CHeQ Informational Webinar
HIE Certification for Meaningful Use Stage 2
September 16, 2013
California Health eQuality Program (CHeQ)

- Implementing California’s Health Information Exchange (HIE) programs with California Health and Human Services Agency (CHHS), under state’s Cooperative Grant Agreement with federal Office of the National Coordinator for Health Information Technology (ONC)

- CHeQ promotes coordinated health care for Californians by catalyzing the adoption and implementation of Health Information Exchange by:
  - Building a trusted exchange environment that enables inter-organizational and interstate exchange while respecting and protecting patient privacy
  - Supporting uniform standards for exchanging health information
  - Improving public health capacity
  - Accelerating HIE implementation by supporting regional HIE initiatives
## Agenda

<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenter(s)</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome and Introductions</td>
<td>Rebecca Kriz, Senior Manager, CHeQ</td>
<td>1:00PM</td>
</tr>
<tr>
<td></td>
<td>Rim Cothren, Technical Director, CHeQ</td>
<td></td>
</tr>
<tr>
<td>HIE Certification Process</td>
<td>Paul Tuten, Senior Advisor, ONC</td>
<td>1:05PM</td>
</tr>
<tr>
<td>Questions</td>
<td></td>
<td>1:40PM</td>
</tr>
<tr>
<td>Wrap-up</td>
<td></td>
<td>1:55PM</td>
</tr>
</tbody>
</table>
Current CHeQ Projects

- California Trust Framework
- CAIR IMP Interface Pilots
- California Blue Button Initiative
- Lab LOINC/SNOMED Mapping Assistance Project (MAP)
- Rural Incentive Program
- Greater Los Angeles County HIE Coordination Project
- Emerging HIE Forum - November 14th
- Foster Youth Demonstration Project (Ventura County)
Meaningful Use Stage 2
Information Exchange Requirements

Paul M. Tuten, PhD
September 16, 2013
Stage 2 Meaningful Use
Transitions of Care
Meaningful Use

• When looked across both Stages 1 & 2, the ToC objective includes 3 measures:

  • Measure #1 requires the provision of a summary of care record for more than 50% of transitions of care and referrals.

  • Measure #2 requires that the provision of a summary of care record using electronic transmission through CEHRT or eHealth Exchange participant for more than 10% of transitions of care and referrals.

  • Measure #3 requires at least one summary care record electronically transmitted to recipient with different EHR vendor or to CMS test EHR

2014 Edition Certification

• Two 2014 Edition EHR certification criteria:

  • 170.314(b)(1) : Transitions of care—receive, display, and incorporate transition of care/referral summaries.

  • 170.314(b)(2) : Transitions of care—create and transmit transition of care/referral summaries.
ToC Measure #2

• The eligible provider, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either:
  • (a) electronically transmitted using CEHRT to a recipient; or
  • (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.

170.314(b)(2)

• Transitions of care—create and transmit transition of care/referral summaries.
  • (i) Enable a user to electronically create a transition of care/referral summary formatted according to the Consolidated CDA with, at a minimum, the data specified by CMS for meaningful use.
  • (ii) Enable a user to electronically transmit CCDA in accordance with:
    • “Direct” (required)
    • “Direct” +XDR/XDM (optional, not alternative)
    • SOAP + XDR/XDM (optional, not alternative)
Data Requirements:
Transitions of Care

Cert. Category

Care Coordination 170.314(b)

Criterion

Transition of Care 170.314(b)(1)&(2)

when transitioning a patient to another care setting, the EP or EH/CAH should provide a summary care record

Description

Transition of Care/Referral Summary

Summary Type

Common MU Data Set

- Patient name
- Sex
- Date of birth
- Race **
- Ethnicity **
- Preferred language**
- Care team member(s)
- Medications **
- Medication allergies **
- Care plan
- Problems **
- Laboratory test(s) **
- Laboratory value(s)/result(s)
- Procedures **
- Smoking status **
- Vital signs

Criterion-Specific Data Requirements

- Provider Name & Office Contact Information (Ambulatory Only)
- Reason for Referral (Ambulatory Only)
- Encounter Diagnoses **
- Cognitive Status
- Functional Status
- Discharge Instructions (Inpatient Only)
- Immunizations **

NOTE: Data requirements marked with a double asterisk (**) also have a defined vocabulary which must be used
Transmit Summary Care Record Using CEHRT “Direct”

Example 1

Provider A

Direct (SMTP + S/MIME)

Provider B

Example 2

Provider A

Any Edge Protocol

HISP

Direct (SMTP + S/MIME)

Provider B

Example 3

Provider A

Any Edge Protocol

EHR Affiliated HISP

Direct (SMTP + S/MIME)

Provider B

Represents Certified EHR Technology or “CEHRT”
Transmit Summary Care Record
Using CEHRT “Direct” + XDR/XDM (Option)

Example 1
Provider A
Direct (SMTP + S/MIME) + XDR/XDM
Provider B

Example 2
Provider A
Any Edge Protocol
HISP
Direct (SMTP + S/MIME) + XDR/XDM
Provider B

Example 3
Provider A
Any Edge Protocol
EHR Affiliated HISP
Direct (SMTP + S/MIME) + XDR/XDM
Provider B

<Data>

Represents Certified EHR Technology or “CEHRT”
Example 1
1. EHR generates CCDA
2. EHR (certified to include optional SOAP + XDR/XDM transport) sends message to Provider B using SOAP + XDR/XDM

Example 2
1. EHR generates CCDA
2. EHR (certified to include optional SOAP + XDR/XDM transport) sends message to Provider B (via HISP) using SOAP + XDR/XDM
3. HISP/HIE repackages content and sends to Provider B

Examples 2 demonstrates how CEHRT may be used to integrate with other HISPs, eHealth Exchange participants, or HIEs offering query-based exchange.
Example 1

NwHIN Example
1. EHR generates CCDA
2. EHR sends CCDA to eHealth Exchange Participant
3. eHealthExchange Participant sends to Provider B

Provider A

Provider B

An eHealth Exchange Participant does not have to be certified in order for Provider A’s transmissions to count for MU.

