Following are the objectives and program requirements for Eligible Professionals (EPs) participating in the Meaningful Use Incentive Program in 2016. Modifications to the original rule are documented in this CMS Tipsheet or view CMS's webpagededicated to the 2016 program requirements.

All providers must attest to objectives and measures using EHR technology certified to the 2014 Edition. All providers may attest to objectives and measures using EHR technology certified to the 2015 Edition, or a combination of the two (if the 2015 Edition is available).

EHR Reporting Period:

The EHR reporting period must be completed within January 1 and December 31 of the 2016 calendar year.

- For all returning participants, the EHR reporting period will be a full calendar year from January 1, 2016 through December 31, 2016.

- For EPs, eligible hospitals, and CAHs that have not successfully demonstrated meaningful use in a prior year will be any continuous 90-day period.

Attestation:

Attestation must be completed by February 28, 2017. Prior to attesting for the EHR Incentive Program for 2016, please review these checklists and the attestation worksheets specific to EPs to help you prepare to participate.

Objectives (2016):

View the objective and measure table for Eligible Professionals or view the individual objective details, including how to achieve the measure within ChartMaker Medical Suite, below:

1. Protect Patient Health Information

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 in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process.

Alternate Exclusions and/or Specifications:

None

How do I achieve this measure?

In order to qualify for this measure, the provider must have a security management process in place to "implement policies and procedures to prevent, detect, contain and correct security violations." The specifications require the practice to conduct an analysis of potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic health information.

Some examples of this may include, but are not limited to:

- Perform Security Risk Analysis/ Assessment
- Implement Security Policies, such as providing passwords to computers and installing anti-virus software, screensaver for auto-log off, changing options in Preferences > User Security in ChartMaker Clinical
- Appoint a Security Official – Prepare and Implement Job Responsibilities
- Implement Audit Control Policies& Procedures
- Implement Automatic Log-off Processes
- Install Virus Protection Software
- Implement Firewall Technology
- Review and Implement Computer Backup Policies and Procedures
- Implement Facility Maintenance Log
- Develop Facility Security and Contingency Plans
- Create Computer Workstation Use Policies and Procedures

- Obtain Signed Workforce Confidentiality Agreements form all Physicians and Staff
- Create Workforce Termination Procedures
- Implement Sanction Policy

As part of the process in creating such a manual, STI Managed Services can perform a basic Security Risk Analysis on network and hardware vulnerability for your office by request. The practice is responsible for maintaining HIPAA compliance; however STI will work with you to assure the Information Technology portion of the Security Risk Analysis is complete. Upon completion of your analysis, you will be informed of STI findings whether positive or negative. The analysis will include some, but not all, of the examples listed above.

This service is provided free of charge for Platinum level maintenance clients and for a fee for all other clients. Contact STI Managed Services (800-487-9135; option 2) for more information.

Please keep in mind that the analysis completed by STI or another IT vendor is only a subset of this measure. There are other requirements that must be completed by the practice itself. If your practice would like a more thorough analysis, we can recommend a vendor to do so.

2. Clinical Decision Support

In order for EPs to meet the objective they must satisfy both of the following measures:

Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions.

Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.

Exclusion: For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.

Alternate Exclusions and/or Specifications:

None

How do I achieve this measure?

See instructions on ~~Clinical Decision Support~~ rules.

3. Computerized Provider Order Entry (CPOE)

An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.

Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period.

Measure 2: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Exclusion: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

Measure 3: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Exclusion: Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

Alternate Exclusions and/or Specifications:

Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for *measure 2* (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for *measure 3* (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

How do I achieve this measure?

In order to qualify for this measure, the provider must enter patient medications (through the “Medication” button), lab and radiology orders (using a Procedure

Checklist) through ChartMaker Clinical.

> **NOTE:** Entering medications through the "Add Medication" functionality on the Face Sheet will not qualify for this measure.

To configure lab and radiology procedures:

In Clinical, go to Edit > System Tables > Conditions > Procedures
Search for the procedure by typing the description or code

> **NOTE:** If you do not have the applicable procedure codes in your database, they should be added through Practice Manager (Administration > Transaction Tables > Procedure).

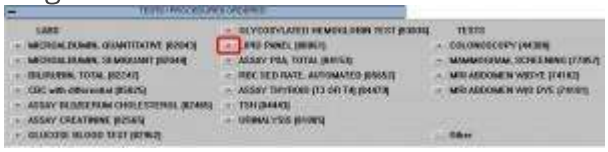
Highlight the procedure and click "Properties"
Change the "Type" field to either Lab or Image, depending on the procedure

> **NOTE:** If you do not bill for this procedure, "Auto-charge" should not be selected.

Click "Save"
Repeat steps 2 – 5 for each additional procedure
Click "Close" to close the Procedure Search dialog

To enter a lab or radiology order for a patient:

In an office visit note, select the applicable lab or radiology procedure from a procedure checklist by clicking the + sign



Enter any applicable information on the Order Procedure dialog

NOTE: If the checkbox for "Initial order created outside of Clinical" is selected, you will not receive credit for this procedure for this measure.

