

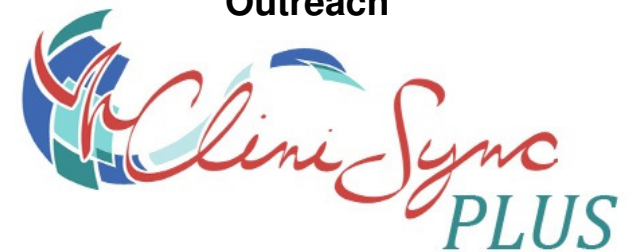
Stage 3 Meaningful Use FINAL Rule



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Your trusted advisor for Health IT

himss

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Conflicts of Interest

Cathy Costello and Scott Mash have no actual or potential conflict of interest in relation to this presentation.

Learning Objectives

1. Review the new and modified objectives and requirements for Stage 3 of Meaningful Use.
2. Discuss potential challenges providers may face in achieving Stage 3 and the planning necessary to overcome those challenges.
3. Discuss potential strategies for meeting the Stage 3 care coordination related objectives.
4. Describe the patient engagement requirements focusing on the potential provided by the new API requirement.
5. Review the variance in Stage 3 Meaningful Use and CQM reporting from 2017 to 2018.

Before we begin. . .



Stop & take a breath!

HiMSS

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MU Rules Released 10-6-15

The policy rule released on Tuesday, October 6, 2015 covers:

- 2015 and 2016 MU reporting
- 2017 transitional reporting for Stage 3
- 2018 Stage 3

The certification criteria rule was released simultaneously; criteria cover the Stage 3 upgrades. This version is referred to as “2015 Edition” CEHRT.

Timeline for MU Rules

- The MU measures for 2015 - 2016 and Stage 3 are final effective 60 days after publication.
- The policy rules for 2015-2017 MU and Stage 3-RIN 0938-AS58 (2015-2017) and RIN 0938-AS26 (Stage 3) have been combined and were formally published in the Federal Register October 16, 2015.
- The policy rule will become final effective December 15, 2015.
- The related rule, certification criteria for Stage 3, was released as a separate rule, RIN 0991-AB93. It will not become effective until 90 days after publication, January 14, 2016.
- Comments are still being sought for specific provisions for Stage 3 related to alternative payment programs.

MU Reporting Timeline for Stage 3

*Blended
Stage 1 & Stage 2
2016*

- One unified set of reporting measures with exclusions & alternate measures
- 1 year reporting

*Blended
Stage 1 & Stage 2
OR Stage 3
2017*

- A. 2015 blended measures with fewer exclusions; 1 year reporting OR
- B. Stage 3 measures; 90 day reporting

*Stage 3
2018*

- Stage 3 measures
- 1 year reporting
- CQM measures electronically reported

How MU Will Change in 2016

Blends Stage 1 & 2 into one set of measures; some exclusions & alternate measures

- 9 required EP measures + 2 public health/registry reporting measures.
- 8 required EH measures + 3 public health/registry reporting measures.
- All reporting will be 1 year
- CQM reporting:
 - **EPs:** 9 CQMs across at least 3 domains; either attestation or electronic; 365 day reporting period
 - **EHS (Subsection(d) Hospitals):** 4 CQMs submitted electronically (eCQMs) for either Q3 or Q4 through QualityNet portal
 - **CAHs:** 16 CQMs across at least 3 domains either attestation or electronic; 365 day reporting period

How MU Will Change in 2017

A. If attesting to blended Stage 1 & 2:

- Same measures as 2016; some exclusions different
- Reporting will be 1 year
- CQM reporting:
 - **EPs:** 9 CQMs across at least 3 domains; either attestation or electronic; 365 day reporting period
 - **EHS (Subsection(d) Hospitals):** 16 CQMs across at least 3 domains either attestation or electronic; 365 day reporting period
 - **CAHs:** 16 CQMs across at least 3 domains either attestation or electronic; 365 day reporting period

How MU Will Change in 2017 (cont)

B. If attesting to Stage 3:

- 7 EP measures + 2 public health/registry reporting measures
- 7 EH measures + 4 public health/registry reporting measures
- Reporting will be 90 days
- Attestation can't occur until January 2018
- CQM reporting must be for 365 days even if attesting to MU CQMs:
 - **EPs:** 9 CQMs across at least 3 domains; either attestation or electronic; 365 day reporting period
 - **EHS (Subsection(d) Hospitals):** 16 CQMs across at least 3 domains either attestation or electronic; 365 day reporting period
 - **CAHs:** 16 CQMs across at least 3 domains either attestation or electronic; 365 day reporting period

