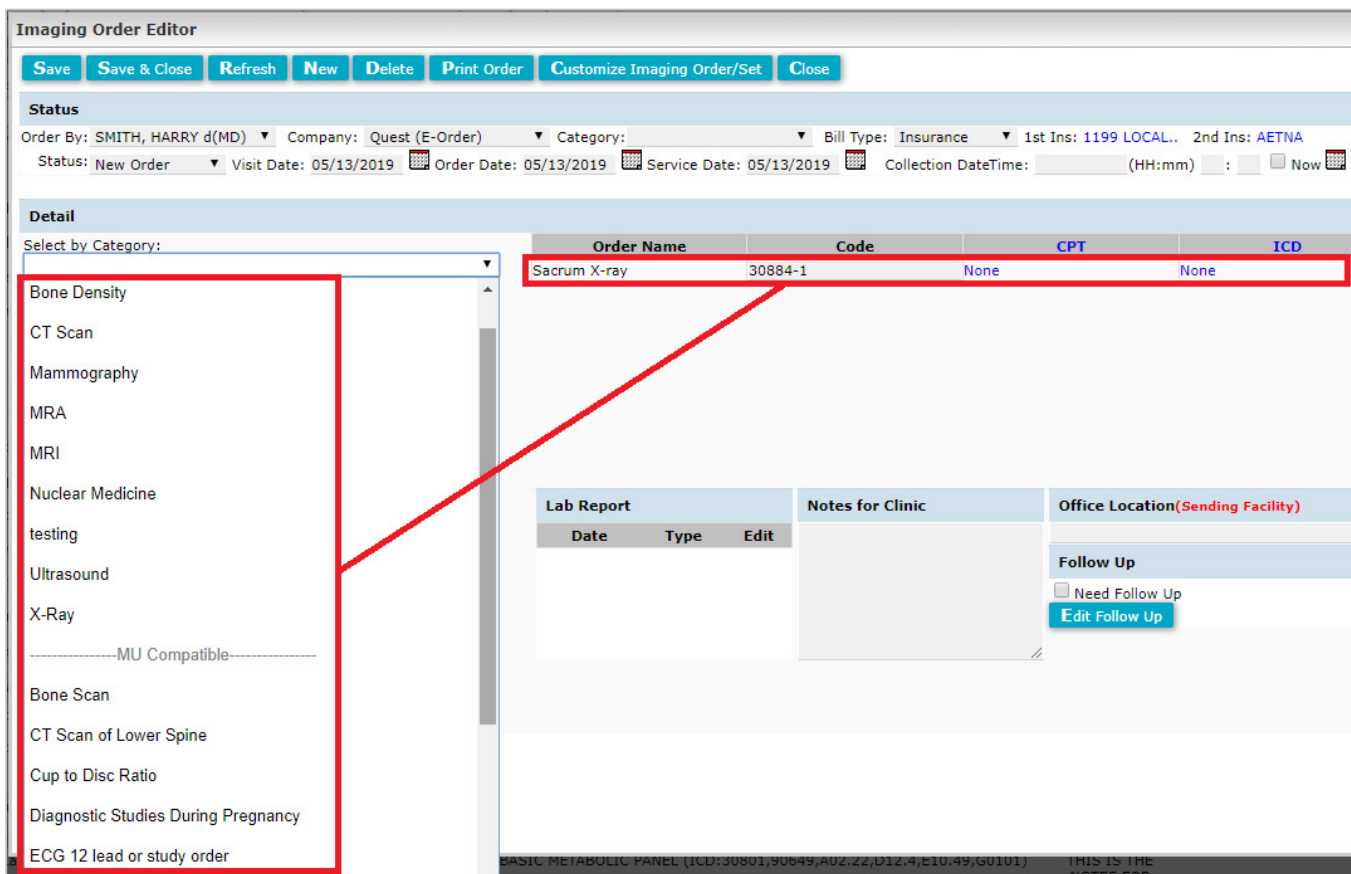
Order Name	Code	LOINC	CPT
CBC With Differential/Platelet	MDL100182		None

The 'Search' dialog box shows the following results:

- CBC W Diff pnl,unspecified Bld(69742-5)
- CBC W ordered manual diff Bld(57782-5)
- CBC WO diff Bld(24317-0)
- CBC WO Platelets Bld(24358-4)
- CBC WO platelets W man diff Bld(24359-2)
- Deprecated CBC, Platelets + Diff Bld(24361-8)
- Deprecated CBC WO Platelets BldCo(47287-8)
- CBC WO diff BldCo(47288-6)
- CBC (hemogram) Bld Auto(58410-2)
- Deprecated CBC,Platelets,Retics+Diff...(34527-2)
- CBC W Auto Diff Bld(57021-8)
- CBC W Reflex Manual Diff Bld(57022-6)
- CBC W Diff Pnl BldCo(74412-8)

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:

