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Meaningful Use Overview for Program Year 2017

Massachusetts Medicaid EHR Incentive Program

October 23 & 24, 2017

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Agenda

- 2017 Meaningful Use Attestation Framework
- Objectives and Measures
  - Setting the Stage: Modified Stage 2 vs. Stage 3
  - Review of Each Objective: Requirements, Supporting Documentation, and Potential Issues
- Questions

2017 Meaningful Use Attestation Framework

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The Next Chapter for Meaningful Use (MU) and Health IT

- Improved care coordination
- Increased patient engagement
- Fostering bi-directional information exchange
- Increased accuracy and timeliness of information shared
- Opportunity for analytics and better population health management
- Expanded data collection and reporting
- Leveraging Health IT for improved efficiencies

Program Year (PY) 2017

Requirements

- Eligible Professionals (EPs) may attest to either Modified Stage 2 or Stage 3
- EPs must be using a 2014 Edition CEHRT, 2015 Edition CEHRT or combination 2014 & 2015 CEHRT
- Objectives and measures must be achieved within the calendar year
  - Can no longer include actions taken after CY but before date of attestation
- Threshold percentages have increased for some measures
- Alternate Exclusions are NOT available for PY 2017
- EPs must have successfully attested at least once (2016 was last year to initiate participation)

Timeline

- EHR reporting period of any continuous 90-day period within CY 2017
- Last possible reporting period: October 3, 2017 – December 31, 2017
- Deadline to attest for PY 2017: March 31, 2018

- There's still time to earn total incentive of $49,585 (board-certified pediatricians) or $63,750 (all other EPs) by 2021
- Number of CQMs required decreased from 9 to 6; reporting CQMs across 3 domains no longer required

Attestation Protocol

For Program Year 2017 and beyond:

- All attesting Providers must prove eligibility each Program Year:
  - ✓ Be an Eligible Professional (MD, DO, NP, CNS, or certified Nurse-Midwife)
  - ✓ Be Non-Hospital-Based or Practice Predominantly at an FQHC
  - ✓ Be using a 2014 Edition CEHRT or higher
  - ✓ Satisfy the Medicaid Patient Volume Threshold (PVT) requirement
- All MU supporting documentation must be uploaded to the EP's MAPIR application
- All PHI must be removed from supporting documentation detail
- All EPs attesting to MU must upload an MU Aggregation Form to confirm data was combined across all locations where the EP rendered services

Objectives and Measures for Modified Stage 2 and Stage 3

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Modified Stage 2 vs. Stage 3 Objectives

Modified Stage 2	Stage 3
(1) Protect ePHI (Security Risk Analysis or Review)	(1) Protect ePHI (Security Risk Analysis or Review)
(2) Clinical Decision Support (CDS)	(2) Generate & transmit prescriptions electronically (eRx)
(3) Computerized Provider Order Entry (CPOE)	(3) Clinical Decision Support (CDS)
(4) Generate & transmit prescriptions electronically (eRx)	(4) Computerized Provider Order Entry (CPOE)
(5) Health Information Exchange (HIE)	(5) Patient electronic access
(6) Patient-specific education resources	(6) Coordination of Care
(7) Medication reconciliation	(7) Health Information Exchange (HIE)
(8) Patient electronic access	(8) Public Health Reporting
(9) Secure electronic messaging	
(10) Public Health Reporting	

Modified Stage 2 vs. Stage 3

Modified Stage 2	What Happens in Stage 3?
(1) Protect ePHI (Security Risk Analysis or SRA)	Remains the same
(2) Clinical Decision Support (CDS)	Becomes Objective 3
(3) Computerized Provider Order Entry (CPOE)	Becomes Objective 4
(4) Generate & transmit prescriptions electronically (eRx)	Becomes Objective 2
(5) Health Information Exchange (HIE)	Becomes Objective 7 and includes new measures (receiving, incorporating, reconciliation of Summary of Care)
(6) Patient-specific education resources	Incorporated into Objective 5 – Patient Electronic Access (along with Measure 1 of Mod Stage 2 Objective 8 -- patient electronic access)
(7) Medication Reconciliation	Incorporated into Objective 7 – Health Information Exchange
(8) Patient electronic access Measure 1 – provide ability to view, download, transmit Measure 2 – patients *actually* view, download, transmit	Measure 1 → Objective 5 (Patient Electronic Access) Measure 2 → Objective 6 (Coordination of Care)
(9) Secure electronic messaging	Incorporated into Objective 6 – Coordination of Care (along with Measure 2 of Mod Stage 2 Objective 8 -- patient electronic access)
(10) Public Health Reporting	Becomes Objective 8 and includes new measures