2015 - 2017



Stage 3

2015 – 2017 Measures	
1	Protect Electronic Health Information
2	Clinical Decision Support
3	Computerized Provider Order Entry (CPOE)
4	Electronic Prescribing (eRx)
5	Health Information Exchange
6	Patient-Specific Education
7	Medication Reconciliation
8	Patient Electronic Access
9	EP Secure Messaging
10	Public Health Reporting

Stage 3 Measures	
1	Protect Electronic Health Information
2	Electronic Prescribing (eRx)
3	Clinical Decision Support
4	Computerized Provider Order Entry (CPOE)
5	Patient Electronic Access
6	Coordination of Care through Patient Engagement
7	Health Information Exchange
8	Public Health & Clinical Data Registry Reporting



Meeting MU Stage 3 by Year

#	Measure or Attestation Information	2017	2018
	Reporting Period	90 days	1 year
	Certification Criteria for CEHRT	Any combination of 2014, 2015 Edition CEHRT	2015 Edition CEHRT
1	Protect Electronic Health Information	Review in calendar year prior to attestation	Review in calendar year
2	Electronic Prescribing (eRx)	>60%	>60%
3	Clinical Decision Support	5 across 4 domains	5 across 4 domains
4	CPOE	Med orders: >60% Lab orders: >60% Imaging orders: >60%	Med orders: >60% Lab orders: >60% Imaging orders: >60%
5	Patient Electronic Access	Access: >80% unique patients to portal & API Education: >35% unique pts.	Access: >80% unique patients to portal & API Education: >35% unique pts.
6	Coordination of Care through Patient Engagement	1) VDT/API: 5% 2) Secure message sent: 5% 3) Health data incorporated: 5%	1) VDT/API: 10% 2) Secure message sent: 25% 3) Health data incorporated: 5%



Meeting MU Stage 3 by Year (cont)

#	Measure or Attestation Information	2017	2018
7	Health Information Exchange	<ol style="list-style-type: none"> 1) Electronic summary of care sent: 50% 2) Incorporation of summary of care into record: 40% 3) Perform clinical information reconciliation for meds, med allergies and current problems for new patients: 80% 	<ol style="list-style-type: none"> 1) Electronic summary of care sent: 50% 2) Incorporation of summary of care into record: 40% 3) Perform clinical information reconciliation for meds, med allergies and current problems for new patients: 80%
8	Public Health & Clinical Data Registry Reporting	<p>EPs: 2 (syndromic no longer available except for urgent care)</p> <p>EHS: 4</p>	<p>EPs: 2 (syndromic no longer available except for urgent care)</p> <p>EHS: 4</p>
	CQM Reporting	2016 Annual Update; attestation or eCQM reporting; 365 day reporting period	2017 Annual Update; eCQM reporting; 365 day reporting period

Protect Patient Health Information

OBJECTIVE 1: Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

MEASURE: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements and implement security updates as necessary and correct identified security deficiencies as part of the risk management process.

Rule references Office of Civil Rights (OCR) guidance on conducting security risk analysis in accordance with HIPAA Security Rule (dated July 14, 2010) (<http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/rafinalguidancepdf.pdf>) and the ONC/OCR Security Risk Assessment (SRA) Tool: (<http://www.healthit.gov/providers-professionals/security-risk-assessment-tool>)



Protect Patient Health Information

- **More clarification on timing and content of security reviews:**
- Review needs to incorporate anticipated changes in the CEHRT system:

“We note that a security risk analysis is not a discrete item in time, but a comprehensive analysis covering the full period of time for which it is applicable.....the analysis and review are not merely episodic but should cover a span of the entire year, including a review planning for future system changes within the year or a review of prior system changes within the year.”
- If attestation period is 90 days, the period of time for security review is clarified:

“ If the EHR reporting period is 90 days, it must be completed in the same calendar year. This may occur either before or during the EHR reporting period; or, it occurs after the EHR reporting period, it must occur before the provider attests or before the end of the calendar year, whichever date comes first.”
- Security risk analysis tool (<http://www.healthit.gov/providers-professionals/security-risk-assessment-tool>) is applicable to all organizations regardless of size.

EP Electronic Prescribing (eRx)

EP OBJECTIVE 2: Generate and transmit permissible prescriptions electronically (eRx).

EP MEASURE: > 60% of all permissible prescriptions are:

- Queried for drug formulary
- Transmitted electronically

EP EXCLUSION: EP who writes < 100 prescriptions during the reporting period.

EH Electronic Prescribing (eRx)

EH OBJECTIVE 2: Hospital discharge medications for permissible prescriptions (eRx) are queried for drug formulary and transmitted electronically.