- 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

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

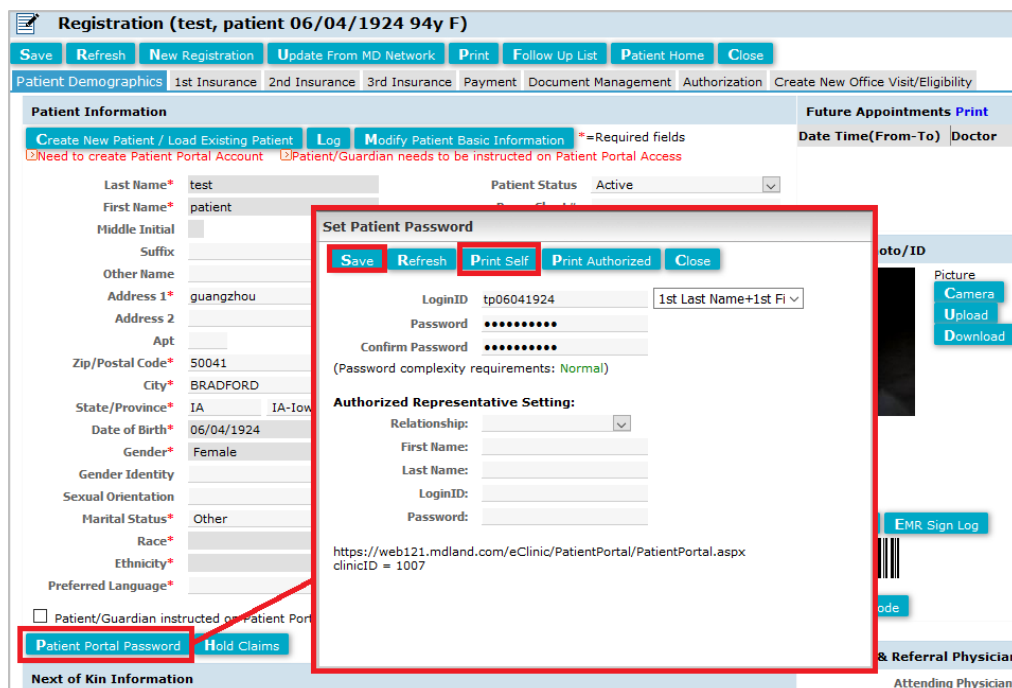
BASIC METABOLIC PANEL (ICD:30801,90649,A02.22,D12.4,E10.49,G0101) THIS IS THE

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.



The screenshot displays the 'Registration (test, patient 06/04/1924 94y F)' form. A red box highlights the 'Set Patient Password' dialog box, which is overlaid on the main form. The dialog box contains the following fields and options:

- Buttons:** Save, Refresh, Print Self, Print Authorized, Close.
- LoginID:** tp06041924
- Password:** [masked]
- Confirm Password:** [masked]
- (Password complexity requirements: Normal)**
- Authorized Representative Setting:**
 - Relationship: [dropdown]
 - First Name: [text field]
 - Last Name: [text field]
 - LoginID: [text field]
 - Password: [text field]
- URL:** https://web121.mdland.com/eClinic/PatientPortal/PatientPortal.aspx
- clinicID:** 1007

Below the dialog box, the main form shows the 'Patient Information' section with fields for Last Name, First Name, Middle Initial, Suffix, Other Name, Address 1, Address 2, Apt, Zip/Postal Code, City, State/Province, Date of Birth, Gender, Sexual Orientation, Marital Status, Race, Ethnicity, and Preferred Language. A checkbox labeled 'Patient/Guardian instructed on Patient Portal Access' is visible at the bottom left of the form.

Print and provide the portal credentials to the patient.


Automatic Zoom

<https://web121.mdland.com/eClinic/PatientPortal/PatientLogin.aspx>
 Patient Name: test , patient
 Clinic ID: 1007
 User ID: tp06041924
 Password: MYpw1924


(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.


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:** 111111111 **Policy Number:** 2222222 **Exp Date:** **Co-Pay:** 0.00 **Annual Deduct:** 0.00 **Part:** B

Last Visit: 04/02/2010

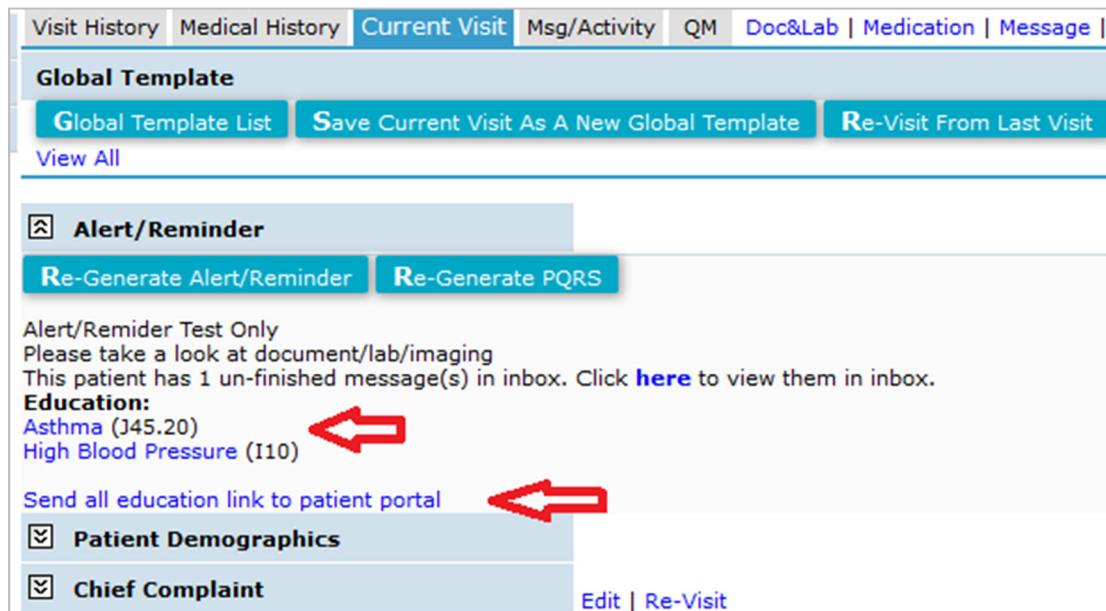
Last Vital Sign:
Date: 04/02/2010 10:15 AM, **HT:** 4'4.0" (ft/inches)

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.

