MeHI
MASSACHUSETTS eHEALTH INSTITUTE
at the MassTech Collaborative

Objective 7:
Health Information Exchange (HIE)

Massachusetts Medicaid EHR Incentive Program

August 12, 2020

Today's presenters:
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MeHI
MASSACHUSETTS eHEALTH INSTITUTE
at the MassTech Collaborative

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Reminder: PY2019 Deadline

The attestation deadline for Program Year 2019 is

August 31, 2020

Agenda

- Purpose of This Webinar
- MU Objective 7: Health Information Exchange (HIE)
- Entering Data Into MAPIR
- MU Supporting Documentation: HIE
  - Supporting Documentation Examples
- Strategies and Tips for Success

Purpose of This Session

We want to help you:

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

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

- Options and strategies for meeting all of the measures for Objective 7 while minimizing potential issues
- Examples of approved HIE supporting documentation

Overview of Objective 7: Health Information Exchange

For Objective 7, the EP must:

- provide a Summary of Care (SoC) record when transitioning a patient to another setting of care (measure 1),
- receive or retrieve* a summary of care record upon receipt of a transition or upon the first encounter with a new patient (measure 2),
- and incorporate summary of care information from other providers into their EHR using the functions of CEHRT. (measure 3)

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

Objective 7: Health Information Exchange

Measure 1

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

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

Measure 2

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

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

Measure 3

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

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

Objective 7: Health Information Exchange (continued)

Exclusions

Measure 1

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

Measure 2

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

Measure 3

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

Objective 7: Health Information Exchange

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

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

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

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

Using Requests and Query HIE for Measure 2

What is Query HIE?

Expanded CEHRT functionality that allows EPs to conduct searches for Summary of Care records. Query HIE allows providers to search for (query) and retrieve patient information that was made accessible by other care providers. Query HIE is often used to support unplanned care, but it is beneficial in many instances of planned care as well.

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

What is the difference between a request and a query?

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

Using Requests and Query HIE for Measure 2

Does my EHR vendor support Query HIE?

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

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

Using Requests and Query HIE for Measure 2

How can requests and queries help me meet Measure 2?

If you receive an electronic Summary of Care in response to a request* and/or a query** and incorporate the Summary of Care into your EHR:	If you make a request and conduct a query but don't receive an electronic Summary of Care:	If you don't have access to Query HIE, and you make a request but don't receive an electronic Summary of Care:
Your EHR will automatically add the patient to your numerator, thereby helping you meet the measure. No further action is needed.	The patient can be deducted from the Measure 2 denominator. If your EHR does not deduct these patients automatically, you can do so manually by following the instructions in the addendum to these slides.	The patient can be deducted from the Measure 2 denominator. If your EHR does not deduct these patients automatically, you can do so manually by following the instructions in the addendum to these slides.

For more information on the benefits of Query HIE, please see our Query HIE Toolkit

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

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

Entering Data Into MAPIR

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

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

Measure 1

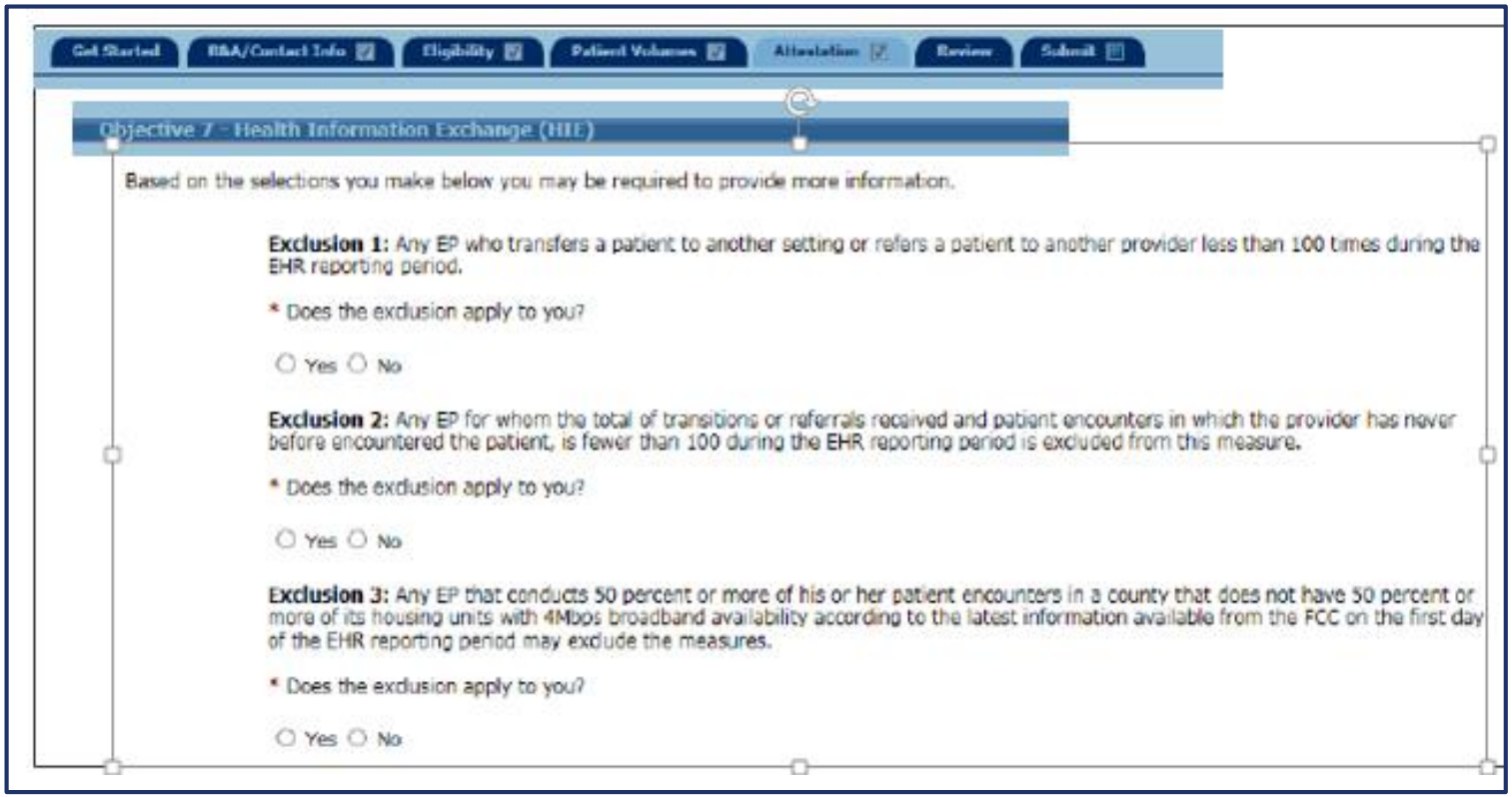
EP who transfers a patient to another setting less than 100 times during the EHR reporting period