EH MEASURE: > 25% of all hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are:

- Queried for a drug formulary
- Transmitted electronically

EH EXCLUSION: No internal pharmacy that accepts eRx and no pharmacy within 10 miles accepts eRx.

Issues Raised about Electronic Prescribing of Controlled Substances (EPCS)

Role of controlled substances E-prescribing unclear in Stage 3

- The term “controlled substances” used in the proposed rule is replaced by the term “permissible prescriptions.”
- There is a significant discussion on the use of E-prescribing of Controlled Substances (EPCS) in the rule. The status changes from permitted to include them in 2015-2017 to being required to include them if it is permissible under state law (such as Ohio):

“We are modifying the denominator (for eRx) to remove this language (i.e., controlled substances). Again, we note this is only a change in wording and does not change the substance of our current policy that providers have the option, but are not required, to include prescriptions for controlled substances in the measure for Stage 3. For EHR Incentive Programs in 2015-2017, we note that inclusion of controlled substances under permissible prescriptions is optional...For Stage 3, while we intended to maintain this option, based on public comments and the progress of states toward acceptance of EPCS we are modifying this policy that the inclusion of controlled substances should be required where it is feasible to electronically prescribe the drug and where allowable by law.”

Issues Raised about Electronic Prescribing of Controlled Substances (EPCS) cont

Role of controlled substances e-prescribing unclear in Stage 3 (cont):

“Therefore, we are changing the measure for this objective to remove the language regarding controlled substances. Instead, we are adopting that under “permissible prescriptions” for the Stage 3 objective providers **must** **may** include electronic prescriptions of controlled substances in the measure where creation of an electronic prescription for the medication is feasible using CEHRT and where allowed by law for the duration of the EHR reporting period.”

- There are no corresponding certification criteria for controlled substances e-prescribing in the CMS 2015 Ed. rule.
- For more information on requirements for EPCS and available pharmacies, see: <http://surescripts.com/products-and-services/e-prescribing-of-controlled-substances>

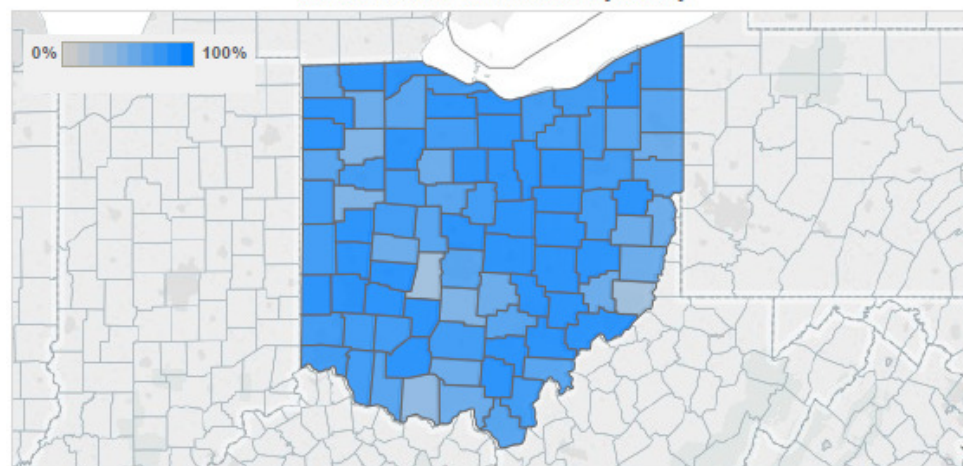
Ohio Electronic Prescribing of Controlled Substances (EPCS)

PHARMACY STATUS

month from all prescriber settings.

State	Total Pharmacies (1)	Active eRx Pharmacies (2)	EPCS Enabled Pharmacies (3)	% eRx Active Pharmacies	% EPCS Enabled Pharmacies	Total New Rx (4)	EPCS Transactions (4)
OH	2,179	2,099	1,815	96.3%	83.3%	4,786,221	43,625
National	64,048	60,674	51,880	94.7%	81.0%	104,524,184	1,351,848

%EPCS Enabled Pharmacies - By County



OH Pharmacy EPCS Enablement - September 2015

- 83% of pharmacies are EPCS enabled
- 1,815 of 2,179 community pharmacies are enabled
- 88 counties out of 88 have at least 1 enabled pharmacy

Definitions:

1. Total Pharmacies: total number of pharmacies in the country based on NCPDP data.
2. Active eRx Pharmacies: ready and processing e-prescriptions from prescribers applications.
3. EPCS Enabled Pharmacies: certified and audit approved software at prescriber, ready to receive EPCS transactions from prescribers; training may be needed.
4. Total New Rx and EPCS Transactions: Surescripts network transactions in the current month from all prescriber settings.