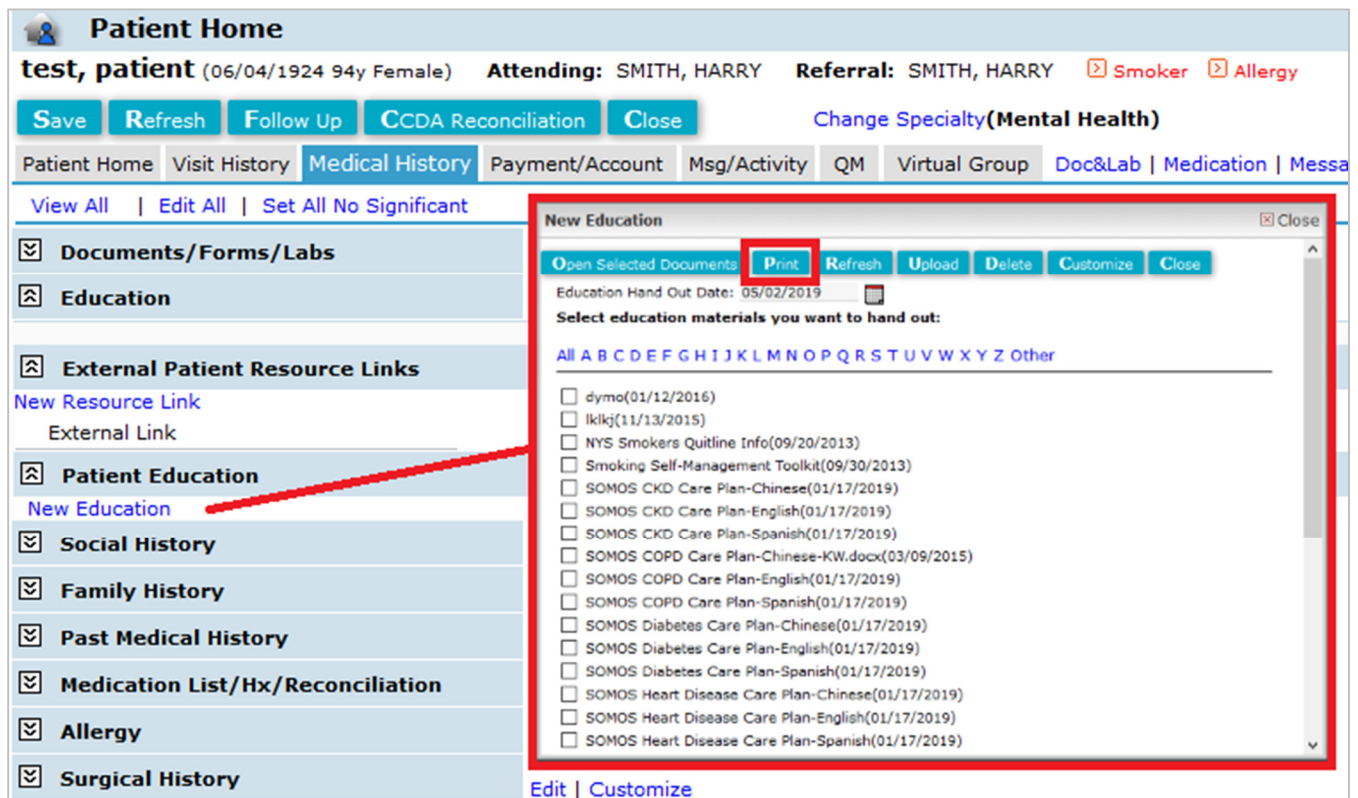
Education:
[Asthma \(J45.20\)](#)
[High Blood Pressure \(I10\)](#)

[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.



Patient Home
test, patient (06/04/1924 94y Female) **Attending:** SMITH, HARRY **Referral:** SMITH, HARRY Smoker Allergy

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

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

View All | Edit All | Set All No Significant

Documents/Forms/Labs
Education
External Patient Resource Links
New Resource Link
External Link
Patient Education
New Education
Social History
Family History
Past Medical History
Medication List/Hx/Reconciliation
Allergy
Surgical History

New Education Close

Open Selected Documents Print Refresh Upload Delete Customize Close

Education Hand Out Date: 05/02/2019

Select education materials you want to hand out:

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 Other

- ☐ dymo(01/12/2016)
- ☐ lklkj(11/13/2015)
- ☐ NYS Smokers Quitline Info(09/20/2013)
- ☐ Smoking Self-Management Toolkit(09/30/2013)
- ☐ SOMOS CKD Care Plan-Chinese(01/17/2019)
- ☐ SOMOS CKD Care Plan-English(01/17/2019)
- ☐ SOMOS CKD Care Plan-Spanish(01/17/2019)
- ☐ SOMOS COPD Care Plan-Chinese-KW.docx(03/09/2015)
- ☐ SOMOS COPD Care Plan-English(01/17/2019)
- ☐ SOMOS COPD Care Plan-Spanish(01/17/2019)
- ☐ SOMOS Diabetes Care Plan-Chinese(01/17/2019)
- ☐ SOMOS Diabetes Care Plan-English(01/17/2019)
- ☐ SOMOS Diabetes Care Plan-Spanish(01/17/2019)
- ☐ SOMOS Heart Disease Care Plan-Chinese(01/17/2019)
- ☐ SOMOS Heart Disease Care Plan-English(01/17/2019)
- ☐ SOMOS Heart Disease Care Plan-Spanish(01/17/2019)

Edit | Customize

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.