Click "OK"

To enter medications for a patient:

In an office visit note, click the "Medication" button (

)
Choose "Add Medication"
Search for and select the medication
Enter all appropriate fields and click "Next"

NOTE: Designating the medication as "pre-existing" (un-checking the "Started" field) **WILL NOT** qualify for this measure. If the medication is a Schedule II controlled substance, a date must be entered in the Earliest Fill Date field.

Select a Location (if necessary) and the patient's Pharmacy

NOTE: If prescribing a controlled substance, you must have your IdenTrust token inserted into your computer and check the box for "Ready to sign" prior to completing Step 6.

Click "Confirm" or "Confirm and Send" (depending on the Transmission selected)

4. Electronic Prescribing (eRx)

Measure: More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

Exclusions: Any EP who:

- Writes fewer than 100 permissible prescriptions during the EHR reporting period; or
- Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

Alternate Exclusions and/or Specifications:

None

How do I achieve this measure?

In order to qualify for this measure, the provider must electronically prescribe medications (excluding controlled substances).

To electronically prescribe a medication:

In an office visit note, click the “Medication” button (

)
Choose “Add Medication” (or “Renew Medication”)
Search for and select the medication
Enter all appropriate fields and click “Next”

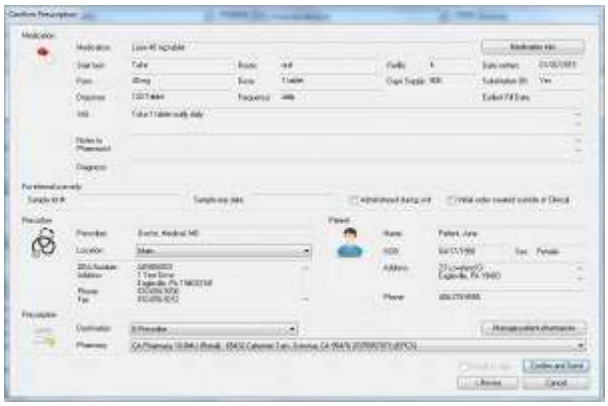
> **NOTE**: Select “E-Prescribe” in the Transmission field. If the medication is a Schedule II controlled substance, a date must be entered in the Earliest Fill Date field.

Select the Location (if necessary) and the patient’s Pharmacy

> **NOTE**: If prescribing a controlled substance, you must have your IdenTrust token (see below) inserted into your computer and check the box for “Ready to sign” prior to completing Step 6.

> **Sample IdenTrust Token**: 

Click “Confirm and Send”



> **Alternative Method**: Use the options available (to queue or renew) when you right-click on the medication from the Face Sheet.

5. Health Information Exchange

Measure: The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

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

Alternate Exclusions and/or Specifications:

None

How do I achieve this measure?

In order to qualify for this measure, the provider must provide a summary of care record to the receiving provider when a patient is transitioning to a new provider, or has been referred to another provider and still remains under the referring provider's care.

To generate a Transition of Care Summary (to fulfill Measure 1):

Go to Chart > Export > Patient Data

> **ALTERNATE METHOD**: If you are outside of a patient's chart, you will use the same steps to access the Transition of Care Summary, however you will need to search for the patient first after opening the Export Patient Document dialog.

Select "Transition of Care Summary" from the Document to Export dropdown

Select the appropriate Provider from the "Provider Selection" dropdown
Click "Save"
(Optional) If prompted with the Patient Information Document Exclusions dialog, select the information that you do not want to print on the Transition of Care Summary and click "OK"
Browse to where you would like to save the file and click "Save"

> **NOTE**: The file will be named "LastName_FirstName_PatientID" by default. You can change the name of the file if you prefer. (The patient ID is not the same as their account number).

Click "OK"

NOTE: The file(s) will now be saved to the specified location. The CCD file will be saved as an .xml file and the HTML file will be saved as a .html file.

CCD: **HTML**:

The HTML file is a human readable formatted document that when opened is displayed in a web browser. The CCD file is a file format that can be imported into another EHR, therefore it is not in a human readable format. You may choose to unselect this file format when generating the file if you do not plan to send a copy to another practice.

To generate a Transition of Care Summary and send via a Direct Message (to fulfill Measure 2):

Open the patient's chart
Go to To-Do > Direct Messaging> Send New Message...

NOTE: If the option for Direct Messaging is greyed out, this means your practice has not been configured for this functionality. Please call Clinical Support for assistance.

Click "To..."
Search for and select the appropriate provider by double-clicking on their name

ALTERNATE METHOD: Highlight the appropriate provider in the Search Results box and click "To -->".