Protect Patient Health Information (PHI)

Objective: Protect Patient Health Information (PHI)

Protect electronic health information (PHI) created or maintained by CEHRT through implementation of appropriate technical capabilities

Measure

Conduct or review security risk analysis (SRA), including:

- Address security to include encryption of ePHI
- Implement security updates & correct identified security deficiencies as part of EP's risk management process (Mitigation plan)

No Exclusions

*** * New for both Stage 2 & Stage 3 in PY 2017 * ***

SRA must be conducted or reviewed within the calendar year of the EHR reporting period (Jan 1 – Dec 31, 2017)

Supporting Documentation: Protect ePHI

Modified Stage 2 & Stage 3

- Security Risk Analysis (SRA)/Security Risk Review (SRR) must be submitted for **each location** where the EP practiced and utilized CEHRT during the EHR reporting period.

  Be sure to include:

  - Name of practice
  - Location
  - Date completed
  - Signature of authorized official
  - Name and title of person who conducted SRA/SRR
  - Mitigation plan detailing action steps to correct/diminish identified security gaps

- Completed SRA/SRR cover sheet attesting to the truthfulness and accuracy of the analysis must also be submitted.

Clinical Decision Support (CDS)

Objective: Clinical Decision Support (CDS)

Use clinical decision support (CDS) to improve performance on high-priority health conditions

Measure 1

Implement 5 CDS interventions related to 4 or more CQMs for entire EHR reporting period

Measure 2

Enable and implement drug-drug & drug-allergy interaction checks for entire EHR reporting period

Exclusion for Measure 2

Any EP who writes fewer than 100 medication orders during EHR reporting period

Supporting Documentation: Clinical Decision Support (CDS)

Modified Stage 2 & Stage 3

Upload Supporting Documentation for Measure 1

- EHR-generated screenshots of 5 CDS interventions dated within EHR reporting period and identifying both EP and organization
- Documentation showing interventions relate to 4 or more CQMs related to the scope of practice, **OR** a letter from EP's Supervisor or Medical Director explaining CDS's relationship to patient population and high priority conditions

For global CDS implementations:

- Screenshot with practice name and enabled date
  - If screenshots don't display enabled dates, submit either CEHRT audit logs with enabled dates, **OR** a vendor letter confirming enabled dates and that EPs are unable to deactivate interventions
- Letter on letterhead and signed by Medical Director confirming relevance to EP and including a list of all EPs using the CDS

Supporting Documentation: Clinical Decision Support, continued

Modified Stage 2 & Stage 3

Upload Supporting Documentation for Measure 2

- Documentation from CEHRT identifying both EP & organization showing drug-drug & drug-allergy interaction checks were enabled for the entire reporting period

Computerized Provider Order Entry (CPOE)

Objective: Computerized Provider Order Entry (CPOE)

Use CPOE for medication, laboratory and radiology orders entered by licensed healthcare professional who can enter orders into medical record per state, local, and professional guidelines

Measure 1 More than 60% of medication orders created during EHR reporting period recorded using CPOE

Measure 2 More than 30% of laboratory orders (increases to >60% for Stage 3)

Measure 3 More than 30% of radiology orders (increases to >60% for Stage 3)

Exclusions – Any EP who during EHR reporting period:

- Measure 1: writes fewer than 100 med orders
- Measure 2: writes fewer than 100 lab orders
- Measure 3: writes fewer than 100 radiology orders

Supporting Documentation: Computerized Provider Order Entry (CPOE)

Modified Stage 2 & Stage 3

- In MAPIR, enter the numerators/denominators lifted directly from the MU report to show the EP meets the required threshold

Upload Supporting Documentation

EHR generated report that displays:

- Selected MU reporting period
- EP's name
- Recorded volumes for; medication, lab and radiology orders

ePrescribing (eRx)

Objective: Electronic Prescribing (eRx)

Generate and transmit permissible prescriptions electronically (eRx)

Measure

More than 50% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT (increases to >60% for Stage 3)