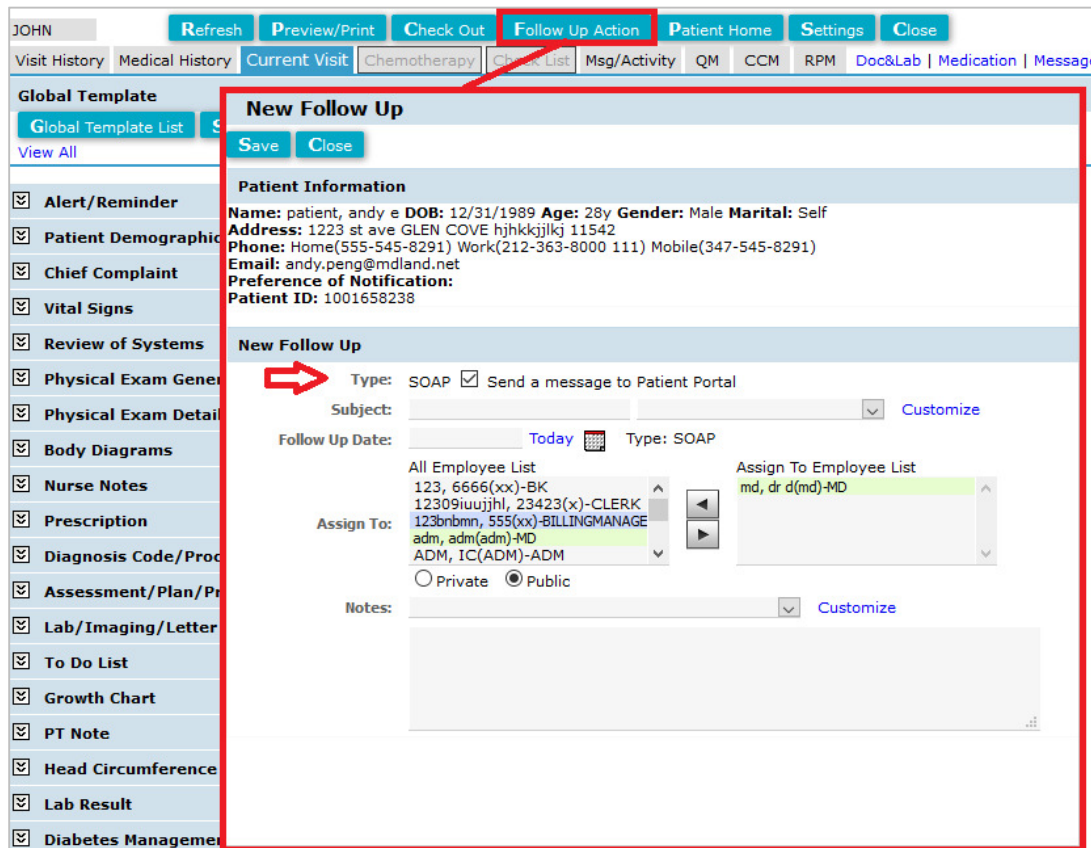


Patient portal login page.

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 MDSave software interface. The top navigation bar includes tabs like 'Refresh', 'Preview/Print', 'Check Out', 'Follow Up Action' (highlighted with a red box), 'Patient Home', 'Settings', and 'Close'. Below this is a sub-navigation bar with 'Visit History', 'Medical History', 'Current Visit', 'Chemotherapy', 'Check List', 'Msg/Activity', 'QM', 'CCM', 'RPM', 'Doc&Lab', 'Medication', and 'Message'. The main content area is titled 'New Follow Up' and contains a 'Save' button and a 'Close' button. The 'Patient Information' section includes fields for Name, DOB, Age, Gender, Marital, Address, Phone, Email, and Patient ID. The 'New Follow Up' section includes a 'Type' dropdown (set to SOAP), a 'Send a message to Patient Portal' checkbox (checked, with a red arrow pointing to it), a 'Subject' field, a 'Follow Up Date' field (set to Today), and an 'Assign To' dropdown (set to ADM, IC(ADM)-ADM). The 'Notes' section is a large text area for entering the message content.

