



2024 Workflow Workshop Webinar Series

Promoting Interoperability
Health Information Exchange:
Receive & Reconcile



Agenda

Support Electronic Referral Loops by Receiving and Reconciling Health Information:

- Measure Overview
-
- Measure Specifications
-
- Measure Special Considerations
-
- Recommended Workflow
-

HIE – Receive & Reconcile

Measure Overview

HIE – Receive & Reconcile	
Description	<p>For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for:</p> <ol style="list-style-type: none"> 1) medication 2) medication allergy 3) current problem list
Exclusion	<p>Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period</p>
Points Available	Up to 15 Points

Measure Specifications

<u>Denominator</u>	<u>Numerator</u>
<ul style="list-style-type: none"> • Number of electronic summary of care records received using CEHRT for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, and for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient • QP Translation: A patient will only pull into the denominator if a Summary of Care record is received electronically, and the Transition Into Care checkbox is marked, or if the patient is a new patient 	<ul style="list-style-type: none"> • The number of electronic summary of care records in the Denominator for which clinical information reconciliation is completed using CEHRT for the following three clinical information sets: <ul style="list-style-type: none"> ○ Medication: Review of the patient's medication, including the name, dosage frequency, and route of each medication ○ Medication allergy: Review of the patient's known medication allergies ○ Current Problem List: Review of the patient's current and active diagnoses

Special Note: For a complete list of qualifying encounters, please reference the measure papers

Measure Special Considerations

In order to receive credit for this measure, the following items must be documented and then reconciled for the patient:

- ✓ Medications
- ✓ Medication Allergies
- ✓ Problems

Even if a patient does not have any, an indication of none must still be documented, and then reconciled

QP Tip: It is recommended to complete the reconciliation workflow, regardless of whether a CCD is attached to the patient's visit

Failure to be on NextGen 6.2021 or higher will result in a 0 on the Promoting Interoperability Category and have a significant negative impact on your practice's overall MIPS score.

Manual Reconciliation Workflow

Manual Medication Reconciliation Workflow

1. Open the **Intake** template
2. Scroll to Medications
3. Select Reconcile

The screenshot displays the 'Intake' template in a clinical system. The navigation bar at the top shows 'Intake' as the active tab, highlighted with a red circle 1. Below the navigation bar, there are tabs for 'Care Guidelines', 'Global Days', and 'Clinical Trial'. A 'Panel Control' section includes 'Toggle', 'Cycle', and 'View Appointment' buttons. A list of sections includes 'General', 'Reason for Visit', 'History Summary', 'Vital Signs', and 'Medications' (marked with a red circle 2). Below the 'Medications' section, there are checkboxes for 'Patient status: Summary of care received', 'No medications this encounter', and 'Medications reconciled'. A table with columns 'Medication' and 'Sig Description' is visible. At the bottom right, there are 'Add/Update' and 'Reconcile' buttons (marked with a red circle 3).

Note: Selecting the Summary of Care Received checkbox will **not** count towards the measure

Manual Medication Reconciliation Workflow

4. Select either the “Review – adherence” checkbox (you would have to select each medication from the list) OR you may select “Review All – Taken As Directed”

Medication Review

How to conduct a medication review: ⓘ

Panel Control: Toggle Cycle

Reconciliation Type

Manual reconciliation: ☐ Manual medication reconciliation completed

Electronic reconciliation: **Electronic Reconciliation**

Medication Module

Medication Review

To move items from the Medication List to Medication Review, select the checkbox and click individual grid rows, or “Review All - Taken As Directed” button.

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Medication List ☒ Review - adherence: taking as directed

Medication	Sig Desc	Last Refilled
amoxicillin 250 mg/5 mL oral suspension	chew box by dental route every 4 mornings for Anxiety	

Or

Go to Medication Module above to add/edit medication list

Medication Review

Adherence	Medication Name	Sig Desc	Start Date	Stop Date	Rx Else	Last Refilled	Status

Medication: Sig desc: Adherence:

OK Cancel

Manual Medication Reconciliation Workflow

5. If the patient is considered a transition into care, select the “Transitioning Into Care” checkbox
6. Click “OK” to close the pop-up

Medication Review

Reconciliation Type

Manual reconciliation: ☐ Manual medication reconciliation completed

Electronic reconciliation:

Medication Module

Medication Review

To move items from the Medication List to Medication Review, select the checkbox and click individual grid rows, or "Review All - Taken As Directed" button.