Measure 2

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

Measure 3

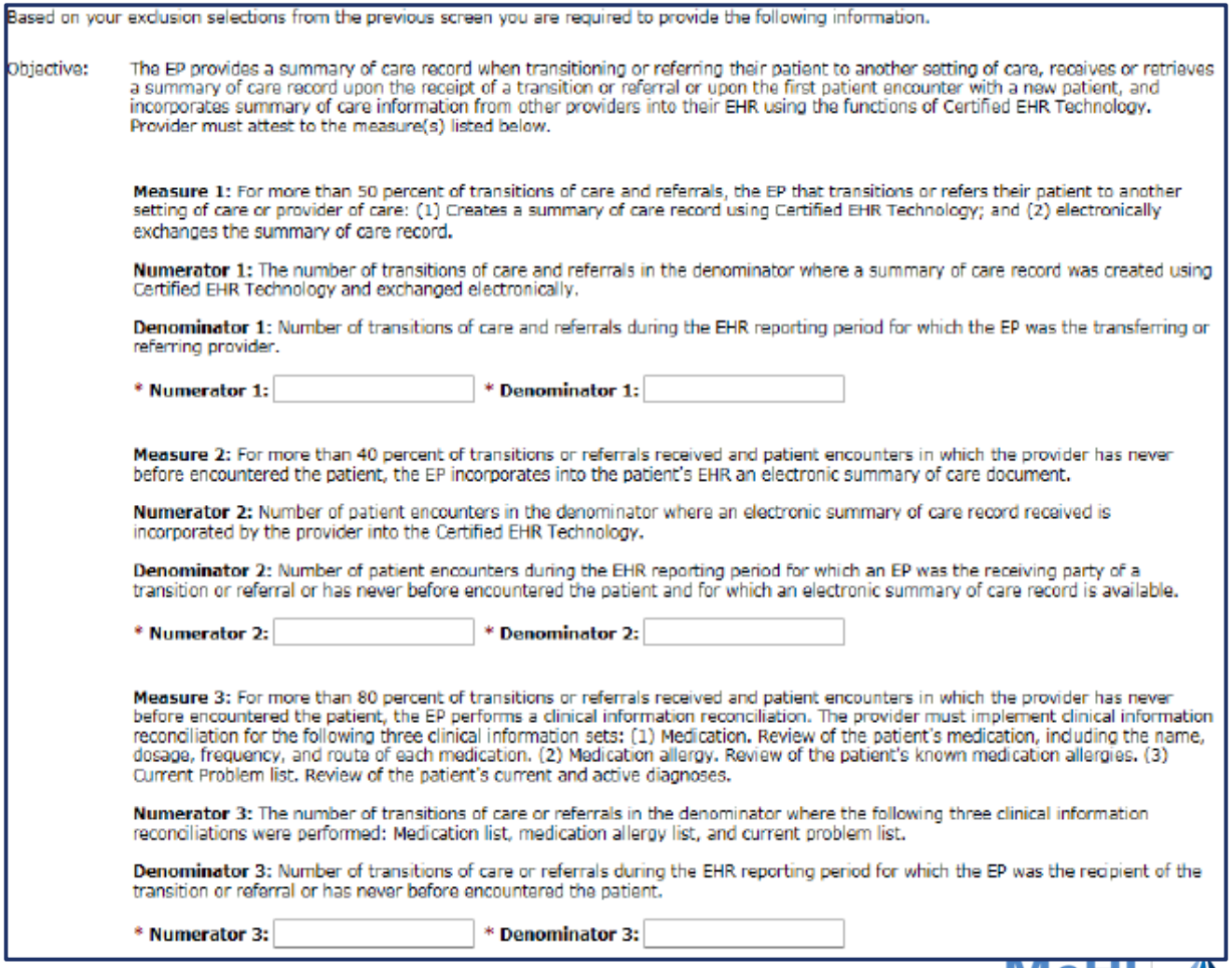
Same as Measure 2



Entering Data Into MAPIR, continued

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

MU Supporting Documentation: HIE

Upload Supporting Documentation

Measure 1: Referrals and transitions of care electronically exchanged

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

Measure 2: Electronic summary of care records received and incorporated

- EHR-generated MU Dashboard or report

Measure 3: Clinical information reconciliation

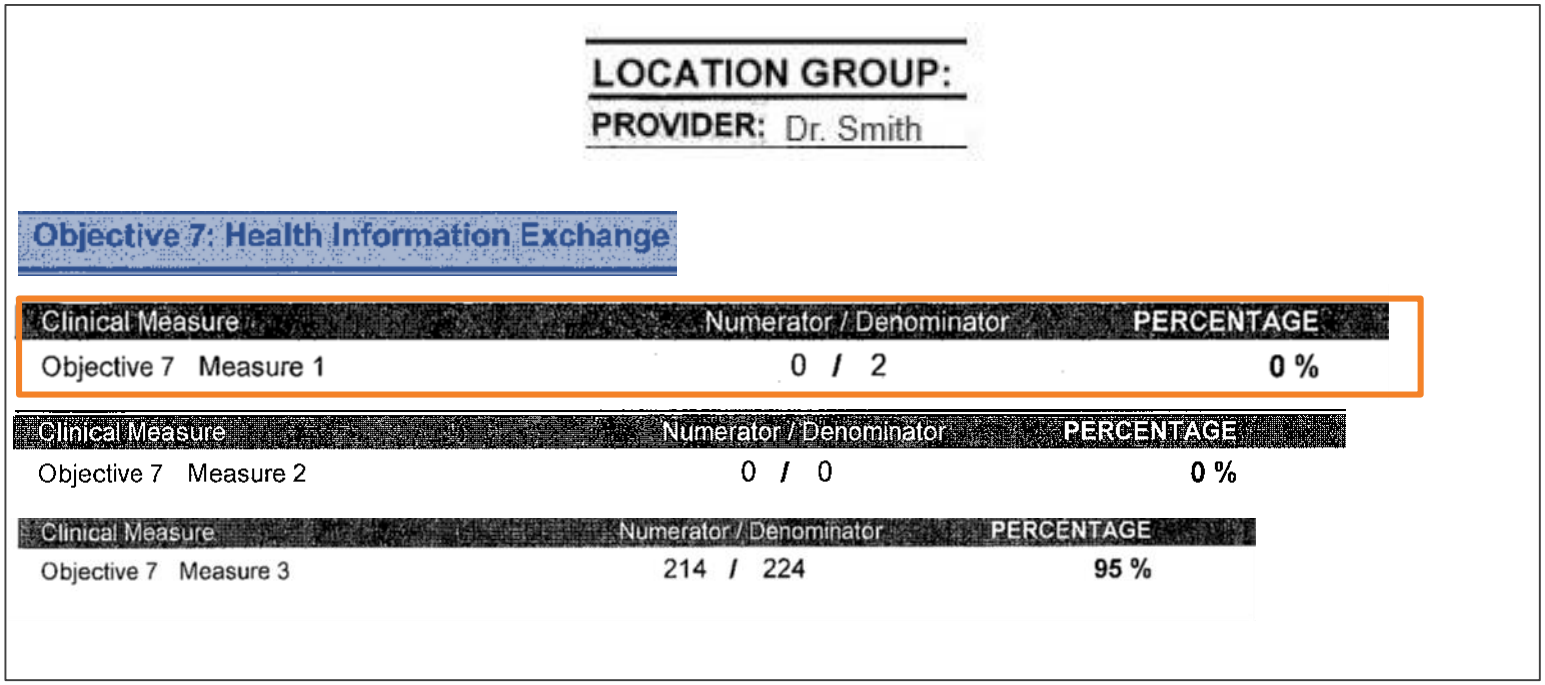
- EHR-generated MU Dashboard or report covering clinical reconciliation of medication, medication allergies and current problem list

Measure 1
Supporting Documentation Examples