Click "OK"
Enter a "Subject"
Enter a "Message"
Click "Generate and Attach CDA"
Search for and select the appropriate patient
Select the appropriate Provider from the "Provider Selection" dropdown

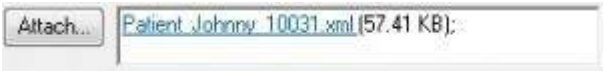
Click “Save”

(Optional) If prompted with the Patient Information Document Exclusions dialog, select the information that you do not want to print on the Transition of Care Summary and click “OK”
Browse to where you would like to save the file and click “Save”

> **NOTE**: The file will be named “LastName_FirstName_PatientID” by default. You can change the name of the file if you prefer. (The patient ID is not the same as their account number).

Click “OK”

> **NOTE**: You will see the Transition of Care Summary attached to your Direct Message:



Click “Send”

To view previously sent Direct Messages:

Go to To-Do > Direct Messaging > View Sent Messages...

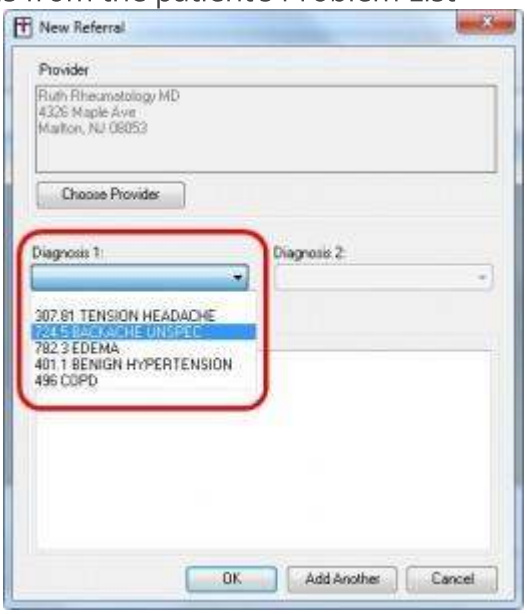
> **NOTE**: If you would like to view messages sent by another user in your practice, click the “User” dropdown and select the applicable user.

To document the transition of care (Optional):

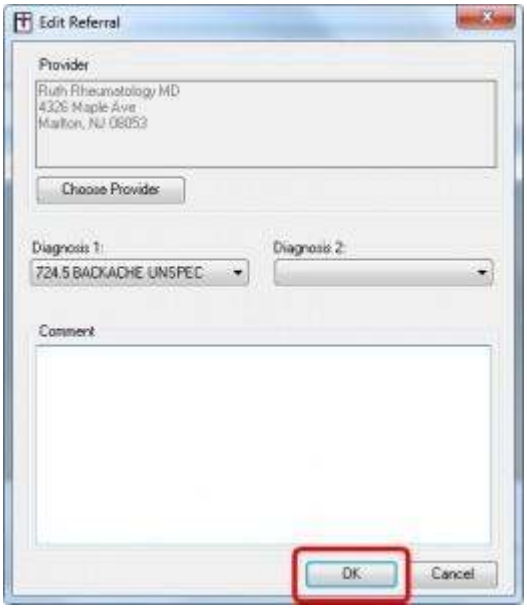
In an office visit note, click the “Referral” button (

)
Click “New”
Click “Choose Provider”

Search for and highlight the appropriate Provider. Click “OK”.
Select at least one diagnosis from the patient’s Problem List



Enter Comments, if applicable
Click “OK”



Click “OK” to close the Referral dialog

NOTE: Entering information into the office visit note through the “Referral” button will only contribute to the denominator. Generating the Transition of Care Summary report will contribute to the numerator. If you enter information through the “Referral” button but do not generate a Transition of Care Summary report, you will never contribute to the numerator (meaning you will only be at 50% for this measure).

In order to be at 100% for this measure, you either need to:

a) Enter information into the “Referral” button and generate a Transition of Care Summary report

or

b) Generate a Transition of Care Summary report

6. Patient Specific Education

Measure: Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.

Exclusion: Any EP who has no office visits during the EHR reporting period.

Alternate Exclusions and/or Specifications:

None

How do I achieve this measure?

In order to qualify for this measure, the provider must provide the patient with educational materials specific to the patient. In a patient note, you will have the option to select from your pre-defined list or from information found on MedlinePlus.

To add educational material options to the database:

Go to Edit > System Tables > Education Materials
Click "Add"
Type the description of the educational resource
Click "OK" to close the Education Materials System Table dialog

> **NOTE:** Repeat steps 2-3 for any additional educational resource options before clicking "OK".

To document educational materials using the "Education Materials" button:

In an office visit note, click "Education Materials" (Education Materials)
Select the checkbox for the item(s) you would like to document in the current note from the box at the top

OR

Click “MedlinePlus” () and either search by selecting one of the patient’s Diagnoses, Medications or Labs from the boxes at the top:

Or by typing the subject you are looking for into the following box and clicking “Go”:

After selecting the appropriate item, click “Save” or “Save and Print”.

Click “OK” to close the Education Materials dialog
Enter an appropriate CPT code

To document educational materials using Clinical Decision Support:

See the section on “~~Clinical Decision Support~~”. The only step that would be different is when setting up the Rule, the Rule Type should be set to “Education Materials”.