Exclusions

- EP writes fewer than 100 prescriptions during EHR reporting period
- No pharmacy within organization and no pharmacies accepting eRx within 10 miles of EP's practice at start of reporting period

Supporting Documentation: Electronic Prescribing (eRx)

Modified Stage 2 & Stage 3

- In MAPIR, enter the numerators/denominators lifted directly from the MU report to show the EP met the required threshold

Upload Supporting Documentation

EHR generated report that displays:

- Selected MU reporting period
- EP's name
- Recorded volumes for eRx

Health Information Exchange (HIE)

Objective: Health Information Exchange (HIE) – **Modified Stage 2**

Modified Stage 2: EP who transitions or refers their patient to another setting of care or another provider of care provides a summary care record for each transition of care or referral

Measure

- use CEHRT to create a summary of care record; and
- electronically transmit each summary to a receiving provider for more than 10% of transitions of care and referrals

Exclusion

Any EP who transfers patient to another setting or refers patient to another provider less than 100 times during EHR reporting period

* * New for PY 2017 * *

Action must occur within the calendar year

Objective: Health Information Exchange (HIE) – **Stage 3**

Stage 3: 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 receipt of a transition/referral or upon first encounter with a new patient, and incorporates summary of care info from other providers into their EHR.

New for PY 2017
Action must occur within the calendar year

Measure 1

- For more than 50% of transitions of care and referrals, EP that transitions or refers their patient to another setting/provider of care creates a summary of care record using CEHRT, and electronically exchanges the summary of care record

Measure 2

- For more than 40% of transitions/referrals received and patient encounters in which the provider has never before encountered the patient, EP incorporates into the patient's EHR an electronic summary of care

Measure 3

- For more than 80% of transitions/referrals received and patient encounters in which the provider has never before encountered the patient, EP performs a clinical information reconciliation. EP must implement clinical information reconciliation for the following:
  - Medication, including the name, dosage, frequency, and route of each medication
  - Medication allergies
  - Current Problem List

Exclusion: Any EP who transfers patient to another setting or refers patient to another provider less than 100 times during EHR reporting period

Supporting Documentation: Health Information Exchange (HIE)

Modified Stage 2 & Stage 3

In MAPIR, enter the numerators/denominators lifted directly from the MU report to show the EP met the required threshold

Upload Supporting Documentation

Measure 1:

- EHR generated report that displays:
  - Selected MU reporting period
  - EP's name
  - Recorded volumes for HIE
- One unique Summary of Care Record per EP that:
  - Occurred within the same calendar year of the EHR reporting period
  - Includes, at a minimum, current problem list, current medication list, current medication allergy list
  - Is in human readable format
- Confirmation of receipt (*or for Stage 3, proof that the receiving provider made a query*) of this one Summary of Care record

Supporting Documentation: Health Information Exchange (HIE)

Stage 3 only

In MAPIR, enter the numerators/denominators lifted directly from the MU report to show the EP met the required threshold

- **Measure 2**: a SOC document is created for transitions or referrals received and patient encounters where the EP never before encountered the patient
- **Measure 3**: for transitions or referrals received and patient encounters where the EP never before encountered the patient, the EP incorporates the Summary of Care into the electronic health record and performs a clinical information reconciliation. The EP must implement reconciliation for the following clinical information sets:
    1. Medication
    2. Medication Allergy
    3. Current Problem List

Upload Supporting Documentation

EHR generated report that displays:

- Selected MU reporting period
- EP's name
- Recorded volumes for HIE

HIE Workflow Issues – Sender

Potential Problem	Potential Solution
Staff reluctant to give up using fax and/or phone	Provide technical support to clinicians and administrative staff
Protocol for routine use of HIE not institutionalized	Create standardized protocol, train staff on its use, solicit and incorporate feedback
Content of Consolidated Clinical Document Architecture (CCD-A) not refined	Develop short term project team to design, review and adopt CCD-A
Some personnel are on board with HIE, some are not	Acquire high level endorsement within practice

HIE Workflow Issues – Receiving End

Potential Problem	Potential Solution
Unclear whom to contact at trading partner	Use other contacts at partner; contact MeHI for help
Trading partner will not accept electronic transmission	Get to know key HIE personnel at trading partner
Correct handling of Summary of Care Record unreliable	Create test environment parallel to existing communication channel; customize content to conform both to CMS requirements & specs of receiving party; learn their workflow
Hard to ascertain receipt	Include vendors in problem solving
Receiving specialist not interested in Summary of Care Record	Emphasize regulatory trend is mandating increased interoperability
No incentive for receiver to cooperate	Start by engaging with high volume trading partners