Medication List ☒ Review - adherence: taking as directed


Medication	Sig Desc	Last Refilled
amoxicillin 250 mg/5 mL oral suspension	chew box by dental route every 4 mornings for Anxiety	

Go to Medication Module above to add/edit medication list.

Medication Review

Adherence	Medication Name	Sig Desc	Start Date	Stop Date	Rx Else	Last Refilled	Status

Medication: Sig desc: Adherence:

Patient status: ☒ **Transitioning into care** ☐ Summary of care received  Transitioning into care checkbox can only be unchecked on the [Transitioning Into Care](#) template.

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Manual Medication Reconciliation Workflow

7. Confirm the “Medications Reconciled” checkbox has been marked

Intake Histories SOAP Finalize Checkout

Care Guidelines | Global Days

Panel Control:

☐ Record contains substance use disorder information

General Reason for Visit History Summary Vital Signs Medications

Patient status: ☐ Summary of care received ☒ No medications this encounter ☒ Medications reconciled

Medication	Sig Description

Add/Update Reconcile

Special Note: If a patient has no medications, you must select the “No Medications” *and* “**Medications Reconciled**” checkbox

Manual Allergies Reconciliation Workflow

1. Open the **Intake** template
2. Scroll to Allergies
3. Verify with the patient that medication allergies are accurate, then select the applicable checkbox

1 Intake Histories SOAP Finalize Checkout

Care Guidelines | Global Days

Panel Control: Toggle Cycle

☐ Record contains substance use disorder information

General Reason for Visit History Summary Vital Signs Medications Allergies 2

Comment ☒ No known allergies ☐ Reviewed, updated 3 ☐ Reviewed, no changes

Allergen	Reaction (Severity)	Medication Name	Comment
NO KNOWN ALLERGIES			

Add Update

Special Note: If a patient has no known allergies, you must select the “No known allergies” *and* “Reviewed, updated” or “Reviewed, no changes”

Manual Problems Reconciliation Workflow

1. From the Home Page, Histories, or SOAP Template, navigate to the Problems List
2. Select the “Reviewed” checkbox

Special Note: If a patient has no active problems, you must select the “No active problems” **and** the “Reviewed” checkbox

Navigation: Home | Intake | **1 Histories** | SOAP | Finalize | Checkout

Panel Control: Toggle | Cycle

Problem List **2** **3** ☒ Reviewed

Select a problem to edit or click in the problem description to add a new problem

☐ Show chronic ☐ Show my tracked problems Sort Data Grid by:

☐ Active Only ☐ Include Resolved ☐ No active problems

Last Addressed	Problem Description	Note	Onset Date	Chronic	Tracked	Se
04/02/2024	Hypertension		03/20/2024	N	Y	N
04/02/2024	Urinary bladder incontinence		04/09/2024	N	Y	N
04/02/2024	Sacral back pain			Y	N	N

Fully Specified SNOMED Description: Clinical Status: Side: Site:

Problem Description: Onset Date: Resolved Date:

☐ Secondary Condition ☐ Mark as Chronic ☐ Marked as Tracked Problem Responsible Provider:

ICD Description: ICD Code: Status:

☐ Most Recent Note by Current User ☐ Add to Today's Assessment

☐ Most Recent Note

Problem Notes:

How to Add Problems

How to Add Problems

1. Open the SOAP template
2. Navigate to Assessment/Plan
3. Select “Assessments” to launch the pop up

The screenshot displays the HIE SOAP template interface. The top navigation bar includes tabs for Intake, Histories, SOAP (highlighted with a red circle and '1'), Finalize, and Checkout. Below this, a secondary bar contains links for Standing Orders, Immunizations, Radiology, Labs, Joint Injection, Order Management, RHE ScoreCard, and Outcomes. A 'Care Guidelines' section shows 'Global Days' and 'Clinical Trial' buttons. A 'Default Provider' dropdown is set to 'Unassigned', and a 'Panel Control' section includes 'Toggle', 'Cycle', and other icons. A 'Quick Note' section has 'Apply', 'Save', and 'View Appointment' buttons, along with a checkbox for 'Record contains substance use disorder information'.