However, Provider A must still use CEHRT to generate a standard summary record in accordance with the CCDA.
Providers #1-4 (1) have CEHRT, and (2) use the CEHRT’s transport capability (Direct or SOAP) to send a CCDA to a HISP/HIE that enables the CCDA they’ve sent the HISP/HIE to be subsequently pulled by Provider #5.

In this scenario, the HIE does not have to be certified.
If Providers #1-4 do not have CEHRT, their EHR technology will either

1. Need to be certified as a pair with HISP/HIE to be able to create the CCDA and transmit it to Provider 5 (per the prior slides).

2. Need to use an HIE that has been certified to support this criteria (per the prior slides).
Regardless of certification path, Provider #5 needs to “pull” the summary care record in order for Provider #1-4 to potentially count the pull in their numerator.

For all Providers where the patient meets the denominator requirements, when Provider #5 pulls they can then count that pull in their numerator as a transmission to Provider #5 (e.g., Providers #1-3 saw the patient during the reporting period but #4 did not; thus only Providers #1-3 could count the pull).

In the “pull” scenario, accurately counting transactions for the providers’ numerators and denominators represents a non-trivial challenge.
Stage 2 Meaningful Use
View, Download, Transmit
<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Certification</th>
</tr>
</thead>
</table>
| Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP. | **Measure 1:**
More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information. | (e)(1) View, download, and transmit to 3rd party.
(i) EHR technology must provide patients (and their authorized representatives) with an online means to view, download, and transmit to a 3rd party the data specified below. Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at §170.210(f).
(A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data:
(1) The Common MU Data Set (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set).
(2) Ambulatory setting only. Provider’s name and office contact information.
(3) Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization.
(B) Download.
(1) Electronically download an ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) in human readable format or formatted according to the standard adopted at § 170.205(a)(3). That includes, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set):
(i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2) of this section.
(ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(3) of this section.
(2) Inpatient setting only. Electronically download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion adopted at paragraph (b)(2) of this section).
(C) Transmit to third party.
(1) Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) created in paragraph (e)(1)(i)(B)(1) of this section in accordance with the standard specified in § 170.202(a).
(2) Inpatient setting only. Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in accordance with the standard specified in § 170.202(a).
(ii) Activity history log.
(A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section, the following information must be recorded and made accessible to the patient:
(1) The action(s) (i.e., view, download, transmission) that occurred;
(2) The date and time each action occurred in accordance with the standard specified at § 170.210(g); and
(3) The user who took the action.
(B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient. |
Measure 2

More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives)

- view,
- download, or
- transmit to a third party...

...their health information.

**Certification Criteria**

(A) **View.** Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data:

1. The Common MU Data Set (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set).
2. Ambulatory setting only. Provider’s name and office contact information.
3. Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization.

(B) **Download.**

1. Electronically download an ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) in human readable format or formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set):
   - i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2) of this section.
   - ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(3) of this section.
2. Inpatient setting only. Electronically download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion adopted at paragraph (b)(2) of this section).

(C) **Transmit to third party.**

1. Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) created in paragraph (e)(1)(i)(B)(1) of this section in accordance with the standard specified in § 170.202(a).
2. Inpatient setting only. Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in Accordance with the standard specified in § 170.202(a).
(C) Transmit to third party.

(1) Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) created in paragraph (e)(1)(i)(B)(1) of this section in accordance with the standard specified in § 170.202(a).

(2) Inpatient setting only. Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in Accordance with the standard specified in § 170.202(a).
Transmit Summary Care Record Using CEHRT “Direct”

Example 1

Provider A

<Data>

Any Edge Protocol

Direct (SMTP + S/MIME)

Provider B

Example 2

Provider A

HISP

Any Edge Protocol

Direct (SMTP + S/MIME)

Provider B

Example 3

Provider A

EHR Affiliated HISP

Any Edge Protocol

Direct (SMTP + S/MIME)

Provider B

Represents Certified EHR Technology or “CEHRT”
In order to meet measure 2, view, download, and transmit, eligible providers can use this equation:

**NUMERATOR:** The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient’s health information.

**DENOMINATOR:** The number of unique patients seen by the EP during the EHR reporting period.

>5%

Important note: unlike for ToC, VDT transmit doesn’t require the use of CEHRT for the transactions to count in the provider’s numerator.
Stage 2 Meaningful Use
Public Health
Can a public health agency use a Health Information Exchange (HIE) to interface with providers who are submitting public health data to meet the public health objectives of meaningful use (such as submitting information to an immunization registry, reporting lab results to a public health agency or reporting syndromic surveillance information)?

There are a variety of methods for the exchange of public health information, and CMS does not limit or define the receiving capabilities of public health entities. Among other requirements as specified in the regulations, a provider must submit data for the public health objectives of meaningful use as follows:

- The information required by a public health meaningful use objective must originate from the provider’s Certified Electronic Health Records Technology (CEHRT); and
- The information sent from the provider’s Certified EHR Technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective.

If a provider intends to use an intermediary as an extension of their CEHRT to satisfy a meaningful use requirement and not simply to transport the data, the intermediary would need to be certified as an EHR Module for that purpose. When obtaining a CMS certification number from the Certified HIT Products List (CHPL), a provider would need to include the intermediary’s certification number during their attestation.

Source: https://questions.cms.gov/faq.php?faqId=8904
Thank You!

For more information on HIE Certification or on CHeQ projects, please contact us

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