Sevocity® v.12
2018 Meaningful Use Stage 3
User Reference Guide
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Product Support Services

Sevocity offers live US-based support and ongoing web-based training free of charge for all customers.

For questions not answered in this reference guide or to schedule a personalized training session, please contact a Support Specialist at 1.877.777.2298, support@sevocity.com, or via the Contact Us option under the Help menu in Sevocity.

About Sevocity v.12

Sevocity v.12 is ONC 2015 Edition compliant and has been certified by an ONC-ACB in accordance with the applicable eligible certification criteria adopted by the Secretary of Health and Human Services. Sevocity v.12 is certified to Medicaid EHR Incentive Program Stage 3 calculation methods and supports the correlating measure-specific required tests as required by Certification Criteria 170.315(g)(2).

ONC Certified HIT® is a registered trademark of HHS.
About Meaningful Use Stage 3

Meaningful Use Stage 3 (MU 3) is the set of objectives and measures for providers attesting to their state’s Medicaid EHR Incentive Program. MU 3 consists of two types of measures: percentage-based and self-attestation. For the purposes of MU 3 reporting, percentage-based measures require a numerator, denominator, and resulting percent, and self-attestation measures require a Yes or No attestation.

Setup Requirements

To meet the measure requirements for MU 3, the clinic setup must include access to prescribe electronically using Ropia® and an activated Patient-Provider Data Exchange (PPDX) account. The ability to prescribe controlled substances is not required to meet the measures but is available in Sevocity through the activation of an EPCS GoldSM account.

Setup requirements for the Public Health and Clinical Data Registry Reporting objective are detailed in the measure workflow where applicable. Contact Sevocity Support to verify clinic setup options or to request setup of these features.

About This Guide

The 2018 Meaningful Use Stage 3 User Reference Guide has been developed to assist Sevocity users with meeting MU 3 objectives and measures. The steps recommended in this guide are designed to meet the MU 3 measure requirements, although there may be other workflows in Sevocity capable of meeting the measures. The information contained herein is based on the 2015 EHR Incentive Programs final rule and is subject to change.

This guide is designed as a supplemental resource and is not a substitute for the program eligibility and requirements provided by CMS. For full program requirements, refer to CMS’s EHR Incentive website: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms

Terms and Definitions

Terminology used throughout this guide is specific to the language and function of Sevocity within the scope of the topic presented.

Eligible Professional (EP): Sevocity user with an NPI and an Access Level of Full Chart Level

Reporting Period: Date range selected in the current calendar year for which the 2018 Meaningful Use Stage 3 report will be queried

Patient Seen/Seen: A patient having one or more of the following encounters that is finalized by an Eligible Clinician: Multi-System, Exam, Procedure, Initial OB Visit, OB Follow Up Visit, Postpartum Visit, or Urgent Care

Icons Used

🔗 Recommended workflow
🔗 System setup
🔗 Workflow tip
Objective 1: Protect Patient Health Information

Objective: Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.

Measure: 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.

Reporting: EPs must attest YES to conducting or reviewing a security risk analysis and implementing security updates as necessary and correcting identified security deficiencies to meet this measure.

The following Security Administrator tools and reports are available in Sevocity and can be used as part of a security risk analysis:

Tools
Go to Tools > Security Administration to access the following tools:

Security Settings: Configure the length and strength of user passwords and set the number of failed log in attempts that can be performed before imposing a waiting period before a log in can be attempted again or blocking a user from accessing Sevocity.

This tool also allows the Security Administrator to specify the amount of time after which a user will be automatically logged out of the system due to no activity.

Auditabe Events: Configure the types of events to be captured in the Auditable Events Report.

Reports
Go to Reports > Open Reporting Tool... to access the following reports:

Auditabe Events Report: Displays a list of all activity that has been created or modified by a user.

PHI Export Report: Displays a list of all patient health information that has been exported or printed by a user.

Security Audit: Displays a list of all activity for a selected user.

