For 2016, what alternate exclusions are available for the public health reporting objective? There are alternate exclusions available to accommodate the changes to how the measures are counted.

We do not intend to reevaluate previously provider providers for changes to their systems or reporting made necessary by the provisions of the 2015 EHR Incentive Programs Final Rule. This includes alternate exclusions for providers for certain measures in 2016 which may require the acquisition of additional technologies they did not previously have or did not previously intend to include in their activities for meaningful use (EHR Incentive). For 2016, EPs scheduled to be in Stage 1 or Stage 2 must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3 and eligible hospitals or CAHs scheduled to be in Stage 1 or Stage 2 must attest to at least 2 public health measures from the Public Health Reporting Objective Measures 1-4. We will allow Alternate Exclusions for the Public Health Reporting Objective Measures 1-4. If an EHR technology or measure is not fully functional at the start of the EPs EHR reporting period, the provider would not have to have CEHRT at that point, but must own and have CEHRT installed by the first day of their EHR reporting period. There are certain core functions that must be fully functional on the first day of their EHR reporting period, e.g., the CEHRT must be able to receive an order from a provider to allow the electronic submission of data to the PHA. If registering their intent prior to the start of the EHR reporting period, the provider would not have to have Certified EHR Technology (CEHRT) at that point, but must own and have CEHRT installed by the first day of their EHR reporting period. There are certain core functions that must be fully functional on the first day of their EHR reporting period, e.g., the CEHRT must be able to receive an order from a provider to allow the electronic submission of data to the PHA. If registering their intent prior to the start of the EHR reporting period, the provider would not have to have CEHRT at that point, but must own and have CEHRT installed by the first day of their EHR reporting period.

For the meaningful use objective—"Capability to submit electronic syndromic surveillance data to public health agencies," what is the definition of "syndromic surveillance"? Syndromic surveillance uses individual and population health indicators that are available before confirmed diagnoses or laboratory confirmation to identify outbreaks or health events and monitor the health status of a community. For additional information about syndromic surveillance data, please visit: http://www.cdc.gov/surveillance/index.html. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/Initiatives/meaningfuluse/FAQs.html.

We agree that in some situations it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under his/her direct supervision. Therefore in these situations, so long as the order is entered using CEHRT by a licensed healthcare professional or certified medical assistant to create the first record of that order as it becomes part of the patient’s medical record, these orders would count in the numerator of the OPQ measure. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/index.html.

Electronic prescriptions are considered a critical component of the Meaningful Use program and are expected to be implemented as early as possible in the EHR reporting period. Electronic prescribing provides access to an electronic prescription system that allows providers to prescribe medications electronically. When a prescription is written for a patient, the prescription is sent electronically to the pharmacy. The pharmacy can then fill the prescription and send the filled prescription to the patient. This process reduces the time it takes to fill a prescription and reduces errors. Electronic prescribing also provides a record of the prescription that can be stored electronically in the patient’s medical record. This record can be accessed by the provider at any time, which can improve patient care and quality of care. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/index.html.

For the stage 2 objectives of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, what are the reporting period requirements for the remaining measures described in 495.22 (e)(10)(ii)(C). Created 02/25/2016.
To meet the meaningful use objective “use computerized provider order entry (CPOE)” for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, eligible professionals (EPs) must conduct or review a security risk analysis for the certified EHR technology (CEHRT) for the EHR reporting period. There is no threshold for CPOE and it can take place outside the reporting period, but must be conducted for the CEHRT being used by the EP at the time of reporting. EPs must conduct or review their security risk analysis no later than the date the EP submits their attestation for that EHR reporting period. This meaningful use objective complements but does not impose new or expanded requirements on the HIPAA Security Rule. In accordance with the requirements under 45 CFR 164.308(a), providers are required to conduct an accurate and thorough analysis of all the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI). Once the risk analysis is completed, providers must take any additional “reasonable and appropriate” steps to reduce identified risks to reasonable and appropriate levels. Please note that a security risk analysis report or review must be conducted for all EHR reporting years for Stage 1 and Stage 2 of meaningful use to ensure the privacy and security of their patients’ protected health information.

If the provider has conducted a security risk analysis prior to the EHR reporting period, they must conduct or review the analysis for the EHR period, even if no changes were identified. Completing the analysis under a different EHR reporting period will not satisfy the meaningful use objective. If the EHR technology is being used by the EP at the time of reporting, the EP must conduct or review the security risk analysis no later than the date the EP submits their attestation for that EHR reporting period. If the EHR technology is not being used by the EP at the time of reporting, they must conduct or review the security risk analysis no later than the date the EP submits their attestation for that EHR reporting period.

Does the inclusion of certified Medical Assistant in the list of professionals who can enter orders into the EHR using CPOE and have them count in the numerator or denominator matter? The licensed healthcare professional can enter orders into the medical record for purposes of including them in the numerator for the measure of the CPOE objective if they can perform the related acts of practice at the facility. The order must be entered by a state-licensed provider at the facility who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support alerts. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Each such action must be entered by a state-licensed provider at the facility who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support alerts. The expected effect applies to the Secure Electronic Messaging objective, the HIMs measure of the Patient Electronic Access (Hero, Hospital Interoperability and Two-way) objective, and the Patient Specific Education objective. If a patient sends a secure message about a clinical or health-related subject to the group practice of their EP, that patient can be counted in the numerator of the Secure Electronic Messaging measure for any of the EPs at the group practice who use the same certified electronic health records technology (CEHRT) that saw and transmitted to the patient their health information during the EHR reporting period. In 2017, the threshold increases to more than 5% of unique patients. The denominator for measure 2 includes the number of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) on or after the start date. For example, if a patient is discharged from an eligible hospital or CAH on or after the start date and accesses the information on the portal or PHR, then the respective provider can report the patient to the program as an EHR user. However, the respective provider should not report the patient as a provider who enables patient access to the portal or online PHR for their patient. For an eligible hospital or CAH to report a patient as meeting the specialized registry measure, the hospital or CAH should indicate the following exclusion when attesting yes; Does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period. The denominator for measure 3 includes the number of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) on or after the start date. For example, if a patient is discharged from an eligible hospital or CAH on or after the start date and accesses the information on the portal or PHR, then the respective provider can report the patient to the program as an EHR user. The denominator for measure 4 includes the number of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) on or after the start date. For example, if a patient is discharged from an eligible hospital or CAH on or after the start date and accesses the information on the portal or PHR, then the respective provider can report the patient to the program as an EHR user. The denominator for measure 5 includes the number of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) on or after the start date. For example, if a patient is discharged from an eligible hospital or CAH on or after the start date and accesses the information on the portal or PHR, then the respective provider can report the patient to the program as an EHR user.