Measure 1: Referrals and transitions of care electronically exchanged

EHR-generated MU Dashboard or report

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



LOCATION GROUP:

PROVIDER: Dr. Smith

Objective 7: Health Information Exchange

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

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

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

Measure 1: Confirmation of Receipt

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

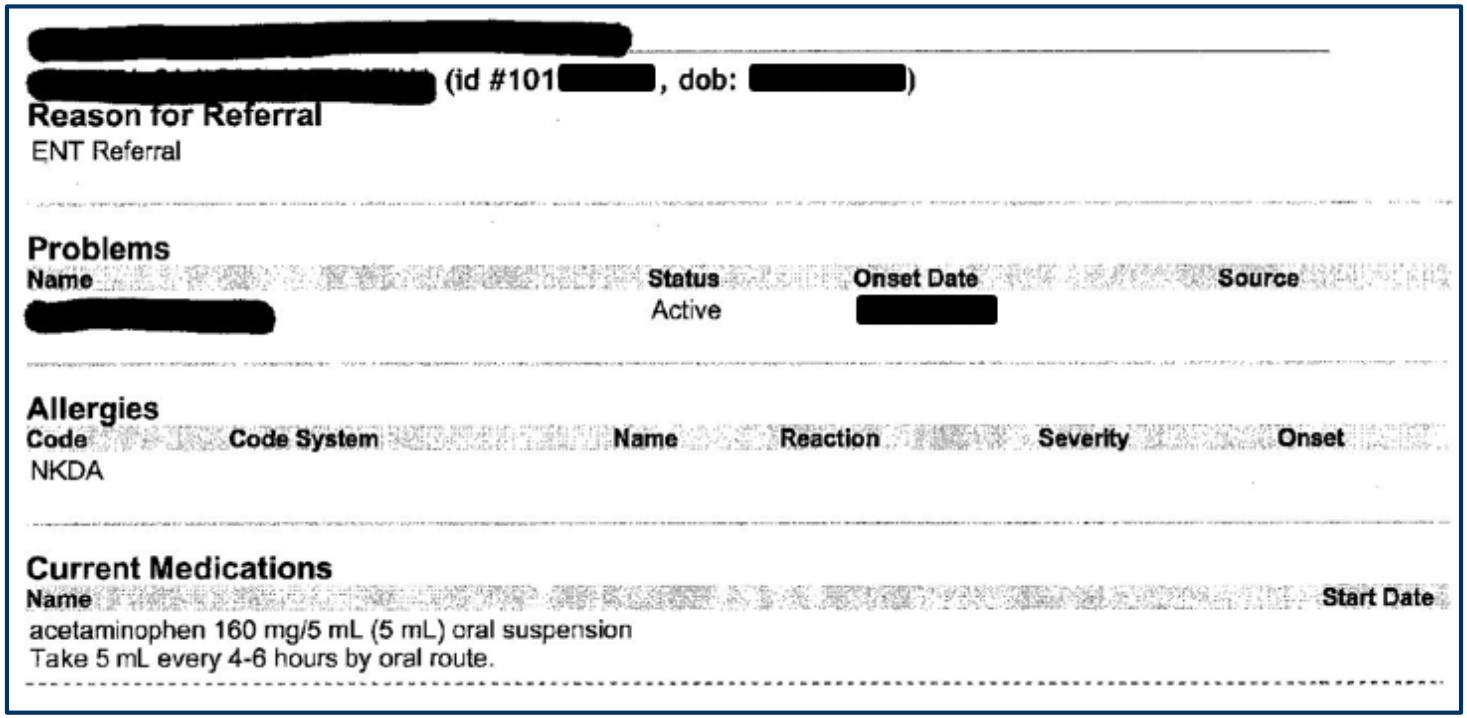
- Referring EP must have reasonable certainty of receipt of the Summary of Care record
- EPs must be able to provide additional supporting documentation to confirm the receiving provider queried the Summary of Care records counted in the numerator*
- See examples on next 5 slides