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

Refresh New Delete Print Print Reminder Letter Close

Subject Patient Follow Up Date #Phone Create By To Status Type

Lab result request TEST, TESTER 12/04/2018 212-555-1212 12/04/2018 SH Pending Patient Portal

Follow Up Action Close

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

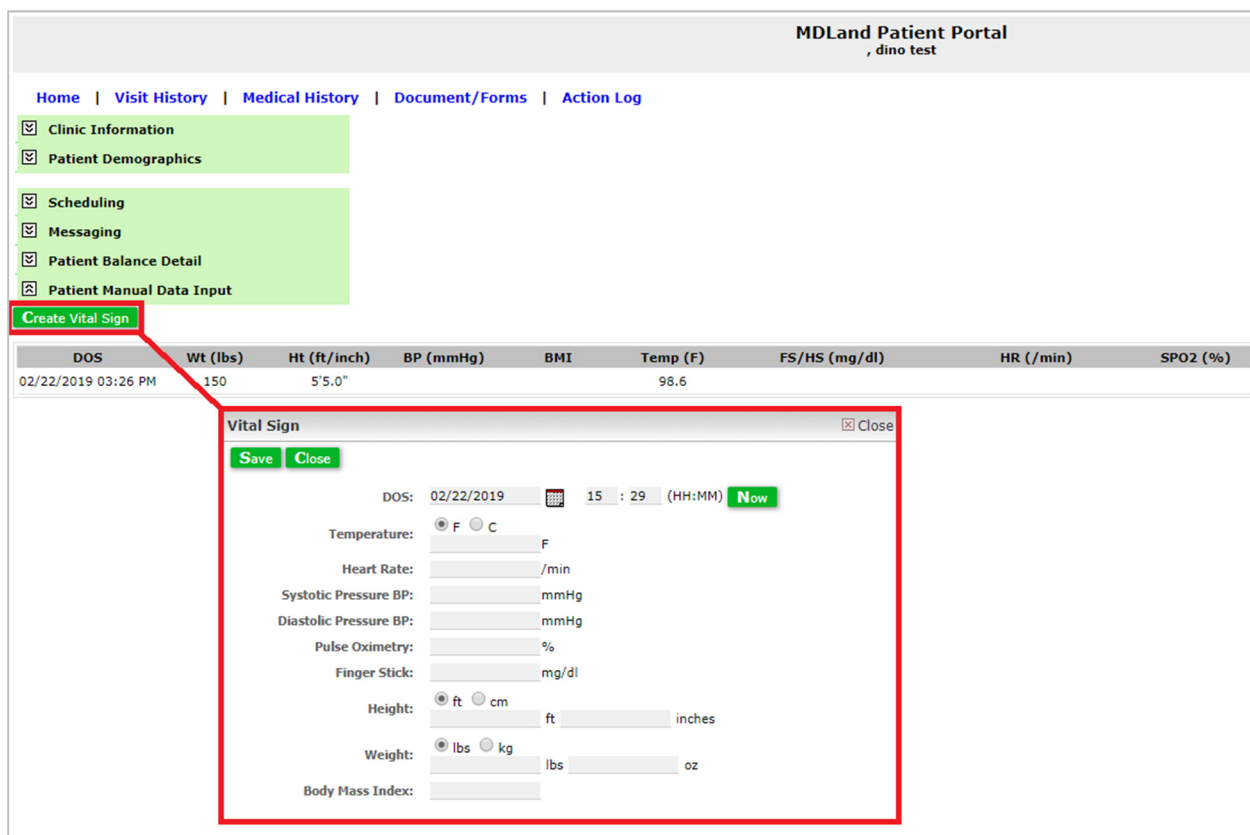
Follow Up Action History

[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 displays the MDLand Patient Portal interface. At the top, the header reads "MDLand Patient Portal" with a sub-header "dino test". Below this is a navigation bar with links: Home, Visit History, Medical History, Document/Forms, and Action Log. A sidebar on the left contains a list of menu items: Clinic Information, Patient Demographics, Scheduling, Messaging, Patient Balance Detail, and Patient Manual Data Input. The "Create Vital Sign" button is highlighted in green and has a red box around it. Below the sidebar, a table shows patient data for DOS 02/22/2019 03:26 PM, Wt (lbs) 150, Ht (ft/inch) 5'5.0", BP (mmHg), BMI, Temp (F) 98.6, FS/HS (mg/dl), HR (/min), and SPO2 (%). A red box highlights the "Vital Sign" form, which includes fields for DOS (02/22/2019), Time (15:29), Temperature (F/C), 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. The form has "Save" and "Close" buttons.

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**

[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](#)

☒ **Active Medication List**

☒ **Allergy**

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

Patient Generated VitalSigns

[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](#)

<input type="checkbox"/>	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
<input checked="" type="checkbox"/>	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
<input checked="" type="checkbox"/>	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
<input type="checkbox"/>	05/14/2019 02:54:00	Patient Portal		5'7.0"	125	19.58		135/85	97					New
<input type="checkbox"/>	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**

[New Vital Signs](#) [Patient Generated Vital Signs](#) [Show All](#)

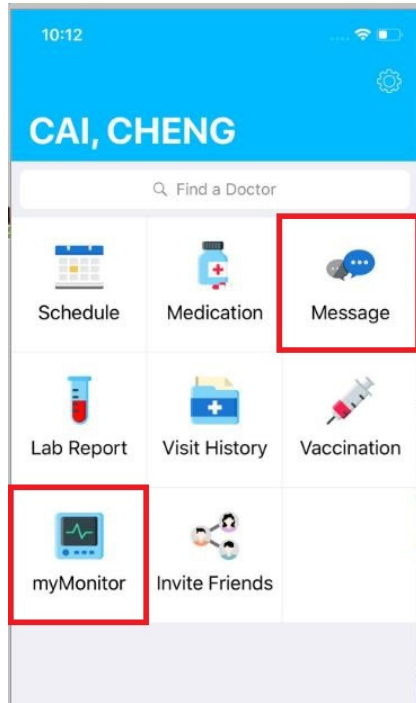
Date	Wt (kg)	Ht (cm)	HC (cm)	BP (mmHg)	BMI	Temp (°C)	BHT (inch)	BWT (kg)	BSA	FS/HS (mg/dl)	HR (/min)	Others	RR (/min)	SPO2 (%)	P	ASB
05/15/2019 10:07 AM	90.700	175.3		119/70	29.5	37.2			2.1	2.8				99		76
05/15/2019 10:07 AM	91.600	175.3		130/100	29.8	36.7			2.1	2.5				99		70