Clinic Administrators can also use the Access reports to view chart access activity by user or per patient. Go to Reports > Access > Chart Access or User Access... to run these reports.
Additional Information

- A security risk analysis must be conducted at least once each calendar year.
- The security risk analysis may be conducted outside the reporting period, but the analysis must be unique for each reporting period.
- Additional guidance on conducting a security risk analysis in accordance with the HIPAA Security Rule can be located here: https://www.hhs.gov/hipaa/professionals/security/guidance/guidance-risk-analysis/index.html
### Objective 2: Electronic Prescribing (eRx)

**Objective:** Generate and transmit permissible prescriptions electronically (eRx).

<table>
<thead>
<tr>
<th>Measure</th>
<th>More than 60 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.</td>
</tr>
<tr>
<td>Numerator</td>
<td>The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.</td>
</tr>
</tbody>
</table>
| Exclusion | Any EP who:  
- Writes fewer than 100 permissible prescriptions during the EHR 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 EHR reporting period. |

**Denominator**  
To be included in the denominator:  
- Patient must have a prescription for a drug created in Rcopia during the reporting period  
  **OR**  
- Patient must have a prescription for a controlled substance created in Rcopia during the reporting period

每个人的处方创建在 Rcopia 的确认

要去创建 Rcopia 中的处方，需要使用`Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication`。

处方 21458548548 for Vicodin (hydrocodone-acetaminophen) for Lavon Earle was created.

![PatientAdvisor](image)

确认处方创建在 Rcopia
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals

Objective 2: Electronic Prescribing (eRx)

**Numerator**

To be included in the numerator:

- Prescription created in Rcopia must be queried for a drug formulary during the reporting period **AND**
- Prescription created in Rcopia must be sent electronically by the EP or authorized Provider Agent on behalf of the EP during the reporting period **AND**
- Encounter in which prescription was sent must be finalized by the EP

**Note:** *Prescriptions created in Rcopia are automatically queried for a drug formulary.*

To send a prescription in Rcopia:

1. Select or create the prescription to be sent
2. Enter the Signature Password, if applicable
   a. The prescribing of a controlled substance will require a passphrase and PIN for transmission authorization
3. Click the **Send** or **Send and Print** or **Send, Signature to Follow** button

**Confirmation of prescription sent electronically in Rcopia**
### Objective 3: Clinical Decision Support

**Objective:** Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

EPs must satisfy both of the following measures in order to meet the objective.

| Measure 1 | Implement five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. |
| Measure 2 | The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. |
| Exclusion | Any EP who writes fewer than 100 medication orders during the EHR reporting period. |
| Reporting | EPs must attest YES to implementing five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period and YES to enabling and implementing the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. |

#### Measure 1

Health Guidelines and system alerts can be used as a clinical decision support tools within Sevocity. The ability to create and maintain Health Guidelines for the clinic and set alerts is available to Clinic Administrators only.

ู่To enable clinic alerts, go to Tools > Preferences > CLINIC > Alerts/Reminders/CDS

Alerts for Vitals, BMI Quality Measure, and Health Guidelines/Disease Management can be enabled in this area.

![Clinic Settings – Alerts/Reminders/CDS options](image)

**Clinic Settings – Alerts/Reminders/CDS options**
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals

Objective 3: Clinical Decision Support

To create, or edit Health Guidelines, go to Tools > Preferences > CLINIC > Health Guidelines/Disease Management > Begin Edit

To set preferences for vital sign parameters, including BMI, go to Tools > Preferences > CLINIC > Vitals Parameters

Health Guidelines for a specific patient can be viewed at the chart level by going to Chart > Health Guidelines/Disease Management > Retrieve. A list of all patients who have not met a recommended Health Guideline can be generated from the Reporting Tool by going to Reports > Health Maintenance Disease Management Reminder Lists

Users with permission to enable clinical decision support interventions can change, override, or customize a Health Guideline for a patient through the patient chart. Security Administrators can enable or disable access for individual users by going to Tools > Security Administration > Edit User and selecting or deselecting the Can Enable CDS Interventions checkbox.

Measure 2
Drug-drug and drug-allergy interaction checks are enabled in Rcopia and will display warnings when medications or allergies are updated or when a medication is prescribed.

Drug-drug interaction alert in Rcopia

Additional Information
- Drug-drug and drug-allergy interactions alerts cannot be counted as clinical decision support interventions.
## Objective 4: Computerized Provider Order Entry (CPOE)

**Objective:** Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

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

<table>
<thead>
<tr>
<th>Measure 1</th>
<th>More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of medication orders created by the EP during the EHR reporting period.</td>
</tr>
<tr>
<td>Numerator</td>
<td>The number of orders in the denominator recorded using CPOE.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure 2</th>
<th>More than 60 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of laboratory orders created by the EP during the EHR reporting period.</td>
</tr>
<tr>
<td>Numerator</td>
<td>The number of orders in the denominator recorded using CPOE.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure 3</th>
<th>More than 60 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of diagnostic imaging orders created by the EP during the EHR reporting period.</td>
</tr>
<tr>
<td>Numerator</td>
<td>The number of orders in the denominator recorded using CPOE.</td>
</tr>
</tbody>
</table>

**Exclusions**

- **Measure 1** Any EP who writes fewer than 100 medication orders during the EHR reporting period.
- **Measure 2** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.
- **Measure 3** Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.

