Modified Stage 2 Meaningful Use:

Objective #5 – Health Information Exchange (Summary of Care)

Massachusetts Medicaid EHR Incentive Payment Program

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Today's presenter:

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Reminder

The attestation deadline for Program Year 2015 is

August 14, 2016

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Agenda

- What is Meaningful Use (MU) Objective #5 all about?
- Steps to meet MU Objective #5
  1. Do the right thing
  2. Ensure data is entered correctly
  3. Ensure data is captured correctly
  4. Ensure Certified EHR Technology (CEHRT) can report data correctly (EHR dashboard)
  5. Generate supporting documentation
  6. Retain supporting documentation
- Attesting for MU Objective #5
- Common Issues
- Questions and Answers

What is MU Objective #5 all about?

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What is MU Objective #5 all about?

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What is MU Objective #5 all about?

Health Information Exchange	
Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
Measures	The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.
Exclusion	Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.
Alternate Exclusion	Provider may claim an exclusion for the Stage 2 measure that requires the electronic transmission of a summary of care document if for an EHR reporting period in 2015, they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

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What is MU Objective #5 all about?

Health Information Exchange - Attestation Requirements

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
- THRESHOLD: The percentage must be more than 10 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.
- ALTERNATE EXCLUSION: Providers may claim an exclusion for this measure if they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

What is MU Objective #5 all about?

Health Information Exchange – Additional Information

- Only patients whose records are maintained using certified EHR technology can be included in the denominator.
- The exchange may occur before, during, or after the EHR reporting period but must take place no earlier than the start of the same calendar year as the EHR reporting period, and no later than the date of attestation.
- The referring provider must have reasonable certainty of receipt by the receiving provider.
- In cases where the providers share access to an EHR, a transition or referral may still count, as long as the referring provider creates the summary of care document using CEHRT and sends the document electronically.

Steps to meet MU Objective #5

Meeting MU Objective #5

1. Do the right thing:

Provide a summary care record whenever transitioning a patient to another setting of care or provider, or referring a patient to another provider.

Meeting MU Objective #5

2. Ensure data is entered correctly

Meeting MU Objective #5

3. Ensure data is captured correctly
   - Ensure that CEHRT is capturing all transitions of care and referrals where a summary of care record was created using CEHRT and exchanged electronically.

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Meeting MU Objective #5

4. Ensure CEHRT can report the data correctly (EHR dashboard)

   - Test EHR reports (or regularly check EHR dashboard) to ensure accuracy

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practice fusion

Home
Dashboard
Schedule
Tasks
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Messages
Reports
eRx
Labs/imaging

Reports Meaningful Use dashboard

Meaningful Use dashboard

Actions

Sophie Scheidlinger | 2015 | Stage 1 | Medicare | New custom period | Apply

CUSTOM PERIOD: 10/3/2014 to 01/01/2015

MEASURE	STATUS	GOAL	CURRENT	NUM/DEN	REPORT
1. CPOE for Medication Orders					
CPOE for Medication Orders	1 to satisfy	>30%	0%	0/0	Included
CPOE for Medication Orders (Alternate)	1 to satisfy	>30%	0%	0/0	Included
2. Drug-Drug & Drug-Allergy Interaction Checks	Incomplete	n/a	Incomplete	n/a	
3. Maintain Problem List	1 to satisfy	>80%	0%	0/0	
4. e-Prescribing	Excluded	>40%	0%	0/0	Excluded
5. Active Medication List	1 to satisfy	>80%	0%	0/0	
6. Medication Allergy List	1 to satisfy	>80%	0%	0/0	
7. Record Demographics	1 to satisfy	>50%	0%	0/0	

Menu

All measures are included in the attestation. To claim an exclusion for a measure, switch the toggle to Exclude, and select your exclusion reason.

MEASURE	STATUS	GOAL	CURRENT	NUM/DEN	REPORT
Drug Formulary Checks	Incomplete	n/a	Incomplete	n/a	Included
Clinical Lab Test Results	1 to satisfy	>40%	0%	0/0	Included

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Meeting MU Objective #5

5. Generate supporting documentation

- An EHR-generated MU dashboard or report that shows the total number of referrals and transitions of care for the selected EHR reporting period that were generated electronically using a Summary of Care Record
- Copy of one Summary of Care Record with EP's name (redact patient's name and address) that occurred before, during, or after the selected MU reporting period, but no earlier than the start of the same calendar year as the MU reporting period and no later than the date of attestation. Submit a unique record for each EP.
  - The Summary of Care record must be in human readable format and cannot be a test record. At a minimum, it must include a current problem list, current medication list, and current medication allergy list. Other patient information must be included if known, but may be left blank if such information wasn’t recorded, or there was nothing to record.

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Meeting MU Objective #5

6. Retain supporting documentation

   - Attestation purposes vs. audit purposes

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Attesting for MU Objective #5

Attesting for MU Objective #5

(*) Red asterisk indicates a required field.

Objective: The EP who transitions their patients to another setting of care or provider of care or refers their patients to another provider of care provides a summary care record for each transition of care or referral.

EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

* Does this exclusion apply to you? If 'Yes', do not complete the measure below. If 'No', complete entries in the measure below.

○ Yes ○ No

Measure: The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

Numerator: ______ **Denominator:** ______

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Common Issues

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Common Issues: Objective #5

Common Issues: Objective #5

- Ambiguity in defining a referral
- Establishing “reasonable certainty” of receipt by the receiving provider may be difficult

Questions

Questions?

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Helpful Links

- CMS 2015 Program Requirements page
- CMS 2015 Objectives and Measures – Table of Contents
- MeHI Medicaid EHR Incentive Program page
- MeHI 2015 Supporting Documentation Requirements Guide

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