When possible, using Clinical Decision Support is the preferred method to generating educational materials as the final rule stated, “we agree with the HIT Policy Committee and others that the objective and associated measure should make clear that the EP should utilize certified EHR technology in a manner *where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology*.”

7. Medication Reconciliation

Measure: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period.

Alternate Exclusions and/or Specifications:

None

How do I achieve this measure?

In order to qualify for this measure, the provider must perform a medication reconciliation whenever a patient is transferred into their care from another setting (i.e. hospital or skilled nursing care), in the last 60 days. This means the provider must compare what the patient was taking while under the care of the outside provider versus what they are taking under your care.

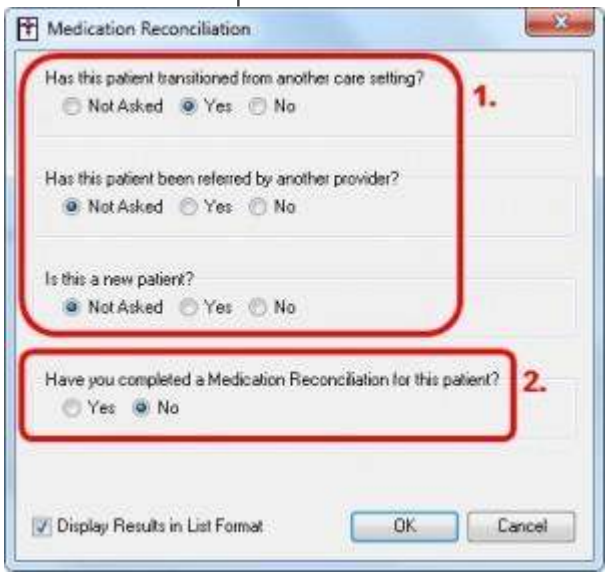
To perform a medication reconciliation:

Obtain a list of medications the patient was on under the care of the transferring provider
Open the patient's chart and compare that list with what is in ChartMaker® Clinical
In a chart note, click "Medication Reconciliation" (Medication Reconciliation)

> **ALTERNATE METHOD**: Enter one of the following medication reconciliation codes from within a procedure checklist. If using this method, you can skip step 4.

- 1110F – Medication Reconciled (from inpatient facility)
- 1111F – Medication Reconciled (from outpatient facility)
- 1111F with 8P - Medications not reconciled with the current medication list in outpatient medical record, reason not otherwise specified

Select "Yes" to the appropriate method of referral and/or if they are a new patient and "Yes" that Medication Reconciliation was performed and then click "OK"



In the same note, enter an appropriate CPT code for the office visit

8. Patient Electronic Access (VDT)

Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.

Measure 2: For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.

Exclusions: Any EP who:

- Neither orders nor creates any of the information listed for inclusion as part of the measures; or
- Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Alternate Exclusions and/or Specifications:

None

How do I achieve this measure?

In order to qualify for this measure, the provider must submit health information for their patients through the ChartMaker® PatientPortal. The provider will need to register the patient on the portal first through Practice Manager and then the patient must verify the registration before an exchange of information can occur. (Once the registration is verified, ChartMaker Clinical will automatically send updates at a pre-configured amount of time.) The patient must also log into their PatientPortal account and either view (Clinical Summaries or Lab Reports), download or transmit their information to a third party.

> **NOTE**: The PatientPortal will need to be configured first before being able to use it. To request enrollment, visit www.sticomputer.com, click "Enrollments", fill out the ~~form~~ and click "Submit". Please contact STI Clinical Support if you need assistance with this process.

To enroll the patient for the PatientPortal (with an email address):

In Practice Manager, open the patient's account
On the Patient tab, click "Patient Portal"

NOTE: You will need the patient's first name, last name and date of birth documented on their account in order to register the patient.

Click the first "Authorize" option

Click "Yes"

NOTE: The status of the registration will now display as "pending".

Click "OK"

NOTE: The Patient Portal button will now show as yellow. Yellow indicates a pending registration. The button will turn green once the patient completes

the registration process.

Click “Save” to close the patient’s account

NOTE: The denominator and numerator are not necessarily tied to the same event. To populate the denominator the provider must have completed an office visit note, with a valid CPT code included, for the patient encounter. To populate the numerator, the patient must be authorized for the PatientPortal through Practice Manager on the Patient tab and the provider must sign all information being sent to the portal (i.e. progress notes, labs, etc.) within 4 business days of receiving it.

To enroll the patient for the PatientPortal (without an email address):

In Practice Manager, open the patient’s account
On the Patient tab, click “Patient Portal”

NOTE: You will need the patient’s first name, last name and date of birth documented on their account in order to register the patient.

Click the second “Authorize” option

Click “Yes”

NOTE: The status of the registration will now display as “pending”.

Click “OK”

NOTE: The Patient Portal button will now show as yellow. Yellow indicates a pending registration. The button will turn green once the patient completes the registration process.