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

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

Measure 1: Copy of one unique Summary of Care record

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



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

Reason for Referral

ENT Referral

Problems

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

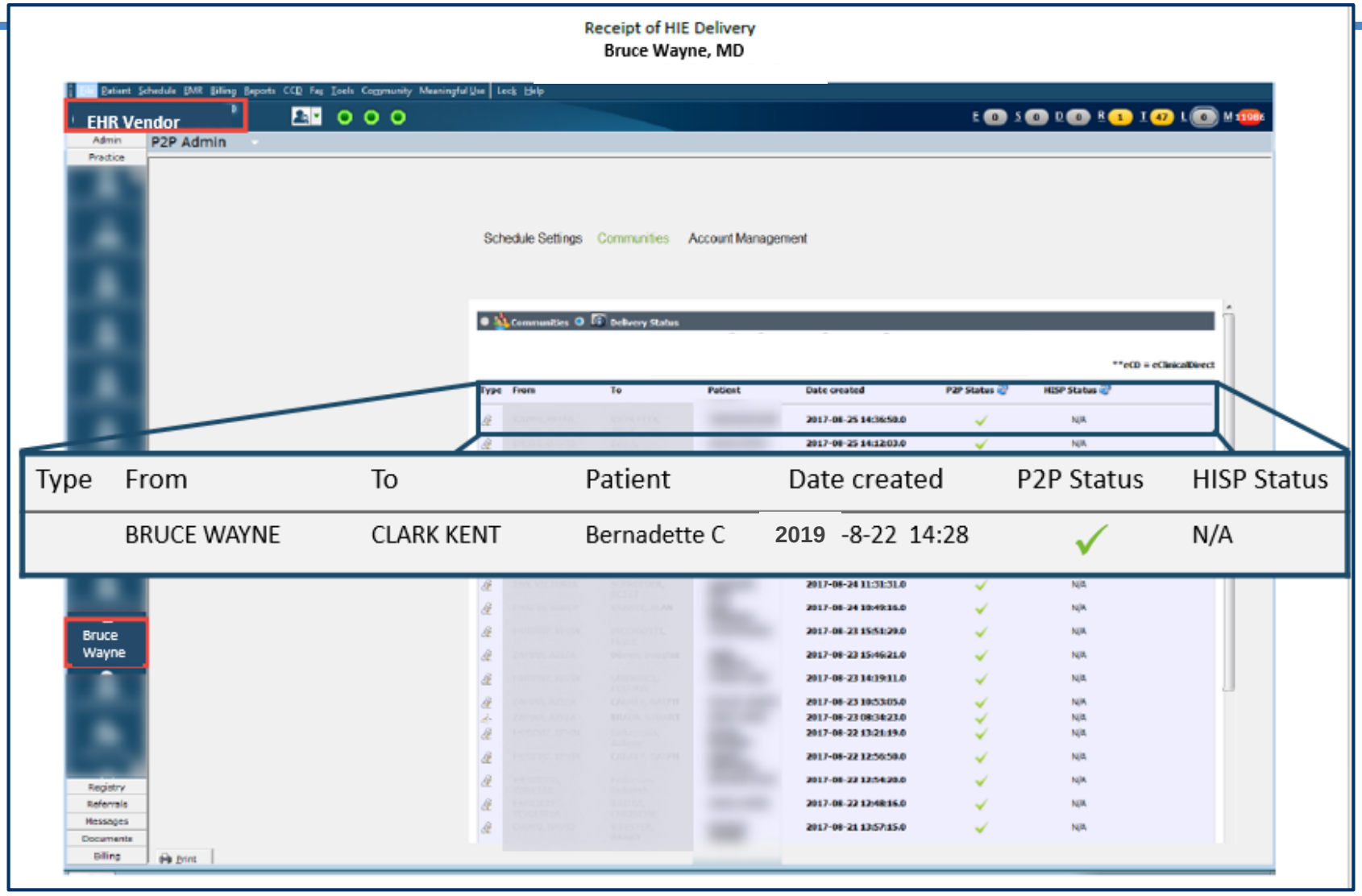
Allergies

Code	Code System	Name	Reaction	Severity	Onset
NKDA					

Current Medications

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

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



*Note: This is a fictional patient record

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

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

10/3/2019

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

Dr. Bruce Wayne
20 West Street
Hudson, MA 01749

Dear Dr. Bruce Wayne,

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

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

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

Clark Kent, MD

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

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

*Note: This is a fictional patient record

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

[redacted] (id # 12345 [redacted]