Clinical Decision Support

OBJECTIVE 3: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

MEASURE 1: Implement 5 clinical decision support interventions related to 4 or more CQMs at a relevant point in patient care for the entire EHR reporting period.

- Absent 4 CQMS, CDS must be related to high-priority health conditions.

MEASURE 2: Drug/Drug and Drug/Allergy interaction checking functionality enabled.

EP EXCLUSION FOR DRUG/DRUG & DRUG/ALLERGY: EP who writes < 100 medication orders during the reporting period.

Computerized Provider Order Entry

OBJECTIVE 4: Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders per state, local & professional guidelines.

MEASURE 1: > 60% of medication orders created by EP or by authorized providers of the EH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

MEASURE 2: > 60% of laboratory orders created by EP or authorized providers of hospital's inpatient or ED recorded using CPOE.

MEASURE 3: > 60% of diagnostic imaging orders created by EP or authorized providers of hospital's inpatient or ED are recorded using CPOE.

EP EXCLUSION: EP who writes < 100 med orders, < 100 lab orders or < 100 diagnostic imaging orders during the reporting period is excluded from that particular measure.

CPOE Notes on Who May Enter

- CMS defers to the provider's discretion to determine the appropriateness of the credentialing to ensure "that any staff entering orders have the clinical training and knowledge required to enter orders for CPOE."
- "We reiterate that CMS does not require any specific or general 'certification' and note that credentialing may take many forms including, but not limited to, the appropriate degree from a health training and education program from which the medical staff matriculated."
- Determination of individuals who should be permitted to do CPOE based on:
 - Organizational workflows
 - Appropriate credentialing of the staff member by an organization other than the employing organization
 - Analysis of duties performed by the staff member
 - Compliance with all applicable federal, state and local laws and professional guidelines

CPOE Expanded for Radiology Orders

“Radiology” CPOE now expanded to “diagnostic imaging” to include:

- Ultrasounds
- CT-scans
- MRIs
- and all other diagnostic imaging

Patient Electronic Access

OBJECTIVE 5: Provide patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

MEASURE 1 (Access): > 80% of unique patients seen by EP or discharged from the EH:

- Provided timely access to view, download, and transmit health information; and
- Provider ensures the patient's PHI is available to access using any application of their choice configured to meet the technical specs of the API in the provider's CEHRT

MEASURE 2 (Patient Education): For >35% of unique patients seen by EP or discharged from the EH:

- EP or EH must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials >35% of unique patients seen by EP or discharged from EH

EXCLUSIONS:

- **EP:** EP has no office visits during the reporting period
- **EP/EH:** EP conducts 50% or more of patient encounter in county with inadequate broadband connectivity or EH is located in such a county, as determined by FCC



Patient Electronic Access

“Timely Access”

- Measure does not specify the timeline for posting; the threshold appears in the language of the rule.
- The rule states that CMS is expanding the timeline for posting to the portal that was required under the proposed rule (24 hours). Now the timeline for posting is:

“We (CMS) are instead finalizing that information must be included for access within 48 hours for EPs and are retaining the current 36 hours for eligible hospitals and CAHs.”

Patient Electronic Access

“Application Programming Interfaces (APIs)”

- API is set of programming protocols
- Enables access to data through 3rd party application
- More flexible than portal; can combine data from numerous sources
- If API provides View, Download and Transmit functionality, then portal not needed separately

API Responsibility

Application:
3rd Party's responsibility

API:
Provider's responsibility



API Responsibility

- Provide list of compatible applications as provided by EHR vendor
- Provide necessary connection information

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Cancel Healthcare Application Next