---

### Measure 1

#### Denominator

To be included in the denominator:

- Patient must have a prescription created by or on behalf of the EP in Rcopia during the reporting period

#### Exclusions

- To create a prescription in Rcopia, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication**
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals

Objective 4: Computerized Provider Order Entry (CPOE)

Confirmation of prescription created in Rcopia

**Numerator**

To be included in the numerator:

- Patient must have a prescription created by or on behalf of the EP in Rcopia during the reporting period

A prescription can be created by following the steps outlined in the denominator.

**Measure 2**

**Denominator**

To be included in the denominator:

- Patient must have a lab order created during the reporting period AND
- EP must be the Ordering Provider for the lab order

To create a lab order, go to Encounter > Orders/Procedure > Orders/Referrals

1. Click the Add button in the Orders section
2. Select a lab order from the user Favorites list or click Search CPT Master List or Search HCPCS Master List to search for and select a lab order code
3. Select EP as the Ordering Provider
4. Click Add to create the lab order
Objective 4: Computerized Provider Order Entry (CPOE)

**Numerator**

To be included in the numerator:

- Patient must have a lab order created during the reporting period
- AND
- EP must be the Ordering Provider for the lab order

A lab order can be created by following the steps outlined in the denominator.

**Measure 3**

**Denominator**

To be included in the denominator:

- Patient must have a diagnostic imaging order created during the reporting period
- AND
- EP must be the Ordering Provider for the diagnostic imaging order

To create a diagnostic imaging order, go to **Encounter > Orders/Procedure > Orders/Referrals**

1. Click the **Add** button in the Orders section
2. Select a diagnostic imaging order from the user Favorites list or click **Search CPT Master List** to search for and select a diagnostic imaging order code
3. Select EP as the Ordering Provider
4. Click **Add** to create the diagnostic imaging order
Objective 4: Computerized Provider Order Entry (CPOE)

Diagnostic imaging order with Ordering Provider populated

**Numerator**

To be included in the numerator:

- Patient must have a diagnostic imaging order created during the reporting period
  
- **AND**
  
- EP must be the Ordering Provider for the diagnostic imaging order

A diagnostic imaging order can be created by following the steps outlined in the denominator.

**Additional Information**

- For Measure 1, the prescription created in Rcopia does not have to be sent electronically to receive numerator credit.
## Objective 5: Patient Electronic Access to Health Information

**Objective:** The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

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

| Measure 1 | 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 CEHRT. |

| Denominator | The number of unique patients seen by the EP during the EHR reporting period. |
| Numerator | The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the provider’s CEHRT. |

| Measure 2 | 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 EHR reporting period. |

| Denominator | The number of unique patients seen by the EP during the EHR reporting period. |
| Numerator | The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the EHR reporting period. |

### Exclusions

Measures 1 and 2

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 EHR 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 EHR reporting period may exclude the measure.

### Measure 1

**Denominator**

To be included in the denominator:

- Patient must be seen by the EP during the reporting period
**Numerator**

To be included in the numerator:

- Patient or patient-authorized representative must have an active patient portal account prior to the patient’s first visit during the reporting period  
  AND  
- The patient or patient-authorized representative must be provided instructions to access the patient’s health information from the patient portal using a third-party application prior to the patient’s first visit during the reporting period  
  AND  
- Encounter in which patient was seen must be finalized by the EP within 48 hours of the visit date

To enroll a patient or patient-authorized representative in the patient portal, go to **Tools > Patient Portal > Add Patient/Alternate**

Prior to creating a patient portal account for a patient-authorized representative, the representative must be added as an alternate contact in the patient’s chart. To add a patient-authorized representative as an alternate contact, go to **Chart > Demographics > Contacts > Alternate > Update**

The **Patient Portal Access** checkbox must be selected to authorize portal access for the representative.