Problems

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

Allergies

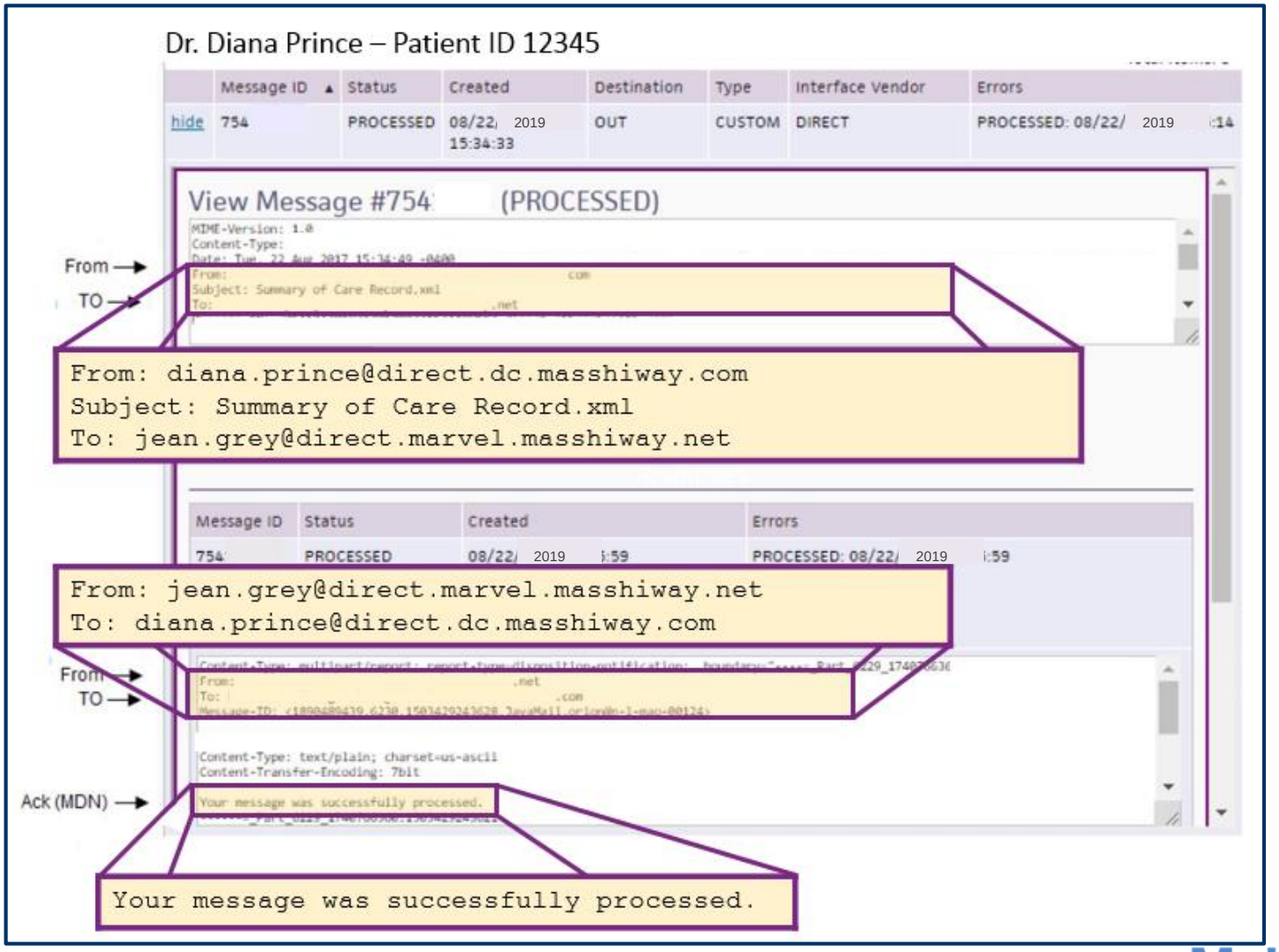
Code	Code System	Name	Reaction	Severity	Onset
NKDA					