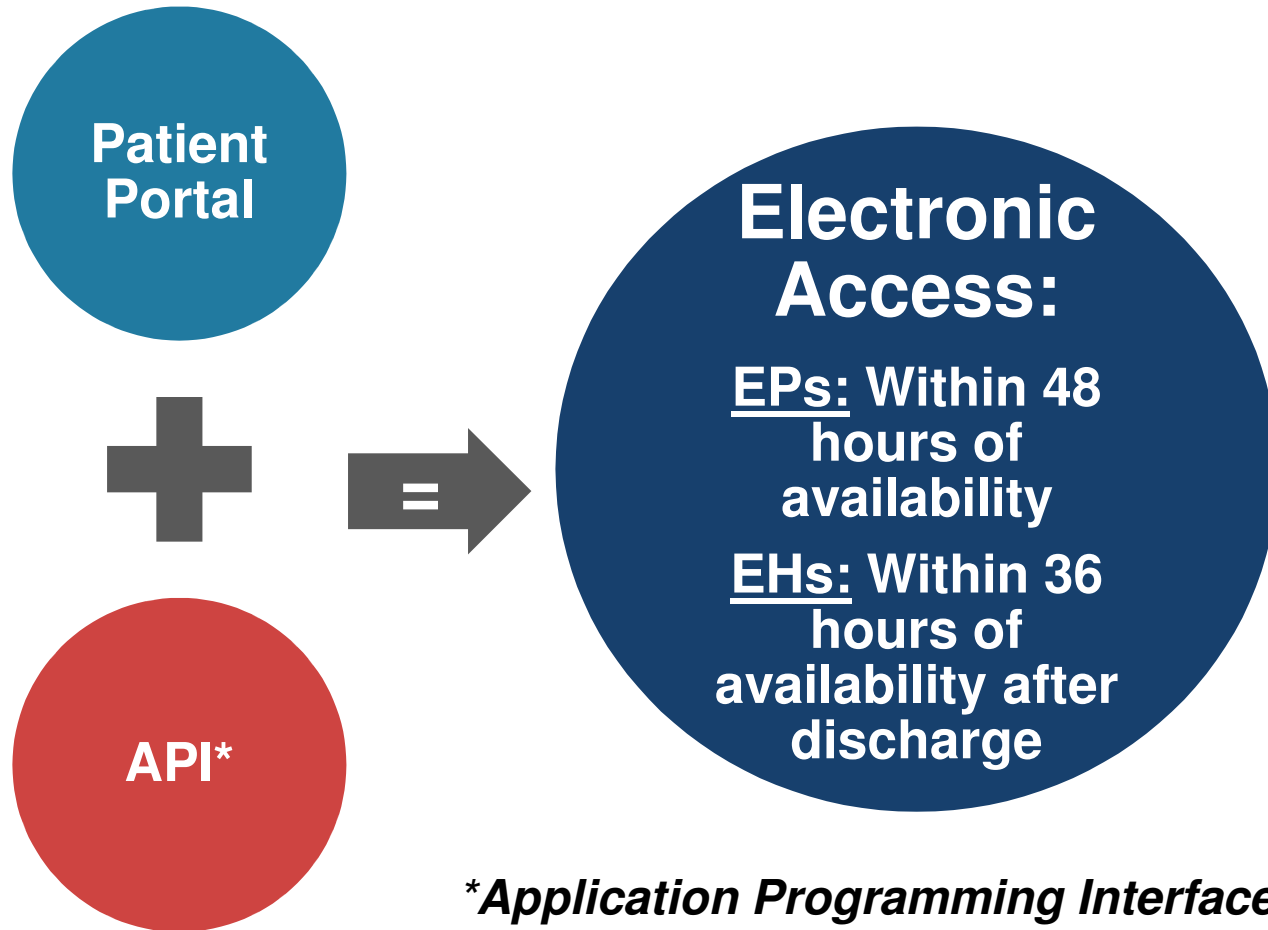
Server contacts.example.com

User Name Required

Password Required

Description My Account

Patient Electronic Access



Coordination of Care through Patient Engagement

OBJECTIVE 6: Use CEHRT to engage with patients or their authorized representative about the patient's care. Must meet threshold for 2 out of 3 measures and attest to all 3 measures.

MEASURE 1: >10% of unique patients or authorized representative either:

- View, download or transmit health info, OR
- Use patient-selected API configured to API in provider's CEHRT to access patient info, OR
- A combination of both view, download or transmit and API

2017 Threshold for Measure 1: >5% of unique patients

Measure 2: >25% of unique patients seen by EP or discharged by EH was sent a secure message through CEHRT or a secure message from patient or representative was responded to using a secure message.

2017 Threshold for Measure 2: >5% of unique patients

MEASURE 3: For >5% of unique patients, either patient-generated health data or data from a non-clinical setting is incorporated into the EHR.

EXCLUSIONS:

- **EP:** EP has no office visits during the reporting period
- **EP/EH:** EP conducts 50% or more of patient encounter in county with inadequate broadband, as determined by FCC, or hospital is located in such a county.

Coordination of Care through Patient Engagement

Measure 1: View/Download/Transmit/API

- Although EP and EH are not required to use the API as part of the threshold for Patient Engagement Measure 1, under Patient Electronic Access (Objective 5), need to have the functionality enabled and information pushing to the API as well as to the portal (if portal is also being used to meet the VDT functionality).



In 2018 it becomes 10%

To meet Stage 3 in 2017, the measure is >5% of patients view/download/transmit or use API.