HIE Technical Issues

Potential Problem	Potential Solution
Interfaces not working	Engage vendors
Transmission mechanism problems	Schedule periodic conference calls with key players to monitor and improve process
Not all components are certified	Identify all technical products required from source to destination and assure compliance
CEHRT functionality	Engage vendors
Numerator/Denominator not captured/reported correctly	Engage vendors

Medication Reconciliation

Objective: Medication Reconciliation – Modified Stage 2 only

Modified Stage 2: EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs a medication reconciliation

Measure

EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP*

Exclusion

Any EP who is not a recipient of any transitions of care during the EHR reporting period

*For Stage 3, threshold increases to >80% and measure is rolled into Objective 7 – Health Information Exchange

Supporting Documentation: Med Reconciliation – Modified Stage 2 only

Modified Stage 2

- In MAPIR, enter the numerator/denominator lifted directly from the MU Dashboard to show the EP met the required threshold

Upload Supporting Documentation

EHR generated report that displays:

- Selected MU period
- EP's name
- Recorded volumes for Medication Reconciliation

Patient-Specific Education, Patient Electronic Access & Secure Messaging (Stage 2)

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Objective: Patient-Specific Education – Modified Stage 2 – Objective 6

Modified Stage 2: Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient

Measure

Patient specific education identified by CEHRT is provided to more than 10% of all unique patients with office visits seen in EHR reporting period. Use EHR-identified education resources.

Exclusion

Any EP who has no office visits during EHR reporting period

Supporting Doc: Patient-Specific Education – Modified Stage 2 – Objective 6

Modified Stage 2

- In MAPIR, enter the numerators/denominators lifted directly from the MU report to show the EP met the required threshold

Upload Supporting Documentation

EHR generated report that displays:

- Selected MU period
- EP's name
- Recorded volumes for Patient Specific Education

Objective: Patient Electronic Access – Modified Stage 2 – Objective 8

Modified Stage 2: Provide patients the ability to view online, download and transmit their health information within 4 business days of info being available to EP

Measure 1

More than 50% of all unique patients seen during EHR reporting period are provided timely access to view online, download, and transmit their health information

Measure 2

More than 5% of unique patients seen by EP during EHR reporting period view, download, or transmit their health information to third party during the EHR reporting period

*** * New for PY 2017 * ***

Measure 2 requirement increased from 1 patient to more than 5% of unique patients

Objective: Patient Electronic Access – Modified Stage 2 – Objective 8

Exclusion Measure 1

- Any EP who neither orders nor creates any of the information listed for inclusion as part of the measure, except “Patient Name” or “Provider’s Name and Office Contact Information”

Exclusion Measure 2

- Any EP who neither orders nor creates any of the information listed for inclusion as part of the measure, except “Patient Name” or “Provider’s Name and Office Contact Information”
- More than half of the EP’s encounters are in an a county that does not have 50% or more of its housing units with 4Mbps broadband

Supporting Doc: Patient Electronic Access – Modified Stage 2 – Objective 8

Modified Stage 2

- In MAPIR, enter the numerators/denominators lifted directly from the MU Dashboard to show the EP met the required thresholds

  Measure 1: Patients were given timely access to View, Download and Transmit (VDT)

  Measure 2: Number of Patients who actually Viewed, Downloaded or Transmitted

Upload Supporting Documentation

EHR generated report that displays:

- Selected MU period
- EP's name
- Recorded volumes for Patient eAccess

Objective: Secure Electronic Messaging – Modified Stage 2 – Objective 9

Modified Stage 2: Use secure electronic messaging to communicate with patients on relevant health information

Measure

A secure message was sent to more than 5% of unique patients seen during EHR reporting period using the electronic messaging function of CEHRT to the patient, or in response to a secured message sent by a patient during the EHR reporting period

Exclusion

Any EP who has no office visits during EHR reporting period, or more than half of EP's encounters are in an a county that does not have 50% or more of its housing units with 4Mbps broadband

*** * New for PY 2017 * ***

Threshold increases from 1 patient to at least 5% of unique patients. All actions must occur within program year.