☒ **Medication List/Hx/Reconciliation**

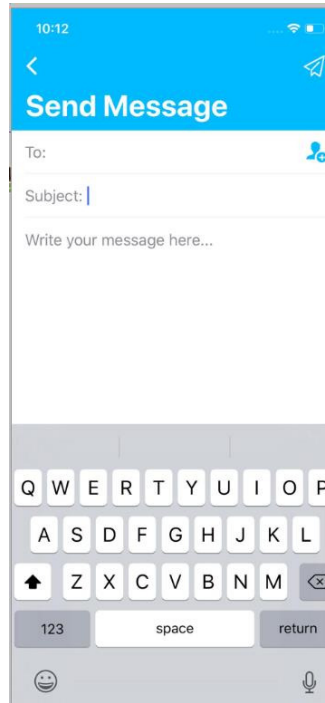
☒ **Allergy**

Records added to Vital Sign History

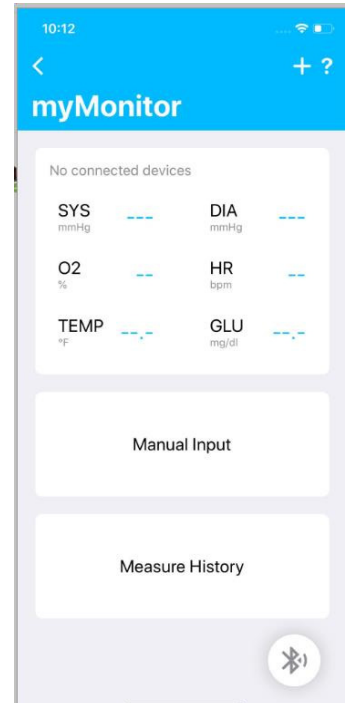
Patient can send health data using VIP Health App. Once within the app, patient has the option to send message or vital signs.



App > click Message or myMonitor



Send Message



Send Vital Signs

Health data arrives in system.

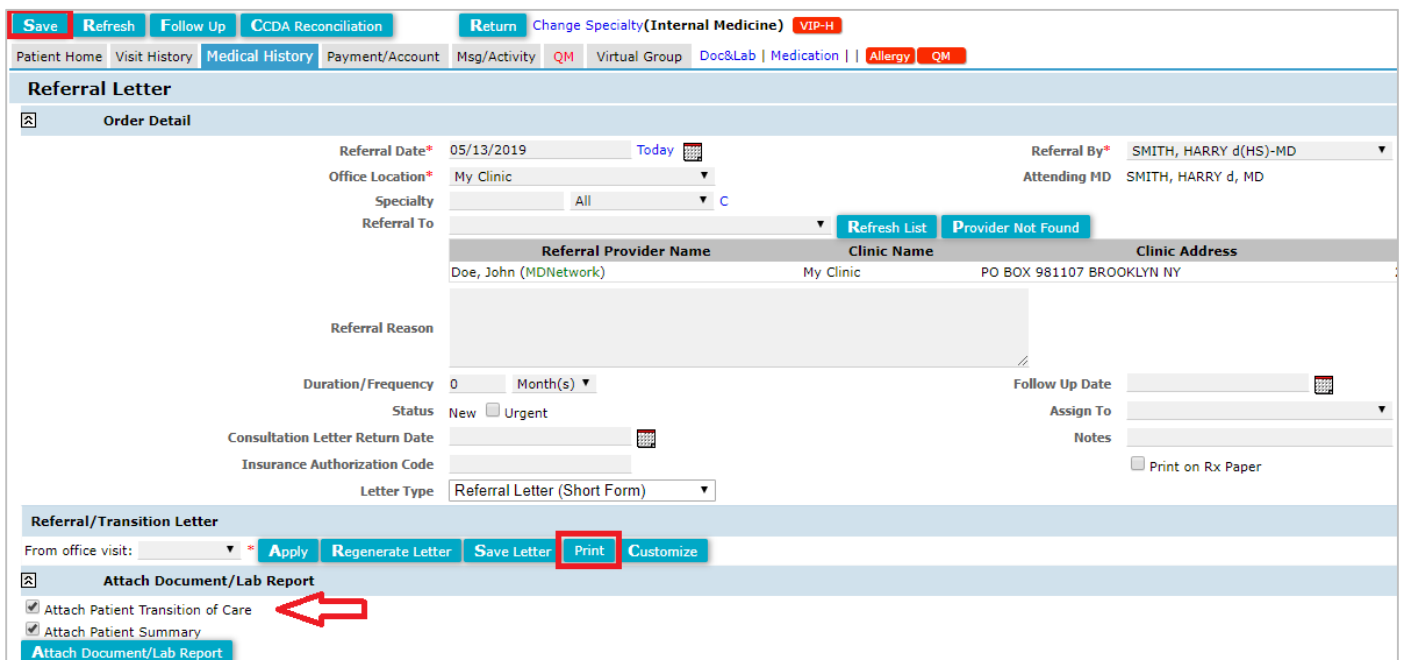
Refresh Check In Delete Outbox Compose Clinic Message Compose Patient Message Close								Total: 3	Pac
Subject	Type	From	To	DOS	Patient				
Test	Patient Message	Cai, Weiming	RX	05/15/2019	Cai, Weiming				
Quest Lab Report - XU,RICHARD Final ABN	Quest Lab Report	RX		03/21/2019	CAI, WEIMING(05/30/1947, M)				
Quest Lab Report - XU,RICHARD Final ABN	Quest Lab Report	RX		03/21/2019	CAI, WEIMING(05/30/1947, M)				

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).



