

The Office of the National Coordinator for
Health Information Technology



Public Health – EHR Vendors Collaboration Initiative

Webinar

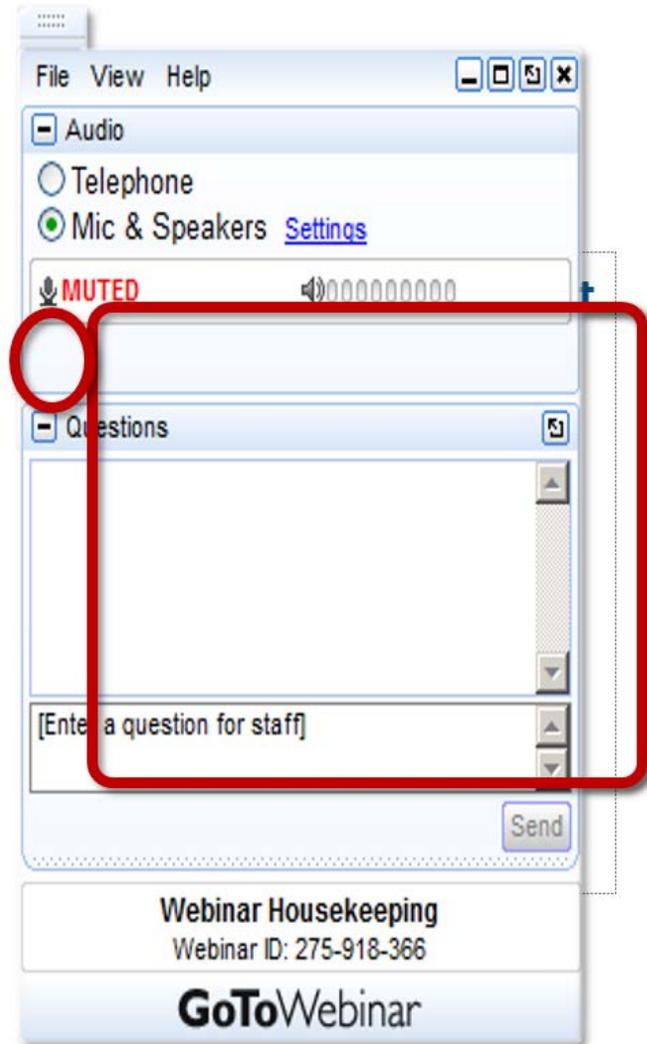
Stage 3 Task Force-Co-chairs

June 20, 2017

Putting the **I** in **HealthIT**
www.HealthIT.gov

Submit or Ask Questions

- **Submit your text question and comments using the Question Panel**
- **Please raise your hand to be unmuted for verbal questions.**





DECLARATION OF READINESS BY PUBLIC HEALTH AUTHORITIES- MEANINGFUL USE STAGE 3 / MIPS

Meaningful Use Public Health Task Force

PUBLIC HEALTH DECLARING READINESS

- Public Health should declare readiness six months prior to being able to receive data.
 - Example 1: By July 1, 2017 for service to begin January 1, 2018
 - Example 2: By September 15, 2017 for service to begin March 15th
- Declarations hosted on public health authorities' publicly available web pages
 - Example: <http://www.dshs.texas.gov/mu/>.

DECLARATION CONTENTS

- Declaration should include:
 - Which measures will be supported
 - Which specific implementation guides and requirements from the ONC rule(s)
 - Any EH/CAH/EP restrictions or targets based on factors such as provider type
 - Date PHA will begin accepting data consistent with the new criteria

AVAILABLE PUBLIC HEALTH AGENCY REGISTRIES

- By federal rule, any public health registry on or after January 1, 2018 must use message standards specified in federal rule for it to be used to meet meaningful use requirements.
- Currently, implementation guides are specified for cancer registries, immunization registries, electronic lab reporting, syndromic surveillance, NHSN antimicrobial reporting and national healthcare surveys.
- Other registries: Providers who began sending to production systems prior to 2018 may be grandfathered and count the measure.

