Public Health Stage 3 Meaningful Use Measures in 2017: Guidance for Public Health Agencies

6/24/16

Providers have the option of attesting to the Stage 3 measures in 2017. The EHR reporting period for providers attesting to Stage 3 in 2017 will be 90 days, whereas providers who choose to attest to Modified Stage 2 in 2017 will have a full calendar year EHR reporting period. A new requirement for Public Health Agencies (PHAs) for Stage 3 is to declare readiness to the Stage 3 measures and 2015 Edition CEHRT criteria at least **six months in advance of the provider's EHR reporting period**. If a PHA plans to accept Stage 3 criteria on or before January 1, 2017, they should declare readiness on their publicly available website by **July 1, 2016**.

Declaration of Readiness

- On the PHA publicly-available website.
- Six months in advance of when the PHA plans to accept (e.g. by July 1, 2016 to capture provider EHR reporting periods beginning January 1, 2017).
- Declaration should include:
    - Which measures will be accepted
    - Which CEHRT edition(s) (2014 and/or 2015) are accepted or 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 the new criteria

General Considerations for 2017

- PHAs may need to be able to accept both 2014 Edition and 2015 Edition CEHRT standards simultaneously.
- Providers will be transitioning to 2015 Edition software and may use a combination of 2014 and 2015 Edition software, regardless of the Stage to which they are attesting.
- As some EHR vendors update their software to 2015 Edition criteria, there may be significant changes that would require revalidation by the PHA for providers in production status.

Immunization Registry

- Readiness for Stage 3 includes:
    - The ability to respond to bidirectional 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).
- Declarations of readiness for Stage 3 MU, bidirectional queries, and NDC codes should be in addition to, rather than replace existing readiness declarations for Stage 2 MU (unidirectional reporting).

Syndromic Surveillance

- In Stage 3, syndromic surveillance for EPs is limited to those in an **urgent care setting**.
    - If the PHA plans to accept syndromic surveillance from EPs in other settings, the PHA should consider declaring this acceptance under the Public Health Registry Reporting Measure (formerly Specialized Registry Reporting).

- The PHIN messaging guide for hospital syndromic surveillance is upgraded to version 2.0 in the 2015 Edition CEHRT (Note: the rule does not specify a guide for syndromic surveillance in regards to EPs). Important changes include:
    - PHAs operating syndromic surveillance systems (SyS) will need to adjust SyS message receiving and data transformation processes.
    - Certification under 2015 Edition CEHRT calls for the testing of the ability to message **inpatient** data (in addition to emergency department or outpatient) for syndromic surveillance purposes; under 2014 Edition this was not a requirement. Under 2015 Edition CEHRT, SyS should also provide additional facility and patient demographic information, including:
        - Facility name
        - Facility address
        - Patient city town
        - Smoking status
    - SyS should have been tested to include the capture and transmission of ICD-9 CM, ICD-10 CM, LOINC, and SNOMED coded data along with Chief Complaint; under 2014 Edition CEHRT, testing for compliance was limited to ICD-9 CM and Chief Complaint.

Cancer Registry (under Public Health Registries)

- The Cancer 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 in the 2015 Edition CEHRT. Important changes include:
    - Addition of "Modification to the cancer patient's EHR" as a second criterion (trigger) for identifying cancer cases
    - Addition of SNOMED cancer reportability list
    - Alignment with Consolidated CDA (C-CDA)
    - New sections, entries and data elements, including:
        - Document versioning elements
        - Use of identifiers within the document to link cancer diagnosis, problems and medications to the related problem
        - TNM Pathologic Stage
        - Tumor grade
        - Smoking and tobacco use
        - Family medical history
    - Changes to optionality, mostly to strengthen the requirements for some key cancer data elements.

Public Health Registries

- Starting in Stage 3, all Public Health Registries and Clinical Data Registries must use certified standards for meaningful use transactions. In 2017, providers can use a combination of 2014 Edition and 2015 Edition CEHRT. This is in contrast to Modified Stage 2 where use of ONC standards are not required if they are not present in the 2014 Edition CEHRT.
- The Centers for Disease Control and Prevention offers two registries (one available starting 2018):

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

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.

Electronic Case Reporting

- Not available for Stage 3 until 2018, however a PHA may elect to have Case Reporting as a Public Health Registry or Specialized Registry prior to 2018.