Click “Save” to close the patient’s account
Give the printed instructions to the patient and encourage them to complete registration at a later time

NOTE: The denominator and numerator are not necessarily tied to the same event. To populate the denominator the provider must have completed an office visit note, with a valid CPT code included, for the patient encounter. To populate the numerator, the patient must be authorized for the PatientPortal through Practice Manager on the Patient tab and the provider must sign all information being sent to the portal (i.e. progress notes, labs, etc.) within 4 business days of receiving it.

Steps taken by the patient to complete registration and login to the PatientPortal to View/Download/Transmit information:

Log into their email account and access the email regarding the PatientPortal registration
Click the link to access the PatientPortal to complete registration

Fill out the required information (Username, Date of Birth, Password, Confirm Password, Security Question and Answer)

NOTE: Date of Birth must match what is documented in Practice Manager/Clinical.

Accept the Terms of Use along with typing the security characters that are displayed in the picture
Click “Register”
Login using the credentials designated in Step 3

Complete one or all of the following actions:

a) View Clinical Summaries by clicking “Clinical Summaries”

b) View Lab results by clicking “Lab Results”

c) Download information by either going to “Clinical Summaries” or “Lab Reports” and then clicking “Download”

d) Transmitting a Clinical Summaryor Lab Report by going to “Messages” and then clicking “Send a Direct message”

9. Secure Messaging

Measure: For at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period..

Exclusion: Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Alternate Exclusions and/or Specifications:

None

How do I achieve this measure?

In order to qualify for this measure, the provider must receive a secure electronic message via the ChartMaker PatientPortal from a patient that was seen during the reporting period.

To send a secure electronic message via the ChartMaker PatientPortal:

NOTE: This will be completed by the patient

Log into the PatientPortal
Click “Messages”
Click “Send a message”
Select the appropriate Message Type

NOTE: As of ChartMaker® Medical Suite 2015, all message types will count toward the calculation of this measure. Prior to this version, only Message Types of "Refill Request" and "Health Question" counted towards this measure.

Select the applicable Provider from the dropdown

NOTE: As of ChartMaker® Medical Suite 2015, the calculation of the numerator has been updated to include all providers that saw the patient within the reporting period as long as one of the provider's meet the requirements for the measure. Prior to this version, only the Provider selected in this dropdown received credit for this measure.

Enter a Phone Number
Enter a Message
Click "Send"

NOTE: The message will be sent to the list of users configured to receive this Message Type. This is configured by going to To-Do > New Message/Task. Click "To" and highlight the applicable Distribution List (Patient Portal Health Questions or Patient Portal Refill Requests) and then click "Edit...".

NOTE: None of the following options are required in order to receive credit for this measure.

To delete a message received via the ChartMaker PatientPortal:

NOTE: The message will only be removed from the current user's To Do List (and not the other users configured on the Distribution List).

Double-click on the message from your To Do List
Click "Delete"

ALTERNATE METHOD: Highlight the message from your To Do List and click "Delete".

To print a message received via the ChartMaker PatientPortal:

Double-click on the message from your To Do List
Click “Print”

ALTERNATE METHOD: Highlight the message from your To Do List and click “Print”.

To reply to a message received via the ChartMaker PatientPortal:

Double-click on the message from your To Do List
Click “Reply”
Type your message and click “Send”

To save a message received via the ChartMaker PatientPortal to the patient’s chart:

Double-click on the message from your To Do List
Click “Yes and sign”
Click “Save”
Enter an applicable Heading and click “OK”
(Optional) If prompted with the Patient Information Document Exclusions dialog, select the information that you do not want to print on the Transition of Care Summary and click “OK”
Select a provider and click “OK”

To send the patient a message to their PatientPortal account:

Open the patient’s chart

NOTE: This process must be done from within a patient’s chart

Click To-Do > New Patient Portal Message...
Enter a “Subject” and your message
Click “Send”

10. Public Health Reporting

EP’s must register with the public health agency no later than 60 days from the first day of their reporting period to be in compliance with measure requirements.

Measure Option 1 – Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data.

Exclusions: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP:

- Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period;
- Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
- Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.

Alternate Exclusions and/or Specifications:

None

How do I achieve this measure?

In order to qualify for this measure, the provider must submit electronic immunization information to their local immunization registry on an ongoing basis for pediatric and adult patients. The state of DE, GA, NY, NJ, MD, PA, and VA, and the city of Philadelphia ("KIDS Plus") currently have immunization registries that accept electronic data. If the entity that you submit immunization information to does not accept them electronically, then you would meet the exclusion for this measure.

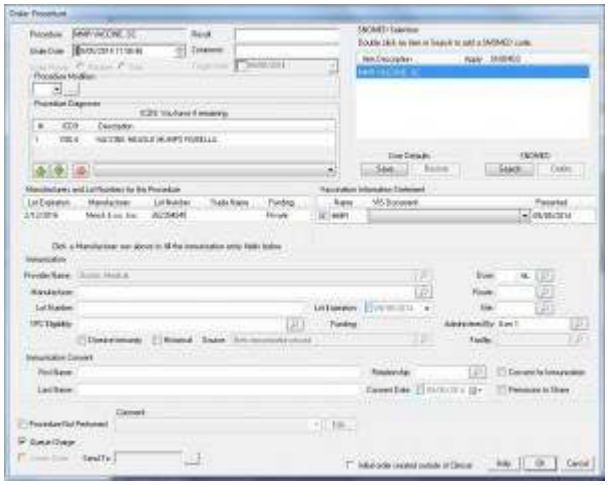
To send immunization information electronically from ChartMaker Clinical:

Go to sticomputer.com and click "Enrollments"
Under "Immunizations", find the applicable registry and fill out/download any applicable materials.