To provide a patient or patient-authorized representative with instructions to access the patient’s health information from the patient portal using a third-party application:

1. Go to **Tools > Patient Portal > Print Patient QR Code**
2. Search for patient
3. Select patient name from search results and click **OK**
4. Instructions will be generated as a PDF  
   a. Instructions should be printed and given to the patient or patient-authorized representative

Sample patient instructions with QR code
Measure 2

Denominator
To be included in the denominator:
- Patient must be seen by the EP during the reporting period

Numerator
To be included in the numerator:
- Patient-specific educational resources must be accessed from the encounter during the calendar year
  AND
- Acknowledgement that education was provided electronically to the patient must be documented in the encounter during the calendar year

Patient-specific education resources can be accessed from the following tabs in an encounter:
- Allergies/Med Hx
- Flowsheets/Labs > Scanned/E-Labs
- Assessment
- Medications
- Plan/Disposition

To access patient-specific education resources from the Allergies/Med Hx or Medications tab:
1. Click the Infobutton next to the medication name
   OR
2. Click the medication name hyperlink

To access patient-specific education resources from the Assessments tab:
1. Click the Infobutton for the selected problem
   OR
2. Click the button in the Pt Ed column for the selected problem

To access patient-specific education resources from the Flowsheets/Labs > Scanned/E-Labs tab, click the button in the Pt Ed column for the selected lab result

To access patient-specific education resources from the Plan/Disposition tab, click the Patient Education Resources button

To document that educational resources were provided electronically to the patient:
1. Go to Encounter > Plan/Disposition
2. Select the Education provided electronically checkbox
Use of the patient portal is recommended to send education or URLs to educational resources.

**Additional Information**

- Patients seen more than once during the reporting period will only count once toward the measure.
- For Measure 1, patient portal account must be active prior to the finalization of the patient’s first encounter during the reporting period.
- For Measure 1, the steps to provide instructions to access the patient’s health information from the patient portal using a third party application must occur prior to the finalization of the patient’s first encounter during the reporting period.
- For Measure 1, if a patient is seen more than once during the reporting period, the patient must meet the numerator conditions during their first visit and all subsequent visits during the reporting period to remain in the numerator.
  - Patients who meet the numerator during their first visit but fail to meet the numerator during their second or subsequent visits during the reporting period will be removed from the numerator.
  - Patients who do not meet the numerator during their first visit are not eligible to meet the numerator during any subsequent visits during the reporting period.
- In Sevocity, 48 hours is calculated based on business days (Monday – Friday) and does not include weekend days (Saturday – Sunday).
**Objective 6: Coordination of Care through Patient Engagement**

**Objective:** Use CEHRT to engage with patients or their authorized representatives about the patient’s care.

EPs must attest to all three measures and must meet the threshold for at least two measures to meet the objective.

<table>
<thead>
<tr>
<th>Measure 1</th>
<th>For an EHR reporting period in 2018, 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)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient’s health information during the EHR reporting period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the EHR reporting period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure 2</th>
<th>For an EHR reporting period in 2018, more than 5 percent of all unique patients seen by the EP during the EHR 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the EHR reporting period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure 3</th>
<th>Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>The number of patients in the denominator for whom data from non-clinical settings, which may include patient-generated health data, is captured through the CEHRT into the patient record during the EHR reporting period.</td>
</tr>
</tbody>
</table>
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals
Objective 6: Coordination of Care through Patient Engagement

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
</table>

**Measures 1, 2, and 3**
A provider may exclude the measures if one of the following apply:
- An EP may exclude from the measure if they have no office visits during the EHR 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 EHR reporting period may exclude the measure.

**Measure 1**

**Denominator**
To be included in the denominator:
- Patient must be seen by the EP during the reporting period

**Numerator**
To be included in the numerator:
- Patient or patient-authorized representative must view or download the patient’s health information during the calendar year
  
  OR

- The patient or patient-authorized representative must transmit the patient’s health information to a third party during the calendar year
  
  OR

- Third party chosen by the patient must access the patient’s health information using Sevocity’s API for the patient portal during the calendar year

The clinic must provide the patient or patient-authorized representative with a login and temporary password for the patient portal. The clinic may also provide training to the patient or patient-authorized representative to assist in their use of the patient portal.

To provide a patient or patient-authorized representative with instructions to access the patient’s health information from the patient portal using a third-party application:
1. Go to **Tools > Patient Portal > Print Patient QR Code**
2. Search for patient
3. Select patient name from search results and click **OK**
4. Instructions will be generated as a PDF
   a. Instructions should be printed and given to the patient or patient-authorized representative
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals

Objective 6: Coordination of Care through Patient Engagement

Sample patient instructions with QR code

To view patient action taken in the portal or third-party access activity of a patient’s data, run the Patient Portal Action Log report from the Reporting Tool.