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Coordination of Care through Patient Engagement

Measure 2: Secure Messaging

- Moves from patient generated e-mail to provider generated e-mail.
- Can count patient generated e-mails but only when provider responds. Not required to respond to all emails, but can only count if EP/EH does respond.
- Includes e-mails to other care team members when “the patient is engaged in the message and has the ability to be an active participant in the conversation.”



In 2018 this becomes 25%

To meet Stage 3 in 2017, the measure is >5% of patients sent an email.

HIMSS

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Coordination of Care through Patient Engagement

Measure 3: Patient-Generated Health Data/Data from a Non-Clinical Setting

A. Data Generated from a Non-Clinical Setting

- Definition: Data generated in a setting by a provider who is not an EP or EH and where provider does not have access to a shared CEHRT system.
- Examples of types of providers: Nutritionists, PTs, OTs, psychologists, home health care providers, behavioral health providers or patient.
- Types of data can include social service data, patient generated data, medical device data, home health monitoring data, and fitness monitoring data.
- Technology used to monitor chronic care is specifically mentioned.

Coordination of Care through Patient Engagement

Measure 3: Patient-Generated Health Data/Data from a Non-Clinical Setting

B. Patient-Generated Health Data (Subset of Non-Clinical Data)

- Definition: Patient self-monitoring of his/her health, either on own or under the direction of a provider.
- Can include information that patient provides remotely as opposed that gathered in the office or hospital setting (e.g., patient sends family health history or advanced directive via mail or email)
- Information must be incorporated into patient record to count, but does not have to be discrete data as long as it is attached to patient record in some manner (e.g., as attachment, a link, or a text reference). If it can be easily incorporated into an existing data field in CEHRT (e.g., demographic info, family history) provider may do so.

Health Information Exchange

OBJECTIVE 7: EP/EH must (1) provide a summary of care record when transitioning or referring the patient to another setting of care; (2) retrieve a summary of care record upon the first patient encounter with a new patient; and (3) incorporate summary of care information from other providers into their EHR. Must meet threshold for 2 out of 3 measures and attest to all 3 measures.

Health Information Exchange

Common Clinical Data Set (CCDS)

All information pertaining to Health Information Exchange is now termed part of the “Common Clinical Data Set” rather than Common MU Data Set.

- Required elements for CCDS are:
 - Demographics
 - Current problem list (can include elements of historical problem list if desired; not required)
 - Current medication list
 - Current medication allergy list
- All other fields may be left blank if information not available and still meet the summary of care requirements.
- Addition of new data items including unique device identifier (UDI) for implantable devices.
- Inclusion of data for CCDS is determined by clinical relevancy, as decided by the provider in conjunction with IT vendor.



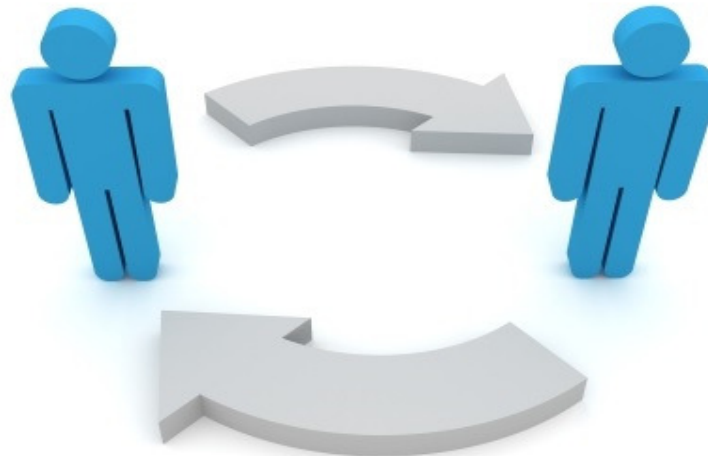
Health Information Exchange

Must Meet 2 Out of 3

50%

Data Out by:

- 1) DIRECT email
- 2) Community Health Record



Data In by:

- 1) Receipt of CCD via DIRECT email
 - 2) Query of Community Health Record
- Must incorporate pertinent results into patient's record

40%

Reconciliation



Exclusion: < 100 referrals or transitions

80%

Clinical Information Reconciliation for:

- 1) Meds
- 2) Med Allergies
- 3) Problems

Health Information Exchange

Measure 1 – Electronic Exchange of Summary of Care

OBJECTIVE 7: EP/EH must (1) provide a summary of care record when transitioning or referring the patient to another setting of care; (2) retrieve a summary of care record upon the first patient encounter with a new patient; and (3) incorporate summary of care information from other providers into their EHR. Must meet threshold for 2 out of 3 measures and attest to all 3 measures.