Supporting Doc: Secure Electronic Messaging – Mod Stage 2 – Objective 9

Modified Stage 2

- In MAPIR, enter the numerator/denominator lifted directly from the MU Report to show the EP met the required threshold

Upload Supporting Documentation

EHR generated report that displays:

- Selected MU period
- EP's name
- Recorded volumes for Secure eMessaging

Patient Electronic Access & Coordination of Care through Patient Engagement (Stage 3)

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Patient Electronic Access – Stage 3 – Objective 5

Stage 3: Provide patients (or patient-authorized representatives) with timely electronic access to their health information and patient-specific education.

Measure 1: For more than 80% 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

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% of unique patients seen by the EP during the EHR reporting period.

Supporting Doc: Patient Electronic Access – Stage 3 – Objective 5

Stage 3

- In MAPIR, enter the numerators/denominators lifted directly from the MU report to show the EP met the required threshold

Upload Supporting Documentation

EHR generated report that displays:

- Selected MU period
- EP's name
- Recorded volumes for Patient Specific Education

Coordination of Care through Patient Engagement – Stage 3 – Objective 6

Stage 3: Use CEHRT to engage with patients or their authorized representatives about the patient's care

Must meet at least two of the following measures:

Measure 1: More than 5% of all unique patients (or their authorized representatives)

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)

Measure 2: For more than 5% of all unique patients, a secure message was sent to the patient (or patient-authorized representative), using the electronic messaging function of CEHRT or in response to a secure message sent by the patient or their authorized representative.

Measure 3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5% of all unique patients.

Stage 3

Upload Supporting Documentation

- In MAPIR, enter the numerators/denominators lifted directly from the MU Dashboard to show the EP met the required thresholds

Measure 1: Access to View, Download and Transmit and API Access

- EHR generated report displaying the selected reporting period, the EP's name, and recorded volumes
- Documentation that shows API was enabled prior to or during the EHR reporting period
- Copy of instructions provided to patients on how to access API

Measure 2: Secure Messaging

- EHR generated report displaying the selected reporting period, the EP's name, and recorded volumes

Measure 3: Incorporation of Patient Generated Health Data or Data from Non-Clinical setting

- EHR generated report displaying the selected reporting period, the EP's name, and recorded volumes for date from non-clinical sources (i.e. social service, home health monitoring, medical device, or fitness monitor)

Patient Portal Workflow Issues

Potential Problem	Potential Solution
No institutionalized method of providing access that links to CEHRT data capture for numerator/denominator	Train staff in exact steps to give access and capture the fact in CEHRT
Confidentiality and privacy issues difficult to standardize	
Not all staff are knowledgeable about patient engagement and how to encourage patients to use portal	

Patient Portal Patient or Client Issues

Potential Problem	Potential Solution
Giving access to minors	Use patient-authorized representative
Cognitive challenges	Coach patient or client in using electronic devices
No computer access	Have laptops/tablets/kiosks available Staff can assist patients as needed
Location challenges	Introduce use of other devices per 2015 Edition requirements
Not interested in using portal	

Patient Portal Technical Issues

Potential Problem	Potential Solution
Method of giving access not recognized by CEHRT logic for generating numerator/denominator	Work with vendor; possibly requiring patch of some sort
Access method used by practice does not fulfill CMS/attestation requirements	Communicate with MeHI before EHR reporting period if there are concerns
Portal module doesn't interface with CEHRT properly	Contact vendors
CEHRT dashboard fails to accurately report true numerator/denominator	Understand logic of how numerator/denominator is populated

Secure Electronic Messaging Workflow Issues

Potential Problem	Potential Solution
EP resistant to using electronic communication to communicate with patients or clients	Develop manual/trainings for clinical advantages and benefits of electronic communication
Practice has not established secure messaging as standard operating procedure --- for providers and staff to communicate with patients or clients	Create standardized content (such as flue shot reminders, etc.) and schedule when secure messages are to be sent, automate when appropriate

Secure Electronic Messaging Patient or Client Issues

Potential Problem	Potential Solution
Cognitive challenges	Use patient-authorized representative
No electronic access	Tutor challenged patients or clients in using electronic device
Location challenges	Have laptops/tablets/kiosks available Staff can assist patients as needed
Not interested in using portal	Periodically re-invite; prepare to adopt wider variety of devices required with 2015 Edition CEHRT