**Measure 2**

**Denominator**
To be included in the denominator:
- Patient must be seen by the EP during the reporting period

**Numerator**
To be included in the numerator:
- EP must send a message to the patient or patient-authorized representative using the patient portal during the calendar year
  OR
- EP must reply to a message received in the Patient Portal Inbox from the patient or patient-authorized representative during the calendar year

Messages can be sent using the patient portal from the following areas:
- Patient Portal Inbox
- Patient chart
- Patient encounter
- Patient Reminders tab
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals
Objective 6: Coordination of Care through Patient Engagement

To send a patient portal message from the Patient Portal Inbox:
1. Click New
2. Enter patient search criteria and click Search
3. Select the patient and click OK
4. Populate the Subject and message body fields
   a. Attachments can be included with the message
5. Click OK to send the message

To send a patient portal message from the chart:
6. Go to Chart Tools > Send Portal Message
7. Populate the Subject and message body fields
   a. Attachments can be included with the message
8. Click OK to send the message

To send a visit plan to the portal from an encounter:
1. Go to the Coding tab and click Done
2. Select the Finalize checkbox
3. Select the Export Plan to Patient Portal checkbox
4. Click Finalize
   a. Encounter must be finalized by EP

Sending a visit plan to the portal upon encounter finalization

To send a message from the Patient Reminders tab, select Portal as the reminder method when creating a patient reminder. Patient reminder message must be sent to count toward the numerator.
Objective 6: Coordination of Care through Patient Engagement

To reply to a message in the Patient Portal Inbox:
1. Select the message from the **Patient Portal Inbox** and click **Reply**
2. Type a message in the message body
   a. Attachments can be included with the message
3. Click **OK** to send the message

### Measure 3

**Denominator**
To be included in the denominator:
- Patient must be seen by the EP during the reporting period

**Numerator**
To be included in the numerator:
- Data from a non-clinical setting must be received in the Patient Portal Inbox as an attachment and stored to the patient chart during the reporting period

To store an attachment from a patient portal message:
1. Select the message from the **Patient Portal Inbox** and click **View**
2. In the message body click **Store Attachment to Chart**
3. Populate the following fields: **Type**, **Provider**, **Clinical Date**, and **Summary**
   a. Provider must be EP
4. Click **Store to Chart**

Storing patient-supplied health data to the patient chart

A message attachment can be viewed from the message body or from the Image/File Import window prior to storing to the chart.
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals
Objective 6: Coordination of Care through Patient Engagement

**Additional Information**

- Patients seen more than once during the performance period will only count once toward the measure.
- For Measure 3, the date on which the attachment is stored to the chart—*not the Clinical Date selected from the Image/File Import window*—is the date on which the numerator will be calculated.
## Objective 7: Health Information Exchange

**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 CEHRT.

EPs must attest to all three measures and must meet the threshold for at least two measures to meet the 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 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.</td>
</tr>
<tr>
<td>Numerator</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure 2</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>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.</td>
</tr>
<tr>
<td>Numerator</td>
<td>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.</td>
</tr>
</tbody>
</table>

| 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.  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>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.</td>
</tr>
<tr>
<td>Numerator</td>
<td>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.</td>
</tr>
</tbody>
</table>

| Exclusions | A provider may exclude the measures if one of the following applies:  
• 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.  
• 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 |
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals

Objective 7: Health Information Exchange

from the FCC on the first day of the EHR reporting period may exclude the measures.

**Measure 2**
A provider may exclude the measures if one of the following applies:

- 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 EHR 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 EHR reporting period may exclude the measures.

**Measure 3**
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 EHR reporting period is excluded from this measure.

---

**Measure 1**

**Denominator**
To be included in the denominator:

- Patient must have a referral documented during the reporting period
  
  OR

- Patient’s clinical summary must be sent electronically during the reporting period

To document a referral from the patient chart or patient encounter:

1. From the **Referrals** tab in the chart or the **Orders/Referrals** tab in the encounter, click **Add**
2. Populate the following sections: **Date Requested** (chart level only), **Requested By**, **Refer To**, **Reason for Referral/Notes**, and **ICD Code** or **CPT/HCPCS**
   a. Requested By must be EP
   b. Refer To must be a contact with a secure email address
3. Select the **Summary of Care Record Provided** checkbox
4. Click **Add**

To send a clinical summary electronically:

1. From the patient chart go to **Chart Tools > Send Clinical Summary**
2. Populate the mandatory fields of **User**, **To**, **Subject**, and **Message**
   a. User selected must be EP
3. **Select Summary of care record or Clinical summary from selected encounter**
   a. If **Clinical summary from selected encounter** is chosen, a patient encounter must be selected to continue sending the clinical summary. Click **Add** in the Patient Encounter section to add an encounter
   b. Lab results may be included by clicking **Add** in the Labs section and selecting the lab result(s) to be sent
4. Click **OK** to send electronically
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals
Objective 7: Health Information Exchange