MEASURE 1: >50% of transitions of care and referrals, the provider that transitions or refers patient to another setting of care:

- (1) Creates a summary of care record using CEHRT; AND
- (2) Electronically exchanges the summary of care record.

MEASURE 1 EXCLUSIONS:

- **EP:** EP who has < 100 transitions of care or referrals during the reporting period
- **EP/EH:** EP conducts 50% or more of patient encounter in county with inadequate broadband, as determined by FCC, or hospital is located in such a county.



Health Information Exchange

Measure 1 – Electronic Exchange of Summary of Care

- Originally limited to EPs or EHs that (1) did not share a tax ID # and (2) did not share access to CEHRT. Now electronic exchange has been broadened to include any providers that have, at a minimum, different billing identities, e.g., different NPIs or CCN #s.
- “Some examples that would be included under this policy would be one EP sending to another EP in the same group practice, an eligible hospital sending to an EP in an ambulatory setting which shares the hospital’s EHR, or a provider sending to a non-EP practitioner who may have shared access to the EHR but whose patient encounters are not included under the referring EPs supervision.”
- Examples that would be excluded are:
 - EP referring patient to another setting but the same EP is the provider
 - Referral from one clinical setting to another within the same hospital
 - EP sending to a non-EP who is under the direct supervision of the EP
- Can tailor the CCDS to send only information deemed “clinically relevant” must maintain all data in CEHRT in case requested in the future.

Health Information Exchange

Measure 2 – Incorporation of Summary of Care in Patient Record

OBJECTIVE 7: EP/EH must (1) provide a summary of care record when transitioning or referring the patient to another setting of care; (2) retrieve a summary of care record upon the first patient encounter with a new patient; and (3) incorporate summary of care information from other providers into their EHR. Must meet threshold for 2 out of 3 measures and attest to all 3 measures.

MEASURE 2: For >40% of transitions or referrals received & provider has never before encountered patient, incorporates into EHR an electronic summary of care document from another source. If provider did not receive a CCDA for the patient then queries at least one external source via HIE functionality.

MEASURE 2 EXCLUSION: EP/EH total transitions received in which provider has never before encountered patient is < 100 during reporting period.



Health Information Exchange

Measure 2 – Incorporation of Summary of Care in Patient Record

- Patient must be a new patient or one that has transitioned back into the practice.
- No proposed limit on when a patient is considered a “new” patient.
- Can also query the Community Health Record (CHR) via the HIE for patient summary of care. If no record found, then do not count in denominator.
- Summary of care document must be consumed as discrete data elements by the CEHRT system to count, not just viewed.

Health Information Exchange

Measure 3 – Clinical Information Reconciliation

OBJECTIVE 7: EP/EH must (1) provide a summary of care record when transitioning or referring the patient to another setting of care; (2) retrieve a summary of care record upon the first patient encounter with a new patient; and (3) incorporate summary of care information from other providers into their EHR. Must meet threshold for 2 out of 3 measures and attest to all 3 measures.

MEASURE 3: >80% of transitions or referrals received & provider has never before encountered patient the provider performs a clinical information reconciliation for the following 3 clinical information sets:

- (1) Medication – review of patient’s medication including name, dosage, frequency, and route of each medication.
- (2) Medication allergy – review of patient’s known allergic medications.
- (3) Current problem list – review of the patient’s current & active diagnoses.

MEASURE 3 EXCLUSION: EP/EH total transitions received in which provider has never before encountered patient is < 100 during reporting period.

Health Information Exchange

Measure 3 – Clinical Information Reconciliation

“Clinical Information Reconciliation” is defined as the process of creating the most accurate patient-specific information in one or more categories.

- Must include reconciliation for the following 3 areas:
 1. Medication
 2. Medication allergy
 3. Current problem list

Health Information Exchange

Information can be limited in C-CDA to information that is clinically relevant, specifically:

- Lab results that best represent the patient status upon admission, any abnormal results, and patient status upon discharge.
- Provider's CEHRT must have ability to send all lab results
- If receiving provider or patient requests it, all lab results must be sent.

Public Health/Clinical Data Registry Reporting

OBJECTIVE 8: EP/EH 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.

Public Health/Clinical Data Registry Reporting

Proposed Single Objective: The EP, EH or CAH is in active engagement with a Public Health Agency (PHA) or Clinical Data Registry (CDR) 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.

Active Engagement: Includes 3 options – (1) Completed Registration of Intent to Submit Data; (2) Testing and Validation; or (3) Production. Clinical data registries must support registration of intent process.

Proposed Centralized Repository: CMS planning a repository of national, state and local PHA and CDR readiness. Public health agencies and clinical data registries **MUST** give 6 month's notice as to whether they will be ready to accept data at the beginning of the reporting period.