Referral Letter

Order Detail

Referral Date* 05/13/2019 Today
 Office Location* My Clinic
 Specialty All
 Referral To
 Referral Reason
 Duration/Frequency 0 Month(s)
 Status New Urgent
 Consultation Letter Return Date
 Insurance Authorization Code
 Letter Type Referral Letter (Short Form)
 Referral By* SMITH, HARRY d(HS)-MD
 Attending MD SMITH, HARRY d, MD

Referral Provider Name Clinic Name Clinic Address
 Doe, John (MDNetwork) My Clinic PO BOX 981107 BROOKLYN NY

Referral/Transition Letter

From office visit: * Apply Regenerate Letter Save Letter Print Customize

Attach Document/Lab Report

☒ Attach Patient Transition of Care
☒ Attach Patient Summary
 Attach Document/Lab Report

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.



Waiting Room

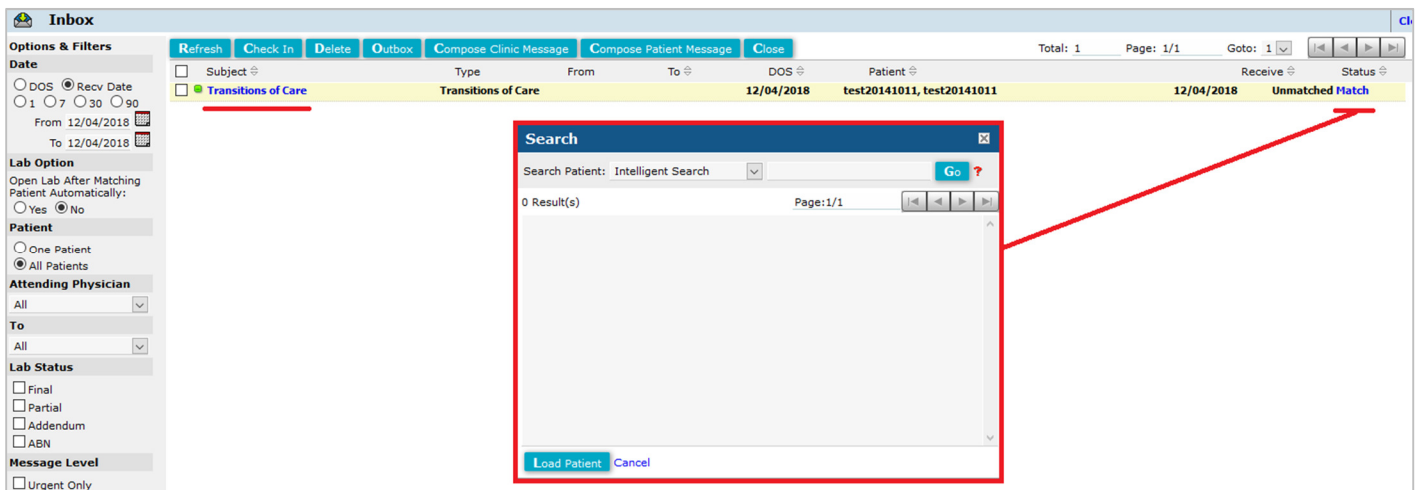
Options & Filters: Refresh, My Activity, Delete, Action Log

Reg Date/DOS: ☐ DOS ☒ Reg Date
 From: 12/05/2018 To: 12/07/2018

Reg Date/Time	DOS	Name	Insurance	Subject	From	To	Open	Office	Location
12/05/2018 10:00:34	12/05/2018	test20141011, test20141011 (09/11/2001)		Appointment	md	SH	md	ALeafTest	Waiting Room

Total: 1 Page: 1/1

Patient came in for an office visit.



Inbox

Options & Filters: Refresh, Check In, Delete, Outbox, Compose Clinic Message, Compose Patient Message, Close

Date: ☐ DOS ☒ Recv Date
 From: 12/04/2018 To: 12/04/2018

Lab Option: Open Lab After Matching Patient Automatically: ☐ Yes ☒ No

Patient: ☐ One Patient ☒ All Patients

Attending Physician: All

Lab Status: ☐ Final ☐ Partial ☐ Addendum ☐ ABN

Message Level: ☐ Urgent Only

Subject	Type	From	To	DOS	Patient	Receive	Status
Transitions of Care	Transitions of Care			12/04/2018	test20141011, test20141011	12/04/2018	Unmatched Match

Search

Search Patient: Intelligent Search Go

0 Result(s) Page: 1/1

Load Patient Cancel

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

1141011, test20141011 (09/11/2001 17y Male) **DOS - 12/05/2018** **Insurance:** Close **Reference**

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** [Edit](#) | [Re-Visit](#)

☒ **Vital Signs** [Edit](#) | [Customize](#)

☒ **Review of Systems** [Edit](#) | [Re-Visit](#) | [Customize](#)

☒ **Physical Exam General** [Edit](#)