Current Medications

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

Example 2: Confirmation of Receipt

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



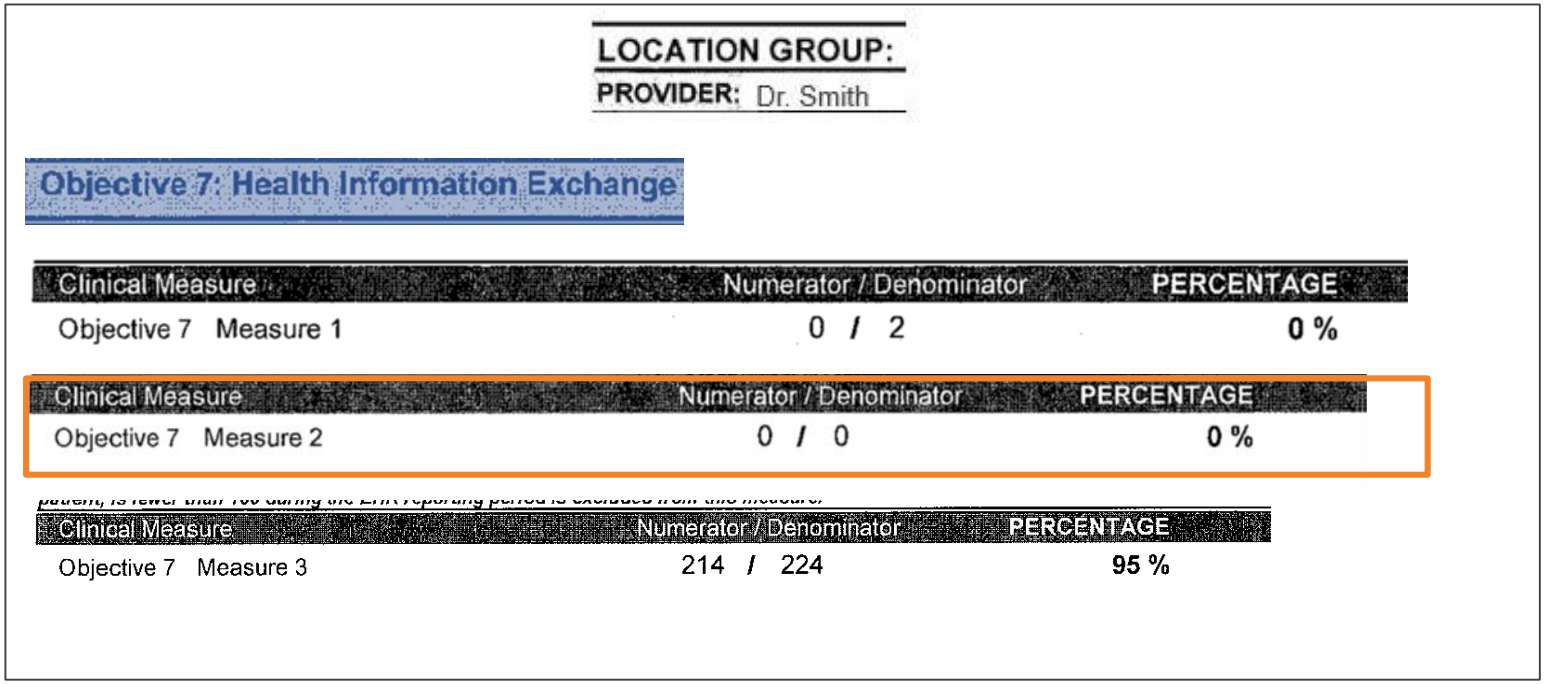
*Note: This is a fictional record

Measure 2
Supporting Documentation Examples

Measure 2: Summary of Care Records Received and Incorporated

EHR-generated MU Dashboard or report

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



LOCATION GROUP:
PROVIDER: Dr. Smith

Objective 7: Health Information Exchange

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

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

patient, is fewer than 100 during the EHR reporting period is excluded from this measure.

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

Measure 2: Summary of Care Records Received and Incorporated

Conditional supporting documentation requirements apply to EPs who:

- used Requests and Query HIE to obtain electronic Summary of Care records, AND
- manually deducted patients from the Measure 2 denominator, because the EP's MU Dashboard did not automatically exclude these patients from the denominator
- For more details, please see the addendum at the end of this presentation and the 2020 Supporting Documentation Guide in our MU Toolkit

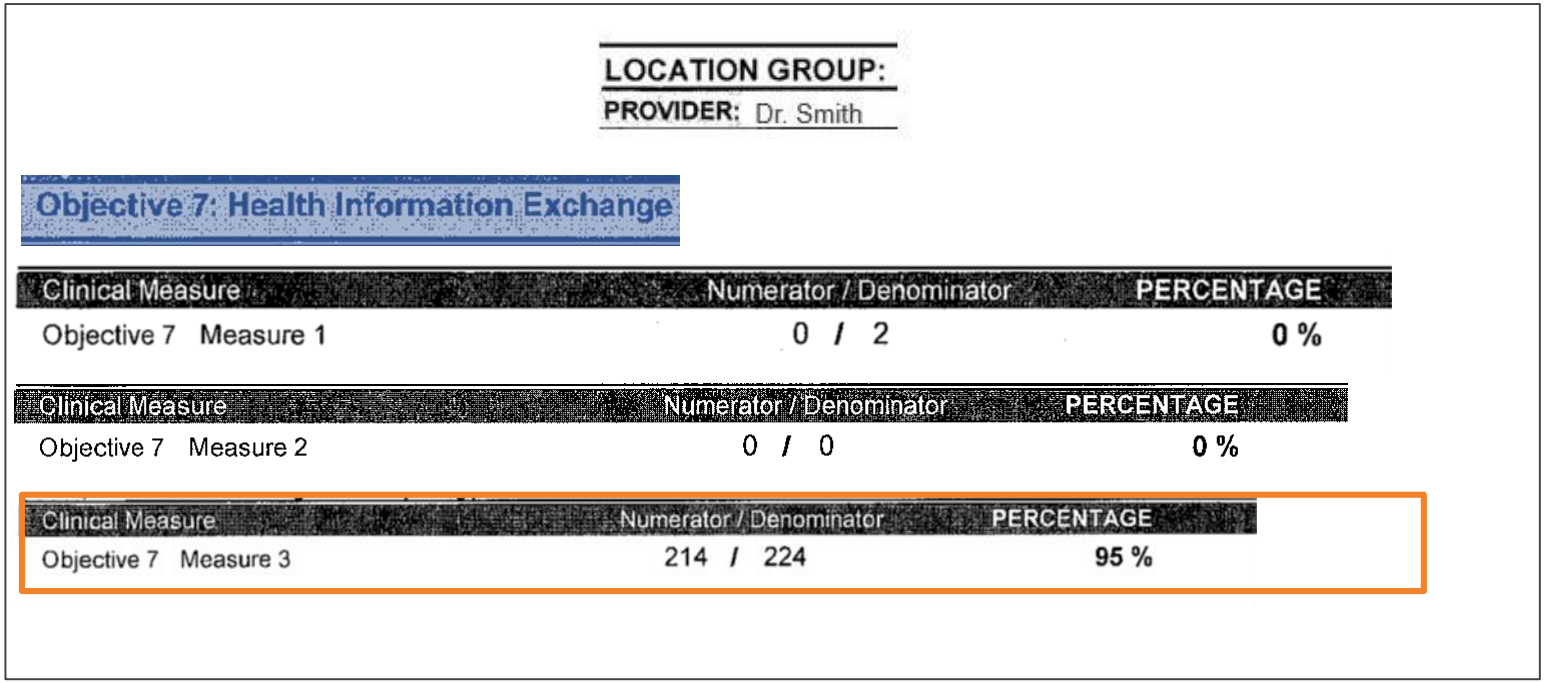
If you are using Query HIE, but your EHR automatically accounts for those patients when calculating your performance on Measure 2, you would simply enter your MU Dashboard numerator and denominator in MAPIR, and no additional supporting documentation is required.