The main content area is divided into sections: Health Monitor, Labs | Diagnostics | Injections | Infusions | Communication, Reason for Visit, Review of Systems, and Vital Signs. Below these are input fields for 'MD Global', 'Patient Global', and 'Fatigue Score', with 'Add', 'Edit', and 'Remove' buttons.

The 'Physical Exam' section is expanded, showing 'Assessment/Plan' (highlighted with a red circle and '2'). A 'Dx/AP History' button is visible. Below this, a list of assessments is shown, with 'Assessments' (highlighted with a red circle and '3') selected. The list includes:

- 1. Assessment: Rheumatoid arthritis, unspecified (M06.9). Plan Orders: Benson, William -Rheumatology. Clinical information/comments: ** 03/20/2024 09:57 AM EDT: CCD sent. ** 03/20/2024 09:57 AM EDT: Message delivered to the recipient. ** 03/20/2024 10:02 AM EDT: CCD sent. ** 03/20/2024 10:02 AM EDT: Message delivered to the recipient.
- 2. Assessment: Fatigue fracture of vertebra, initial encounter for fracture (M48.40xA).
- 3. Assessment: Essential (primary) hypertension (I10).

At the bottom, there is an 'Assessment Details' section with a 'COPY FORWARD >>' button and a 'Sort by' dropdown set to 'Summary'. Other options include 'Phrase', 'My Phrases', and 'Manage My Phrases'.

How to Add Problems

4. Select the assessment from “Today’s Assessments”
5. Select the “Clinical Problems” checkbox to launch the Mapped SNOMED Code pop-up
6. Click “Add/Update”

Add or Update Assessment ×

Assessments | My Plan | A/P Details | Labs | Diagnostics | Referrals | Office Procedures | Cosign Orders

Today's Concerns/Reason For Visit Medications | Immunizations ⓘ

(Select a row from any grid to add to today's ☒ Add assessments on 1-click 0 Hcc

Billing Diagnosis History ☐ Show chronic only

HCC	Description	Code
	Low back pain	M54.5
<input checked="" type="checkbox"/>	Rheumatoid arthritis, unspecified	M06.9
<input checked="" type="checkbox"/>	Essential (primary) hypertension	I10
	Fatigue fracture of vertebra, initial encounter for fracture	M48.40xA

Clinical Problems ☐ Show chronic ☐ Show my tracked problems ☐ No active problems

Onset Date	Description
03/20/2024	Hypertension
04/09/2024	Urinary bladder incontinence
	Sacral back pain

My Favorites Favorites category All Filter

Description	Code

[Add common assessment](#) | [Diagnosis Code Lookup](#) ☐ Staff to look up diagnosis code

ICD description ICD Code Status Side Site

Impression Differential dx

☐ Mark diagnosis as chronic ☒ Add assessment ☒ Clinical problems ☐ My tracked problems ☐ My favorites 6 **Add/Update**