To document immunizations given in ChartMaker Clinical:

Open the patient's chart and create a note
Select the applicable immunization procedure from a procedure checklist

Enter the appropriate information (for the patient encounter and/or immunization registry)



NOTE: The fields with an asterisk are the typical fields the immunization registries are looking for. The "Permission to Share" checkbox is a required field for patients over the age of 18 in the state of New York.

Click "OK"

To generate an immunization batch file (manually for non-bi-directional registries):

In Practice Manager, go to Add-ins > Run > Generate Immunization Batch File
Log in using your Practice Manager username and password
In the Format dropdown, select the applicable registry
Select the appropriate Practice

NOTE: Leave the Provider field blank

(Optional) Select the applicable Facility

NOTE: Depending on the registry, Facility may or may not be required. The states of DE and NY as well as the city of Philadelphia's KIDS registry require the Facility.

Enter the Start & End Dates for the appropriate time range
Specify the Output Directory

NOTE: This is typically a folder located on your Desktop called "Immunization Batch Files".

Specify the File Name (i.e. "1234567Vaccine121720012.HL7")

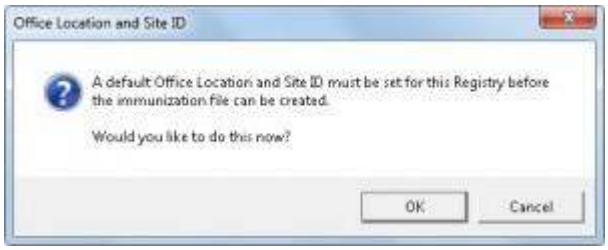
NOTE: It is recommended to include the date the file is created for distinction. Use the file extension of ".HL7" (instead of .asc).

Click "Save" () or go to File > Save As

NOTES:

- If this is your first time generating a file, you will be prompted to save your default Office Location and Site ID. Complete the following steps to set up your Office Locations:

    a) Click “OK” when prompted.



    b) Select the applicable registry from the “Registry Format” dropdown

    c) Click the lookup button () to select the default Office Location. Highlight the appropriate Facility and click “OK”.

    d) Enter your practice’s Site ID

    e) Click “Add”

    f) Repeat steps C – E, as needed

    g) Check the box for “Default” for the default Facility

    h) Click “Save”

- Two files will be created in the location you selected to save the file: The HL7 file and a zipped version of the HL7 file.

Close the Vaccine Registry dialog by clicking the red “X” ()

To upload an immunization batch file to a state registry:

Follow the steps provided by an STI representative or the immunization registry’s representative to upload the HL7 file.

Measure Option 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data.

Exclusion: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP:

- Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
- Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
- Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

Alternate Exclusions and/or Specifications:

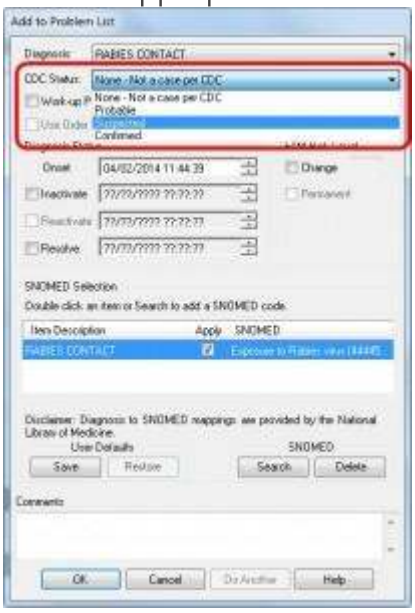
Alternate Specification: EPs may claim an alternate exclusion for measure 2 (Syndromic Surveillance Reporting) for an EHR reporting period in 2016.

How do I achieve this measure?

In order to qualify for this measure, the provider must submit syndromic information about infectious diseases (such as H1N1, Tuberculosis, Rabies, etc.) to the local CDC in an electronic format. If your local agency does not have the capacity to accept this information electronically, then you would meet the exclusion for this measure.

To document syndromic status:

In an office visit note, select a diagnosis
In the CDC Status dropdown, select the appropriate status



NOTE: The status options are:

a) Probable

b) Suspected

c) Confirmed

For complete definitions of these statuses, see the CDC's website.