Measure 3
Supporting Documentation Examples

Measure 3: Clinical Information Reconciliation

EHR-generated MU Dashboard or report

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



LOCATION GROUP:
PROVIDER: Dr. Smith

Objective 7: Health Information Exchange

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

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

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

Measure 3: Clinical Information Reconciliation

EHR-generated MU Dashboard or report

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

Objective 7 — Dr. Allison Jones

Measure Name		Status	Threshold	Score	Count
Send Summaries of Care	Exclusion Available: Minimum denominator	—	>50%	3.6%	1 / 28 Referrals
Incorporate Summaries of Care		✓	>40%	99.7%	254 / 255 Encounters
Clinical Information Reconciliation		✗	>80%	33.9%	88 / 260 Encounters

Measure 3 Considerations

- For Stage 2 MU, the clinical information reconciliation objective only included medications and medication allergies – the current problem list is a new component of this objective for Stage 3
- You will only get credit in your MU dashboard numerator if you performed and documented clinical information reconciliation for all three data sets:
  - Medications
  - Medication allergies
  - Current problem list
- Failure to perform and/or document reconciliation for any of the above will reduce your MU dashboard percentage for this measure

Strategies and Tips for Success

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

Strategies and Tips for Success (continued)

- Ensure the EP performs and documents clinical information reconciliation for **all three** components of Measure 3 (including the current problem list)
  - Check with your vendor to determine how your EHR calculates the Measure 3 numerator
- Contact MeHI for technical assistance with MU
- Request HIway Adoption and Utilization Support (HAUS) Services

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

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

Questions

Questions?

Contact Us

MeHI
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at the MassTech Collaborative

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ehealth@masstech.org Follow us @MassEHealth

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Project Director, Mass HIway

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(508) 870-0312 ext. 241

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Addendum

Addendum:
Supporting Documentation Requirements
for providers who use Requests & Query HIE and manually calculate their MU Denominator

Requests and Query HIE

MU Supporting Documentation if EP has query access

If the EP has access to Query HIE functionality and the EP's MU dashboard does not reflect requests and queries, the EP must upload:

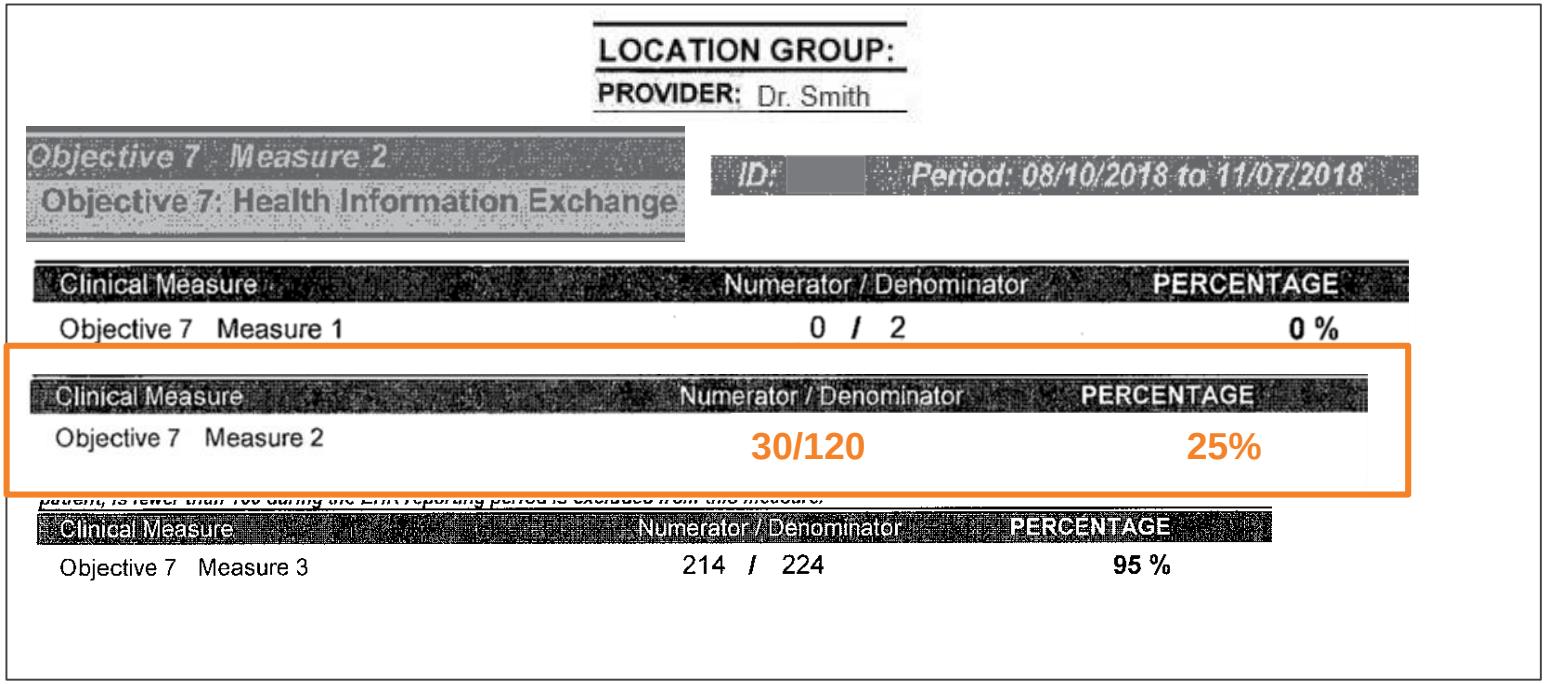
- EHR-generated MU Dashboard
- Letter signed by an authorized official (EP, Designee, Clinical/Medical Director) confirming that:
  - EP had access to Query HIE functionality that supports a query of external sources, and
  - EP's MU dashboard did not account for the patients that can be excluded
- Request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