Today's Assessments 4

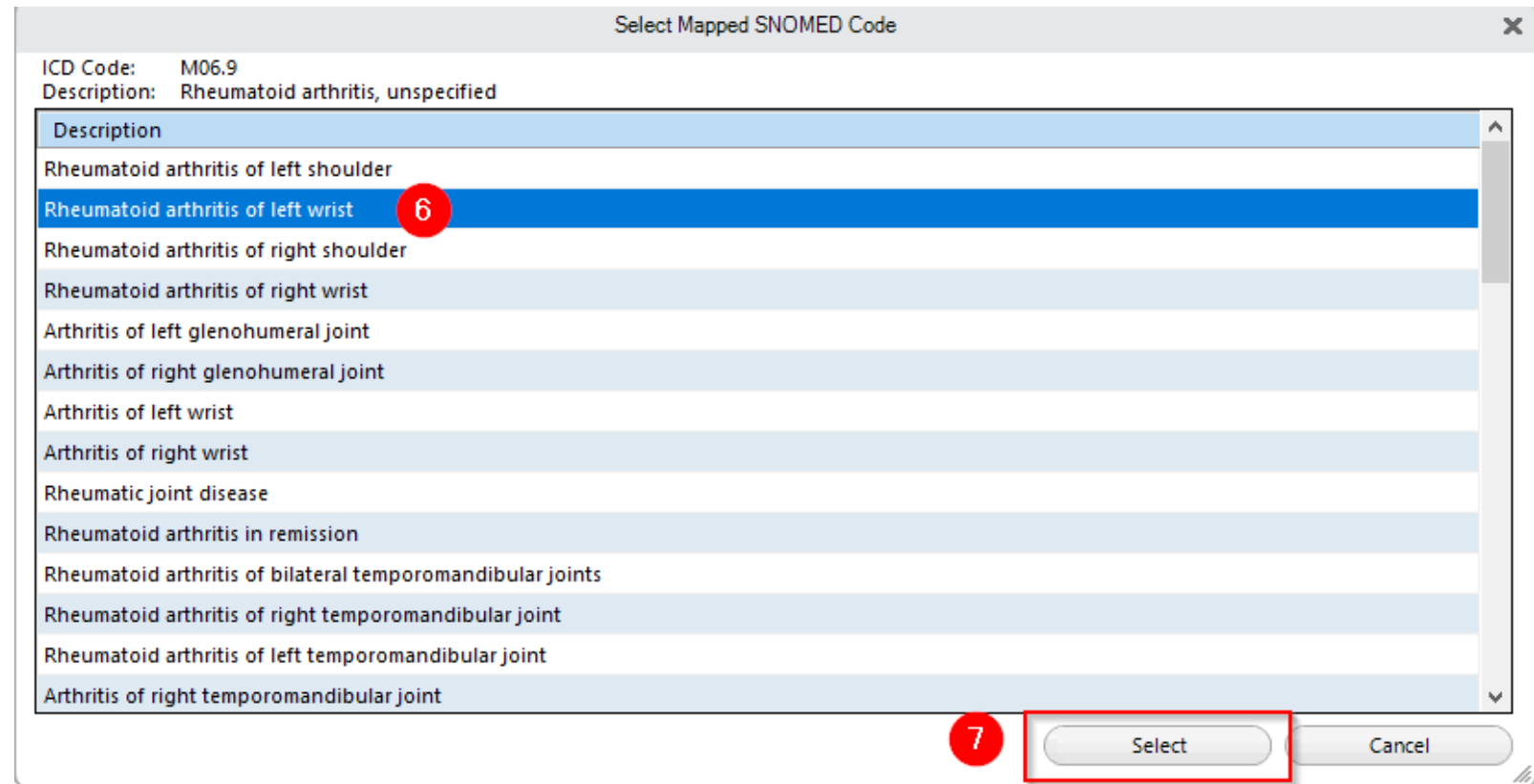
#	Dx (Code), Status, Side, Site	Impression/Differential Dx
1	Rheumatoid arthritis, unspecified (M06.9)	
2	Fatigue fracture of vertebra, initial encounter for fracture (M48.40xA)	
3	Essential (primary) hypertension (I10)	
4	Low back pain (M54.5), chronic	

Quick Task ⚙ Sort Remove Save & Close

How to Add Problems

7. From the “Select Mapped SNOMED Code” pop-up, select the appropriate description of the problem

8. Click “Select” to close the pop-up



How to Add Problems

9. Back on the Assessment pop-up, select “Add/Update”

10. Click “Save and Close” to add the selected problem description to the problems list

Add common assessment | Diagnosis Code Lookup ☐ Staff to look up diagnosis code

ICD description ICD Code Status Side Site

Impression Differential dx

☐ Mark diagnosis as chronic Add assessment to ☐ Clinical problems ☐ My tracked problems ☐ My favorites

8 **Add/Update**

Today's Assessments

#	Dx (Code), Status, Side, Site	Impression/Differential Dx
1	Rheumatoid arthritis, unspecified (M06.9)	
2	Fatigue fracture of vertebra, initial encounter for fracture (M48.40xA)	
3	Essential (primary) hypertension (I10)	
4	Low back pain (M54.5), chronic	

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Quick Task Sort Remove **Save & Close**

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