Public Health Measures Options

Eligible Provider (EP): Must select **2** public health/registry options

Eligible Hospital (EH/CAH): Must select **4** public health/registry options

#	Measure Description	Maximum Time Measure counts for EP	Maximum Time Measure counts for EH
1	Immunization Registry Reporting	1	1
2	Syndromic Surveillance Reporting	1 <i>(N/A except for urgent care settings)</i>	1
3	Case Reporting	1	1
4	Public Health Registry Reporting <i>Includes CDC or Cancer Registry (EP Only)</i>	2	4
5	Clinical Data Registry Reporting	2	4
6	Electronic Lab Reporting <i>(Infectious Disease)</i>	N/A	1

Public Health Exclusions*

EHs and EPs cannot take an exclusion unless available measures are less than the number required (i.e., must show that provider is excluded from all other measures).

#	Measure Description	EH/CAH Exclusions	EP Exclusions
1	Immunization Registry Reporting	Does not administer immunizations during period	Does not administer immunizations during period
2	Syndromic Surveillance Reporting	Does not have ED or Urgent Care	Not eligible to report except those in urgent care settings
3	Case Reporting	Unknown	Unknown
4	Public Health Registry Reporting <i>Includes CDC or Cancer Registry (EP Only)</i>	Does not diagnose or treat disease or condition associated with registry	Does not diagnose or treat disease or condition associated with registry
5	Clinical Data Registry Reporting	Does not diagnose or treat disease or condition associated with registry	Does not diagnose or treat disease or condition associated with registry
6	Electronic Lab Reporting <i>(Infectious Disease)</i>	Does not conduct on-site testing for any of the 13 reportable conditions	N/A

*The official ODH policy on exclusions can be found at

<http://www.odh.ohio.gov/healthstats/HIT/HIT%20and%20Meaningful%20Use.aspx>.



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Public Health Registration of Intent

- Providers that intend to meet MU public health objectives/measures must register their intent to do so with ODH.
- Registration of intent must occur by the 60th day of the provider's EHR reporting period at: www.OhioPublicHealthReporting.info
- Providers should register as entities, not individually unless multiple data feeds are necessary.
- ODH does not require EPs/EHs to re-register intent if they have registered in a prior reporting period.

Clinical Quality Reporting (EPs)

CQM reporting is finalized for 2015 and is the same as 2014 reporting:

- EPs need to report 9 CQMs across 3 domains

Type of Reporting:

- In 2015, can attest to a 90 day reporting period for CQMs
- In 2016, can attest or submit eCQMs for a 1 year reporting period
- In 2017, can either attest or submit eCQMs but must cover 1 full year of CQMs even if attesting for Stage 3 for 90 days
- In 2018, must submit eCQMs

Clinical Quality Reporting (EHs)

CQM reporting is finalized for 2015 and is the same as 2014 reporting.

If submitting electronically, submit through QualityNet Portal

Type of Reporting:

A. IPPS EHs Participating in Hospital IQR Program:

- In 2015, can attest to a 90 day reporting period for CQMs
 - 16 measures
- In 2016, must submit 1 quarter of eCQMs for either Q3 or Q4
 - 4 measures
 - Use 2014 certified measures
 - If can't report, can file for Extraordinary Circumstances Exemption (ECE)
e.g., infrastructure challenges, vendor issues

Clinical Quality Reporting (EHs) cont

CQM reporting is finalized for 2015 and is the same as 2014 reporting.

If submitting electronically, submit through QualityNet Portal

Type of Reporting:

A. IPPS EHs Participating in Hospital IQR Program (cont):

- In 2017, may attest or submit eCQMs
 - Full calendar year, even if attesting for Stage 3 for 90 days (except for new providers)
 - 2016 Annual update for CQM measures; either 2014 or 2015 Edition CEHRT
 - Report by quarter through QualityNet portal
- In 2018, must submit eCQMs 2017 annual update for CQMs; 2015 Edition CEHRT

Medicaid has the option of continuing attestation for Medicaid hospitals (i.e., Children's Hospitals) for all reporting periods.

Clinical Quality Reporting (CAHs)

CQM reporting is finalized for 2015 and is the same as 2014 reporting.

If submitting electronically, submit through QualityNet Portal

Type of Reporting:

B. CAHs:

- In 2015, can attest to a 90 day reporting period for CQMs
 - 16 measures
- In 2016, can attest to a one year reporting period for CQMs
 - If attest, then 16 measures with aggregate data
 - If eCQM, then 4 measures with patient-specific (QRDA-I) data
- In 2017, can either attest or submit eCQMs
- In 2018, must submit eCQMs



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