PROPOSED RULE CHANGES IN FY 2018 INPATIENT PROSPECTIVE PAYMENT SYSTEM PROPOSED RULE

- CMS is proposing to modify the 2018 EHR reporting period from the full calendar year to a minimum of any continuous 90-day period for new and returning participants in the Medicare and Medicaid EHR Incentive Programs.
- Note: MIPS already has a 90 day reporting period for 2018

CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY AVAILABILITY IN 2018

- CMS is monitoring the deployment and implementation status of technology certified to the 2015 Edition.
- Flexibility in use of CEHRT in CY 2018 for all participants of the Medicare and Medicaid EHR Incentive Programs will be considered, as necessary

IMMUNIZATION REGISTRY

- Readiness for Stage 3 includes:
 - Compliance with the Implementation Guide v.1.5
 - The ability to receive and respond to queries (QBP/RSP).
 - The capacity to receive NDC codes (Note: an IIS may also opt to require CVX codes in parallel with NDC codes until full adoption of NDC codes has been completed).
- Registries may choose to support non-vaccinating providers by offering query-only access. Declare which types of providers and transactions you plan to receive.

SYNDROMIC SURVEILLANCE

- In Stage 3, syndromic surveillance for EPs is limited to those in an **urgent care setting**.
- The PHIN messaging guide for hospital syndromic surveillance is updated to version 2.0 (Note: the rule does not specify a guide for syndromic surveillance in regards to ambulatory care, but notes the PHIN 2.0 guide is appropriate for use in urgent care ambulatory settings).
- The PHIN 2.0 guide is to be used for emergency department, urgent care and inpatient settings. While EHs without emergency departments can claim an exclusion for SyS, the new guide allows for the transmission of inpatient data. The PHA should determine if inpatient visits will be requested in addition to emergency department or urgent care visits.

CANCER REGISTRY (UNDER PUBLIC HEALTH REGISTRIES)

- Implementation Guide for ambulatory provider cancer reporting to state cancer registries is updated to *HL7 CDA® Release 2 Implementation Guide: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers, Release 1, DSTU Release 1.1 – US Realm*
 - Addition of “Modification to the cancer patient’s EHR” as a second criterion (trigger) for identifying cancer cases

ELECTRONIC REPORTABLE LAB RESULTS

- There are no changes to the HL7 implementation guide used for Electronic Laboratory Reporting.
- Despite no changes, there may be a need to revalidate if a hospital updates or purchases new certified software.

PUBLIC HEALTH REGISTRIES AT THE CENTERS FOR DISEASE CONTROL AND PREVENTION

- **National Center for Health Statistics** – national health care surveys, which is currently accepting registrations from eligible hospitals, critical access hospitals and eligible professionals.
- **National Healthcare Safety Network** – antimicrobial use and resistance reporting (EH and CAH only), which plans to start accepting in 2018.
- A PHA may post information regarding this option on their MU webpage.

ELECTRONIC CASE REPORTING

- The options for Active Engagement allow for flexibility from the PHA.
 - You may choose to register providers and place them in a hold queue if you plan to have case reporting ready in 2018.

ELECTRONIC CASE REPORTING – ONC 2015 CEHRT RULE

- “To meet this certification criterion, a Health IT Module must be able to
 - (1) consume and maintain a table of trigger codes to determine which encounters should initiate an initial case report being sent to public health to determine reportability; and
 - (2) when a trigger is matched, create an initial case report that includes specific data (Common Clinical Data Set; encounter diagnoses; provider name, office contact information, and reason for visit, and an identifier representing the row and version of the trigger table that triggered the case report). ”

CENTERS FOR MEDICARE AND MEDICAID SERVICES REPOSITORY

- File available as Microsoft Excel file at <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/CentralizedRepository-.html>
- Initial repository data collection was early fall 2016 and published in early 2017.
- Repository is planned to be updated annually; there were no updates in 2017 after the original was published. The 2018 update will potentially be in a different format.
- Lack of an entry in the Centralized Repository does not;
 - Prevent a provider from attesting to reporting to a registry or
 - Allow a provider to claim an exclusion from the measure.
- Providers must check with jurisdictional public health agencies and relevant specialty societies to which they belong and document appropriately.



THANK YOU!

Discussion

*For follow-up please contact:

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