☒ **Physical Exam Detail** [Edit](#) | [Re-Visit](#)

☒ **Diagnosis Code/Procedure Code** [Edit](#) | [Re-Visit](#)

☒ **Assessment/Plan/Procedure** [Edit](#) | [Re-Visit](#)

☒ **Prescription** [Edit](#) | [Re-Visit](#)

☒ **Lab/Imaging/Letter Order** [Edit](#) | [Lab Re-Visit](#)

☒ **Diabetes Management** [Edit](#)

☒ **Risk Screening/Plan/Interventions** [Edit](#)

☒ **Mental Health Service Plan Goals** [Edit](#)

☒ **Mental Health Progress Note** [Edit](#)

☒ **Lab Result** [Edit](#)

☒ **PT Note** [Edit](#)

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 All](#)

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**

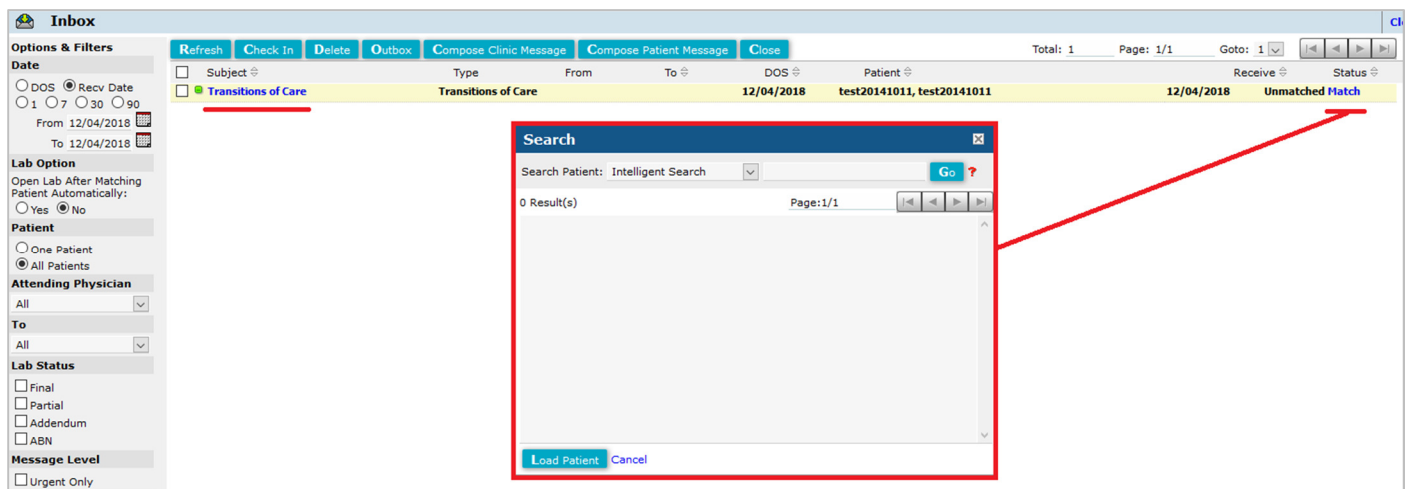
Date	CPT Code	CPT Name	Status
20141011	97813	ACUPUNCT W/STIMUL 15 MIN	Completed

[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.



The screenshot shows the MDLand Inbox interface. On the left, there are filters for Date, Lab Option, Patient, Attending Physician, To, Lab Status, and Message Level. The main area displays a table of messages. A message titled 'Transitions of Care' is highlighted. A search window is open, showing 'Search Patient: Intelligent Search' and '0 Result(s)'. A red arrow points from the 'Unmatched Match' status in the table to the search window.

Subject	Type	From	To	DOS	Patient	Receive	Status
Transitions of Care	Transitions of Care	12/04/2018	test20141011, test20141011	12/04/2018		Unmatched Match	

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

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

H, 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 |

[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](#)

Reconciliation Panel
[Refresh](#) [Save Status](#)

☒ 12/04/2018

☒ **Medication Allergy**

Substance	Reaction	Status	Date
Acetaminophen		Active	20150609

[Show Detail](#) Reconciliation Status: Incompleted ▼

☒ **Medication**

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**

Code	Problem	Status	Date
786.05	SHORTNESS OF BREATH	Active	20150801
Z00.00	"Encntr for general adult medical exam w/o abnormal	Active	20151011
493.9	Asthma	Active	20151211

[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:** **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](#)

Reconciliation Panel
[Refresh](#) [Save Status](#) [Close](#)

☒ 12/04/2018

☒ **Medication Allergy**

Substance	Reaction	Status	Date
Acetaminophen		Active	20150609

[Show Detail](#) Reconciliation Status: Incompleted ▼

☒ **Medication**

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**

Code	Problem	Status	Date
786.05	SHORTNESS OF BREATH	Active	20150803
Z00.00	"Encntr for general adult medical exam w/o abnormal	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

Reconciliation Status: Reconciled

Medication

Medication

Start Date

Status

Instructions

Fill Instructions

Modify Date

Zantac 75 75 MG TABLET [312773 RxNorm] [81421003007 NDC]

20190510

Active

2 tablets (150 mg) orally one time

20190510

Acetaminophen 500 MG TABLET [198440 RxNorm] [70000031202 NDC]

20190318

Active

2 tablets (1,000 mg) orally every 6 hours as needed

20190320

Show Detail

Reconciliation Status: Reconciled

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

2019 MU 3

26

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