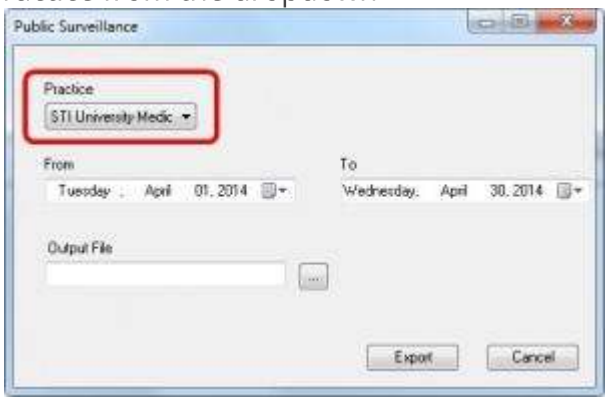
Click "OK"

To export public surveillance data:

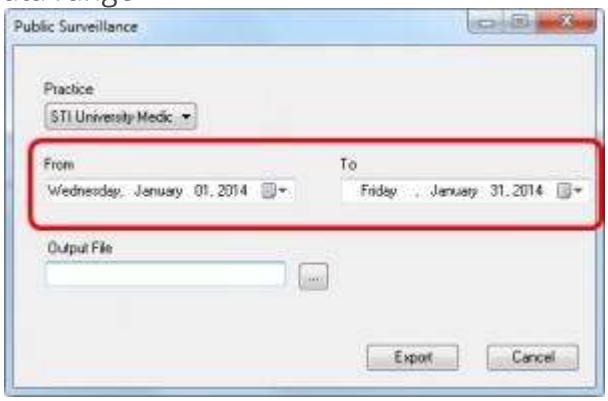
Go to Chart > Export > Public Surveillance Data

NOTE: This must be done outside of the patient's chart.

Select the appropriate practice from the dropdown



Select the appropriate data range

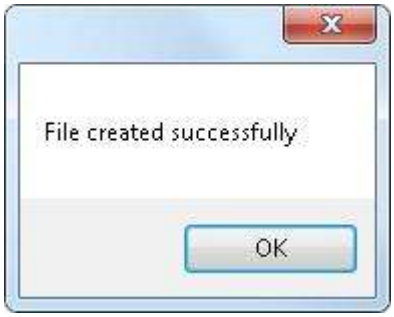


Click the (...) in the "Output File" field
Select where you would like to save the file and click "Save"

NOTE: The file will be saved in a HL7 format and will be named "PublicSurveillanceData" by default. You can change the file name if you want.

Click "Export"

Click "OK"



8. Click "Cancel" to close the Public Surveillance dialog

ADDITIONAL INFORMATION:

As of 9/29/14, the current status for the following registries are as follows:

State Registry	**Status**
Delaware	Not accepting data electronically from EPs yet
Georgia	Currently accepting data electronically from EPs. More information can be found at: http://dph.georgia.gov/meaningful-use
Maryland	Not accepting data electronically from EPs yet
New Jersey	Not accepting data electronically from EPs yet
New York	Not accepting data electronically from EPs yet (outside of NYC)
Pennsylvania	Currently accepting data electronically from EPs through a third party called Health Monitoring Systems (HMS). HMS can only accept data via an interface which is currently not supported by STI.
Virginia	Currently accepting data electronically from Family Medicine, Internal Medicine, Pediatric, or Infectious Disease EPs. More information can be found at: https://www.vdh.virginia.gov/meaningfuluse/mu2/Login/Login.aspx

It is recommended that the practice take a screenshot showing the process of sending the submission as well as the file that was sent. Alternately, a letter or email from the registry or public health agency confirming the receipt of the submitted data, including the date of the submission, name of parties involved, and whether the test was successful could be collected as well.

Diseases that fall into the CDC reporting requirements are as follows:

Diagnosis	**ICD-9 Code(s)**
Acquired immunodeficiency syndrome (AIDS)	042, 073.93
Amebiasis	V02.2, 006.9, 006