Sending a clinical summary from Chart Tools

**Numerator**
To be included in the numerator:
- Patient referral must be sent electronically during the calendar year
  OR
- Patient’s clinical summary must be sent electronically during the calendar year

To send a referral electronically:
1. From the **Referrals** tab in the chart or the **Orders/Referrals** tab in the encounter, select the referral to be sent
2. Click **Send**
3. Type a **Subject** and **Message**
4. If sending from the patient chart, click **Add** in the Past Encounters section to select an encounter to send with the referral and click **OK**
   a. If sending from the encounter, the patient information from the open encounter will be included with the referral
5. Lab results may be included by clicking **Add** in the Labs section and selecting the lab result(s) to be sent
6. Click **OK** to send

A clinical summary can be sent electronically by following the steps outlined in the denominator.

**Measure 2**

**Denominator**
To be included in the denominator:
- Patient must have a clinical reconciliation of a C-CDA performed by the EP during the reporting period
Objective 7: Health Information Exchange

OR

- Patient must have a Continuity of Care Document (CCD) stored to their chart during the reporting period

**Note:** Patients with a CCD stored to their chart can only be counted toward the denominator and cannot be counted toward the numerator. Sevocity recommends performing a clinical reconciliation for all files in C-CDA format received for a patient.

To perform a clinical reconciliation using the C-CDA Reconciliation tool:
1. Go to Chart > Chart Tools > C-CDA Reconciliation or Tools > C-CDA Reconciliation...
2. Click Import to choose a C-CDA file to be reconciled
3. Select file and click Open
4. Verify patient selected matches the file chosen and select the I have verified the document belongs to the above patient checkbox
   a. If reconciling from the Tools menu, click Select to search for and select a patient, then select the verification checkbox
5. Click Next
6. Reconcile the file by selecting the checkbox(es) next to the problems, allergies, and medications to be incorporated into the patient’s chart
   a. At least one problem, allergy, or medication must be selected to complete the reconciliation
7. Click Review
8. Review the incorporated data for accuracy and click Reconcile/Sign to complete the reconciliation

To perform a clinical reconciliation from the Provider PDX Inbox:
1. Go to Provider PDX Inbox and select a message with a clinical summary
2. Click View or double-click the message to view its contents
3. From the Attachments section, select the checkbox next to the C-CDA file to be reconciled
4. Click Import
5. Click Select to search for and select a patient and select the I have verified the document belongs to the above patient checkbox
6. Click Next
7. Click Reconcile
8. Reconcile the file by selecting the checkbox(es) next to the problems, allergies, and medications to be incorporated into the patient’s chart
   a. At least one problem, allergy, or medication must be selected to complete the reconciliation
9. Click Review
10. Review the incorporated data for accuracy and click Reconcile/Sign to complete the reconciliation or click Start Reconciliation Encounter to document additional information in a Reconciliation encounter type
    a. If Start Reconciliation Encounter is selected, the encounter must be finalized by the EP

From the Attachments section of an open message, select the C-CDA file to be reconciled and click View to view the contents of the file prior to beginning a reconciliation.
Objective 7: Health Information Exchange

Reconciling a C-CDA from the patient chart

**Numerator**
To be included in the numerator:
- Patient must have a clinical reconciliation of a C-CDA performed by the EP during the reporting period

The clinical reconciliation of a C-CDA can be performed from the C-CDA Reconciliation tool or the Provider PDX Inbox using the steps outlined in the denominator.

**Measure 3**

**Denominator**
To be included in the denominator:
- Patient must be identified as a transition of care patient in an eligible encounter during the reporting period
  - Eligible encounters for this measure are: Multi-System, Exam, Urgent Care, Reconciliation, Initial OB, Visit, OB Follow Up Visit, and OB Postpartum Visit
  - Encounter must be finalized by the EP
  OR
- Patient must have a clinical reconciliation of a C-CDA performed by the EP during the reporting period
Objective 7: Health Information Exchange

To identify a patient as a transition of care patient during their visit:
1. Go to the Coding tab of the eligible encounter
2. Select the Encounter Related to Transition of Care into Clinic checkbox