Secure Electronic Messaging Technical Issues

Potential Problem	Potential Solution
Imperfect tracking of secure messages by CEHRT (especially messages occurring outside the EHR reporting period but within the program year)	Work with vendor; understand logic behind populating numerator/denominator

Public Health Reporting

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Objective: Public Health Reporting – Modified Stage 2 – Objective 10

Modified Stage 2: EP is in active engagement with public health agency to submit electronic public health data from CEHRT

The EP must meet 2 of the following measures:

Measure 1

Immunization Registry: EP is in active engagement with a public health agency to submit immunization data

Measure 2

Syndromic Surveillance: The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting. Required for EPs who practice in a freestanding Urgent Care facility

Measure 3

Specialized Registry: EP is in active engagement to submit data to a specialized registry

Objective: Public Health Reporting – Modified Stage 2 – Objective 10

Exclusion Measure 1 – Immunization Registry

- EP does not administer any immunizations to any of the populations for which data is collected in the area
  - Massachusetts has MIIS registry, so the other two exclusions are not applicable

Exclusions Measure 2 – Syndromic Surveillance

- Required for EPs who practice in a freestanding Urgent Care facility. Other EPs may take an exclusion

Exclusions Measure 3 – Specialized Registry

- Any EP who does not diagnose or treat diseases or conditions associated with data required by specialized registry in the area
  - Massachusetts has a cancer registry, so the other two exclusions are not applicable

Supporting Documentation: Public Health Reporting - Modified Stage 2

Measure 1 – Immunization Registry

MIIS Immunization Acknowledgement (ACK), MIIS Registration of Intent, or MIIS MU Scorecard to demonstrate active engagement

Exclusion: PCPs claiming an immunization exclusion must upload a letter attesting to the accuracy of the exclusion

Measure 2 – Syndromic surveillance

Applies to EPs in freestanding Urgent Care Facility. Documentation to demonstrate active engagement.

Measure 3 – Specialized Registry

Documentation from a Specialized Registry to demonstrate active engagement with the Cancer Registry and/or Infectious Disease Registry

Objective: Public Health Reporting – Stage 3 – Objective 8

Stage 3: EP is in active engagement with public health agency to submit electronic public health data from CEHRT

The EP must meet 2 of the following measures:

Measure 1

Immunization Registry: EP is in active engagement with a public health agency to submit immunization data

Measure 2

Syndromic Surveillance: The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting. Required for EPs who practice in a freestanding Urgent Care facility.

Measure 3

Electronic Case Reporting: The EP is in active engagement with a public health agency to submit case reporting of reportable conditions. (Not required for PY2017)

Measure 4

Public Health Registry Reporting: The EP is in active engagement with a public health agency to submit data to public health registries.

Measure 5

Clinical Data Registry Reporting: The EP is in active engagement to submit data to a clinical data registry.

Supporting Documentation: Public Health Reporting – Stage 3 – Objective 8

Measure 1 – Immunization Registry

MIIS Immunization Acknowledgement (ACK), MIIS Registration of Intent, or MIIS MU Scorecard to demonstrate active engagement

Exclusion: PCPs claiming an immunization exclusion must upload a letter attesting to the accuracy of the exclusion

Measure 2 – Syndromic surveillance

Applies to EPs in freestanding Urgent Care Facility. Documentation to demonstrate active engagement.

Supporting Documentation: Public Health Reporting – Stage 3 – Objective 8

Measure 3 – Electronic Case Reporting

Not required for PY2017

+

Measure 4 – Public Health Registry

Documentation from a Public Health Registry to demonstrate active engagement with the Cancer and/or Infectious Disease Registry

+

Measure 5 – Clinical Data Registry Reporting

Unavailable in MA

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Questions

Questions?

Helpful Links

- Blueprint Secure™ Security Risk Analysis Tool
- CMS Health Information Exchange Tip Sheet
- MeHI MU Toolkit for EPs

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Medication Reconciliation
Reporting Period
CARE
CPOE
Clinical Decision Support
Patient Encounter
CDS
Secure
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MEANINGFUL USE
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MU
Electronic
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Stage 3
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Electronic Prescribing
Electronic
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Patient Volume Threshold
Patient Portal
HEALTH INFORMATION EXCHANGE
Interoperability
people
documentation
Program Year 2017