Anthrax	V01.81, 022.3, 022.9, 022
Aseptic meningitis	100.81, 322.9, 047.9, 047.0, 047.1. 321.2, 348.2, 053.0, 072.9
Botulism, foodborne	005, 005.1
Botulism, infant	005.1, 040.41, 771, 005
Botulism, wound	005.1, 040, 040.42, 005
Botulism, unspecified	040, 005
Brucellosis	023.8, 023.9, 780.6, 023.1, 023.2, 277.31, 711.4, 716.9, 066.1, 695.9
Chancroid	099, 099.9, 289.3, 682.9
Cholera	001, 001.9, V06.0, V01, V03, 994.9
Congenital rubella syndrome	771.0, 136.9, 323.9, 760.2, 646.9, V22.2, V82.9, 716.9
Diphtheria	032.9, 032.89, V06.3, V06.1, V06.2, V06.5, V03.5, V05.9, V02.4, V07.2, 357.4, 344.9, 604.91, 478.30, 716.9, 580.81
Encephalitis, post chickenpox	052.9, V05.9, 136.9
Encephalitis, post mumps	072.2, 323.9, 072.9, 322.9
Encephalitis, post other	323.41, 064, 072.2, 056.01, 323.9, 323.82
Encephalitis, primary	326, 323.9, 136.29, 011.9, 094.1, 094.89
Gonorrhea	647, 647.1, V02.7, 098.2, 098.0, V01.6, 098.35, 098.11, V65.4
Granuloma inguinale	099.2. 099, 686.1, 099.1
Hansen disease	757.33, V74.2, V82.9, 030.9
Hepatitis A	070, 573.3, 573, 070.5, 570, 354.5, V02.61, V05.3, 155.0
Hepatitis B	070, 070.20, 070.21, 070.22, 070.23, 070.31, 070.32, 070.33
Hepatitis, non-A, non-B	
Hepatitis, unspecified	573.3, 070, 571, 573, 782.4, 070.30, 070.31, 711, 097.9, 646.9, 995.4, 711.90, 084.6, 573,9, 136.9, 155.0, V02.60
Legionellosis	
Leptospirosis	100.9, 100, 100.89, 100.81, 104.9, V82.9, 136.9, 100-104
Lyme disease	088.81
Lymphogranuloma venereum	099, 099.1, 078.8, 099.5, 799.89, 201.9, 569.2
Malaria	084.6, 084, 647, 771.2, 780.6, 581.81, 573.2, 323.2, 760.2
Measles	055.9, 055, V06.4, V04.2, 055.2, V05.9, 057.8
Meningococcal infections	036.3, 036.0, 036.42, 036.89, 036.2, 322.9, 038.9, 716.9, 038.8, 054.9, 429.89, 429.89, 255.8, 323.41, 729.2, 424.90, 255.5, 780.6, 424.9, 136.9, 423.9,
Mumps	072.9, 072.2, V06.4, 527.2, V05.9, 322.9, 711, 356.9
Pertussis	033, V06.1, V05.9, V03.6, V06.2, V06.5, 033.9, V03.1, V03.7, V04, 484.3
Plague	020.9, 020.8, 038.8, V03, 027.2, V05.9, 780.60, V82.9, 020-027
Poliomyelitis, paralytic	045, 045.9, 730.7, 730, 730.73, V06.3, 138, 344.9, 045.03, 045.92, 045.2, 344.1, 321.2,

Psittacosis	073.9, 486, 073, 136.9
Rabies, animal	071, 979.1, V01.5, V04.5, 312.0, 994.9, 136.9
Rabies, human	071, 979.1, V01.5, V04.5, 312.0, 994.9, 136.9
Rheumatic fever	391, 729.0, 391.1, 424.9. 398.91, 398.99, 393, 392
Rocky Mountain spotted fever	082.0, 066.1, 780.60, 082.9
Rubella	771.0, 056.09, 647, V06.4
Salmonellosis	003.0, 003.22, 484.8, 003.23, 558.9, 716.9, 486
Shigellosis	004.9, 004, 004.3, 004.1, 004.2,
Syphilis, all stages	097.1, 095.9, 090, 647, 090.49, 092, 094.9, 796.4, 453.9, 093.22, 091.4, 410.9, V01.6, 647.04, 759.82, 647.03, 095.5, 647.0, 647.01, 647.02,
Syphilis, primary	091.2, 091.1, 097.9, 093.9,
Syphilis, congenital	090, 090.7, 090.49, 090.40, 091.3, 097.3, 097.9, 759.82, 759.82, 379.32, 520.2, 095.5, 095.8, 760.2, 520.4, 738.0, 447.1, 363.13, 583.81
Tetanus	037, 771.3
Toxic shock syndrome	040.82, 040,
Trichinosis	124, 323.41, 323.9
Tuberculosis	017.2, 011, 012.8, 015.9,
Tularemia	021
Typhoid fever	002.0, 002
Varicella	052.9, 053, V01.79
Yellow fever	060.9, 060.1

Measure Option 3 – Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized registry.

Exclusions: Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP:

- Does not diagnose or treat any disease or condition associated with, or collect relevant data that is collected by, a specialized registry in their jurisdiction during the EHR reporting period;
- Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
- Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

Alternate Exclusions and/or Specifications:

Alternate Specification: EPs may claim an alternate exclusion for measure 3 (Specialized Registry Reporting) for an EHR reporting period in 2016.

How do I achieve this measure?

In order to qualify for this measure, the provider must enroll with a specialized registry and submit information to the registry on an ongoing basis.

STI has partnered with the Genesis Registry (provided by CECity). More information can be found at info.cecity.com. CCDAs will be generated for all patients within a specified date range for the provider. The files will be sent to the STI Health Portal which will then pass them along to CECity via an automatic SFTP process.

To enroll with CECity:

Go to sticomputer.com and click “Enrollments”
Click “Meaningful Use” and then select "CECity Enrollment", fill out the ~~form~~ and click “Submit”
It could take up to 3 weeks to complete the process. After enrollment is complete, and STI has configured your Health Portal for this new service, your provider will receive a To Do List notification similar to this:

This To Do List notification should be printed for your records, by clicking “Print”, in case it is needed for attestation and/or an audit.

NOTE: The functionality to perform an export of specialized registry data became available in version ChartMaker® Medical Suite 2015.