To perform a clinical reconciliation using the C-CDA Reconciliation tool:
1. Go to Chart > Chart Tools > C-CDA Reconciliation or Tools > C-CDA Reconciliation...
2. Click Import to choose a C-CDA file to be reconciled
3. Select file and click Open
4. Verify patient selected matches the file chosen and select the I have verified the document belongs to the above patient checkbox
   a. If reconciling from the Tools menu, click Select to search for and select a patient, then select the verification checkbox
5. Click Next
6. Reconcile the file by selecting the checkbox(es) next to the problems, allergies, and medications to be incorporated into the patient’s chart
   a. At least one problem, allergy, or medication must be selected to complete the reconciliation
7. Click Review
8. Review the incorporated data for accuracy and click Reconcile/Sign to complete the reconciliation

To perform a clinical reconciliation from the Provider PDX Inbox:
1. Go to Provider PDX Inbox and select a message with a clinical summary
2. Click View or double-click the message to view its contents
3. From the Attachments section, select the checkbox next to the C-CDA file to be reconciled
4. Click Import
5. Click Select to search for and select a patient and select the I have verified the document belongs to the above patient checkbox
6. Click Next
7. Click Reconcile
8. Reconcile the file by selecting the checkbox(es) next to the problems, allergies, and medications to be incorporated into the patient’s chart
   a. At least one problem, allergy, or medication must be selected to complete the reconciliation
9. Click Review
10. Review the incorporated data for accuracy and click Reconcile/Sign to complete the reconciliation or click Start Reconciliation Encounter to document additional information in a Reconciliation encounter type
    a. If Start Reconciliation Encounter is selected, the encounter must be finalized by the EP

From the Attachments section of an open message, select the C-CDA file to be reconciled and click View to view the contents of the file prior to beginning a reconciliation.
Numerator
To be included in the numerator:
- Patient must have a clinical reconciliation performed in an eligible encounter in which the patient was identified as a transition of care during the reporting period
  - Eligible encounters for this measure are: Multi-System, Exam, Urgent Care, Reconciliation, Initial OB, Visit, OB Follow Up Visit, and OB Postpartum Visit
  - Encounter must be finalized by the EP
- OR
- Patient must have a clinical reconciliation of a C-CDA performed by the EP during the reporting period

To perform a clinical reconciliation from an encounter:
1. From the Allergies/Meds Hx tab, select the Allergies Reviewed checkbox
2. From the Allergies/Meds Hx tab, select the Medications Reviewed checkbox or the Patient Takes No Medications checkbox or from the Medications tab, select the Medication reconciliation performed checkbox
3. From the Assessment tab, select the No active problems checkbox or select the checkbox in the Assessed column for any active diagnosis or add a new diagnosis using the Add (Favorites) or Add (Master List) button
   a. Selecting any active diagnosis and then selecting the Inactivate or Resolve button will count toward reconciling current problems
   b. Selecting any active diagnosis and then selecting the Change button and updating and saving information in the Chronicity, Severity, Progress, Anatomical location site, or Note field will count toward reconciling current problems
   c. Selecting any active diagnosis and then selecting the Map SNO button and mapping to a SNOMED CT® code will count toward reconciling current problems

The clinical reconciliation of a C-CDA can be performed from the C-CDA Reconciliation tool or the Provider PDX Inbox using the steps outlined in the denominator.

Additional Information
- For Measure 1, the electronic transmission of the clinical summary or referral must be successful in order to count toward the numerator
  - Transmissions that are not successful will generate an “Undeliverable” message in the Provider PDX Inbox
### Objective 8: Public Health and Clinical Data Registry Reporting

**Objective:** The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

EPs must attest to at least two measures from the Public Health Reporting Objective.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure 1</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Measure 2</strong></td>
<td>Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.</td>
</tr>
<tr>
<td><strong>Measure 3</strong></td>
<td>Electronic Case Reporting: The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.</td>
</tr>
</tbody>
</table>

#### Measure 1 Exclusion

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 immunization information system during the EHR reporting period;
- Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
- Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the EHR reporting period.

#### Measure 2 Exclusion

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 EHR 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 EHR reporting period.