Requests and Query HIE

MU Supporting Documentation if EP has query access

EHR-generated MU Dashboard or report

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



LOCATION GROUP:
PROVIDER: Dr. Smith

Objective 7 Measure 2
Objective 7: Health Information Exchange

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

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

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

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

Requests and Query HIE

MU Supporting Documentation if EP has query access

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

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

04/24/2019

To Whom It May Concern:

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

Sincerely,

Clark Kent, MD

Clark Kent, MD

Medical Director

Requests and Query HIE

MU Supporting Documentation if EP has query access

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

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

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

Requests and Query HIE

MU Supporting Documentation if EP does NOT have query access

If the EP does not have access to Query HIE and the EP's MU dashboard does not reflect manual requests, the EP must upload:

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

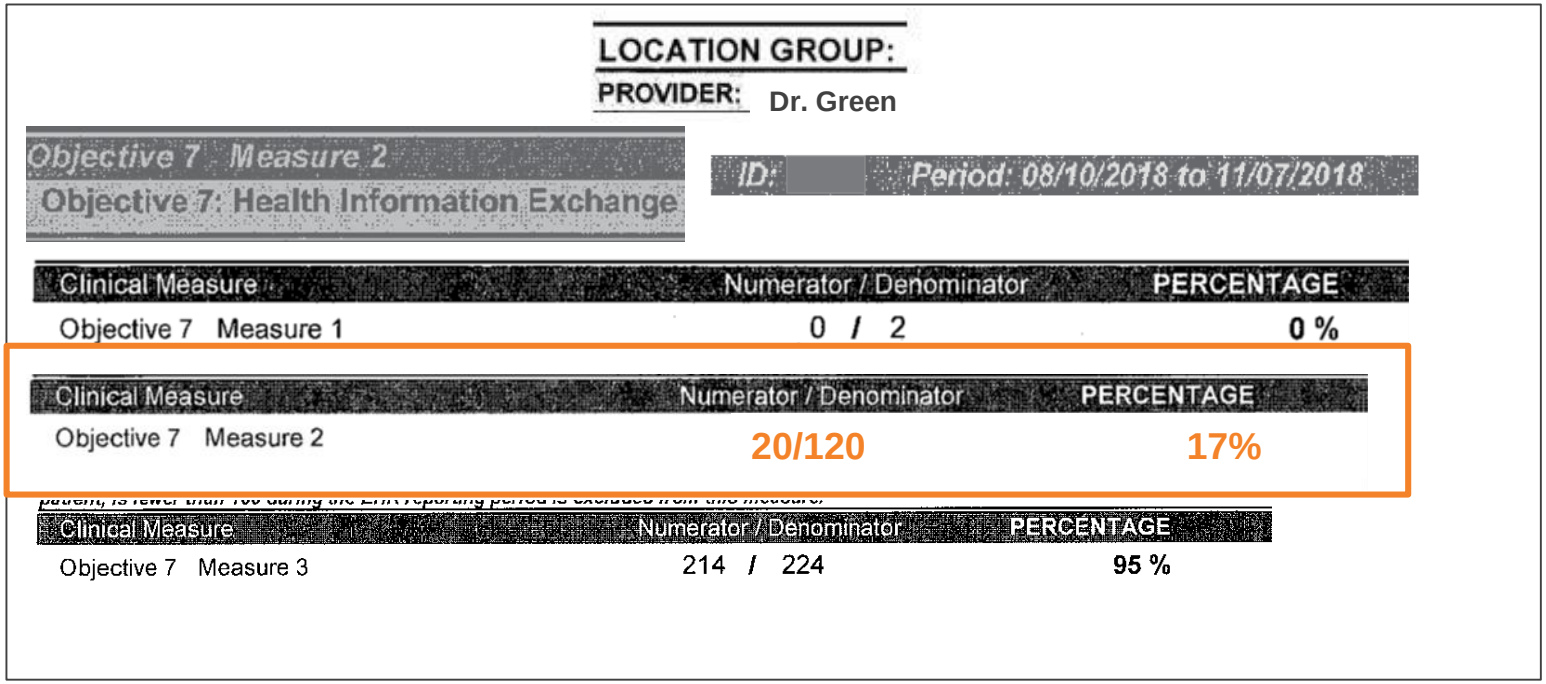
* *Note: Many 2015 Edition CEHRTs support Query HIE, either via vendor functionality or via integration of Query HIE platforms, such as Commonwell or Carequality. Not enabling the functionality does not count as "EP did not have access" nor as "not available in the EP's EHR network." Check with your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

Requests and Query HIE

MU Supporting Documentation if EP does NOT have query access

EHR-generated MU Dashboard or report

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



LOCATION GROUP:

PROVIDER: Dr. Green

Objective 7 Measure 2

Objective 7: Health Information Exchange

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

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

Requests and Query HIE

MU Supporting Documentation if EP does NOT have query access

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

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

04/24/2019

To Whom It May Concern

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

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

MeHI MASSACHUSETTS eHEALTH INSTITUTE at the MassTech Collaborative

Requests and Query HIE

MU Supporting Documentation if EP does NOT have query access

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

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

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