2017 Program Year Requirements for Eligible Professionals
Stage 3

Stage 3

EHR Reporting Period

- 90-day Reporting Period for both new and returning Meaningful Use participants.

Notes & Updates

- There are 8 Meaningful Use Objectives for Stage 3.
- Providers must have a 2015 Edition or at minimum a 2014/2015 combination system in order to attest to Stage 3.
    - The provider cannot successfully demonstrate Stage 3 with only a 2014 Edition system.
- A provider cannot attest to Stage 3 unless he or she has successfully attested to Modified Stage 2 previously.
    - For example, if a provider received payment for an application for Adopt, Implement, or Upgrade for Program Year 2016, then the provider could not submit a Stage 3 application for Program Year 2017. The provider would first have to complete a Modified Stage 2 first.

Specific Changes to Objectives

- Some of the objectives are being modified or provide a new flexibility in order to assist in meeting the measure. The three measures in which allow flexibility are:
    - **Coordination of Care through Patient Engagement** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
    - **Health Information Exchange** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
    - **Public Health Reporting** – Eligible professionals must report on two measures and eligible hospitals must report on four measures.

Stage 3 – A complete list of the 8 Objectives

Objective 1 – Protect Patient Health Information

Objective: Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.

Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.
No exclusion available.

Objective 2 – Electronic Prescribing (eRx)
Objective: Generate and transmit permissible prescriptions electronically (eRx).
Measure: More than 60 percent of all 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 their 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.

Objective 3 – Clinical Decision Support
Objective: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.
Measures: EPs must satisfy both of the following measures in order to meet the objective:
Measure 1: Implement five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs 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:
Measure 2: Any EP who writes fewer than 100 medication orders during the EHR reporting period.

Objective 4 – Computerized Provider Order Entry (CPOE)
Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.
Measures: 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.
Measure 2: More than 60 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Measure 3: More than 60 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.
Exclusions:
Measure 1: Any EP who writes fewer than 100 medication orders during the EHR reporting period.
Measure 2: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.
Measure 3: Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.

Objective 5 – Patient Electronic Access to Health Information
Objective: The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.
Measures: EPs must satisfy both measures in order to meet this objective:
Measure 1: For more than 80 percent 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 percent of unique patients seen by the EP during the EHR reporting period.
Exclusions: Measure 1 and Measure 2: A provider may exclude the measures if one of the following applies:

- An EP may exclude from the measure if they have no office visits during the EHR reporting period.
- Any EP that 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 may exclude the measure.

Objective 6 – Coordination of Care through Patient Engagement
Objective: Use CEHRT to engage with patients or their authorized representatives about the patient's care.
Measure: Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective:
Measure 1: For an EHR reporting period in 2017 and 2018 , more than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either— 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)

Threshold for 2019 and Subsequent Years: The resulting percentage must be more than 10 percent.
Measure 2: For an EHR reporting period in 2017 and 2018, more than 5 percent of all unique patients 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 their authorized representative. Threshold in 2018 and Subsequent Years: The resulting percentage must be more than 25 percent in order for an EP to meet this measure.
Measure 3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.
Exclusions: Measure 1, 2 and 3 Exclusion: A provider may exclude the measures if one of the following apply:

- An EP may exclude from the measure if they have no office visits during the EHR reporting period, or;
- Any EP that 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 may exclude the measure.

Objective 7 – Health Information Exchange
Objective: The 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 the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.
Measures: Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.
Measure 1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: 1) Creates a summary of care record using CEHRT; and 2) Electronically exchanges the summary of care record
Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.
Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: 1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. 2) Medication allergy. Review of the patient's known medication allergies. 3) Current Problem list. Review of the patient's current and active diagnoses.
Exclusions:
Measure 1: A provider may exclude from the measure if any of the following apply:

- 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.
- Any EP that 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 may exclude the measures.

Measure 2: A provider may exclude from the measure if any of the following apply:

- Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure.
- Any EP that 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.

Objective 8 – Public Health and Clinical Data Registry Reporting

Objective: The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Measure Options:

Measure 1 - Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

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

Measure 3 – Electronic Case Reporting: The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.

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.

Exclusions:

Measure 1: 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 their 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 as of 6 months prior to the start of the EHR reporting period.

Measure 2: 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 as of 6 months prior to the start of the EHR reporting period.

Measure 3: Any EP meeting one or more of the following criteria may be excluded from the case reporting measure if the EP—

- Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period;
- Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data 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 electronic case reporting data as of 6 months prior to the start of the EHR reporting period.

Measure 4: Any EP meeting at least one of the following criteria may be excluded from the public health registry reporting measure if the EP—

- Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period;
- Operates in a jurisdiction for which no public health agency 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 public health registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.

Measure 5: Any EP meeting at least one of the following criteria may be excluded from the clinical data registry reporting measure if the EP—

- Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period;
- Operates in a jurisdiction for which no clinical data 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 clinical data registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.