#### Measure 3 Exclusion

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 EHR 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 EHR reporting period; or
- Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data.
<table>
<thead>
<tr>
<th>Objective: Public Health and Clinical Data Registry Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure 4</strong> Public Health Registry Reporting: The EP is in active engagement with a public health agency to submit data to public health registries.</td>
</tr>
<tr>
<td><strong>Measure 4 Exclusion</strong></td>
</tr>
<tr>
<td>Any EP meeting at least one of the following criteria may be excluded from the public health registry reporting measure if the EP—</td>
</tr>
<tr>
<td>• Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period;</td>
</tr>
<tr>
<td>• 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 EHR reporting period; or</td>
</tr>
<tr>
<td>• Operates in a jurisdiction where no public health registry for which the EP is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.</td>
</tr>
<tr>
<td><strong>Measure 5</strong> Clinical Data Registry Reporting: The EP is in active engagement to submit data to a clinical data registry.</td>
</tr>
<tr>
<td><strong>Measure 5 Exclusion</strong></td>
</tr>
<tr>
<td>Any EP meeting at least one of the following criteria may be excluded from the clinical data registry reporting measure if the EP—</td>
</tr>
<tr>
<td>• Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period;</td>
</tr>
<tr>
<td>• 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 EHR reporting period; or</td>
</tr>
<tr>
<td>• Operates in a jurisdiction where no clinical data registry for which the EP is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure 1</strong> EPs must attest YES to being 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).</td>
</tr>
<tr>
<td><strong>Measure 2</strong> EPs must attest YES to being in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.</td>
</tr>
<tr>
<td><strong>Measure 3</strong> EPs must attest YES to being in active engagement with a public health agency to submit case reporting of reportable conditions.</td>
</tr>
<tr>
<td><strong>Measure 4</strong> EPs must attest YES to being in active engagement with a public health agency to submit data to public health registries.</td>
</tr>
<tr>
<td><strong>Measure 5</strong> EPs must attest YES to being in active engagement to submit data to a clinical data registry.</td>
</tr>
</tbody>
</table>
**Measure 1**

EPs interested in exchanging data with a public health immunization registry/immunization information system (IIS) should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

Customers who have an interface with a registry that provides history and forecast information will be able to access a patient’s immunization histories and forecasts from the patient chart or encounter.

- **Chart > Immunizations/Growth Charts > Hx/Forecast button**
- **Encounter > Immunizations > Hx/Forecast button**

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**Measure 2**

EPs interested in exchanging data with a public health agency (PHA) should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

The ability to create a syndromic surveillance data file in Sevocity is available only from the Urgent Care encounter type. Clinic Administrators can enable and disable the Urgent Care encounter type by going to **Tools > Preferences > CLINIC User > Encounter Types**.

To create and export a syndromic surveillance data file for a patient encounter:

1. From the Urgent Care encounter, click the **Syndromic Surveillance Data** button
2. Select a message type: **Registration** or **Discharge**
3. Select the patient’s **County of Residence**
4. Click **Export**
5. Create a name for the file and click **Save** to save to a local machine

The encounter data is exported as an HL7 output file that can be used for submission to a public health agency (PHA).
Meaningful Use Stage 3 Objectives and Measures for Eligible Professionals

Additional Information

Exporting a syndromic surveillance file

**Measures 3 and 4**

- EPs interested in exchanging data with a public health agency (PHA) should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

**Measure 5**

- EPs interested in exchanging data with a clinical data registry (CDR) should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

**Additional Information**

- Active engagement can be the process of moving toward sending data to a CDR, IIS, or PHA or actively sending data to a CDR, IIS, or PHA.
  - The process of moving toward sending data to a CDR, IIS, or PHA is demonstrated by a completed registration with the CDR, IIS, or PHA to submit data or by testing and validating electronic data submitted to the CDR, IIS, or PHA.
  - Registration with the CDR, IIS, or PHA must be completed within 60 days of the start of the reporting period.
- EPs in the process of moving toward sending data to a CDR, IIS, or PHA or actively sending data to a CDR, IIS, or PHA prior to the start of the reporting period may attest YES to active engagement for this measure.
- An exclusion for a measure cannot be counted toward the minimum of two measures required for attestation.
2018 MU3 Report

Sevocity’s 2018 MU3 report allows users to query their patient data to measure performance on Meaningful Use Stage 3 measures which require a numerator, denominator, and measure percent. The report can be run on demand and customized by EP, date range, and measure output.

From the Reporting Tool, go to Reports > Meaningful Use Measures > 2018 MU3

To run the report:
1. Select an EP
2. Select the reporting period for the MU3 data. The report can be run by the following date ranges:
   a. Calendar Year: will report data for the current year to date listed on the report
   b. 90 Days: will report data for a continuous 90 day period, calculated based on the From date
   c. Custom date range: will report data based on a specific date range
3. Click Generate Report to process the data for the report parameters selected

The report data will display a Numerator, Denominator, and Percent for each measure selected. Additionally, the Measure Met column indicates if the measure has met the required threshold for performance.
Click the button to generate a list of patients included in each measure. The Met Objective column will indicate if a patient met the measure requirements.

Use the Select All/Unselect All checkbox or checkboxes next to each measure to run the report for a select set of measures.