ELECTRONIC PHYSICIAN REPORTING TO STATE CANCER REGISTRIES…Present and Future

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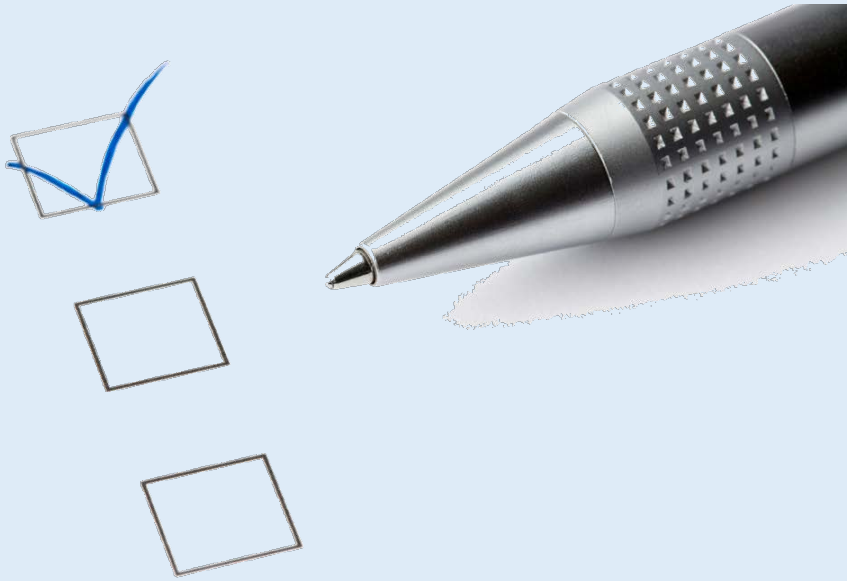
WHERE ARE WE NOW?

Meaningful Use Stage 2: Status

- Most states declared readiness
- At least 20 states are receiving and processing physician EHR data
- 44 EHR vendors (143 total products) are currently certified for Stage 2 cancer reporting criteria
- At least 42 states plan to or currently use eMaRC Plus for physician reporting
- In 2014, 74% of office-based physicians reported using a certified EHR[1]



[1]Report to Congress, February 2016: Update on the Adoption of Health Information Technology and Related Efforts to Facilitate the Electronic Use and Exchange of Health Information

Known Challenges

Proposed Solutions

- Publish registration requirements on website
- Build requirements into registration system
- Take advantage of CDC technical assistance resources
- Participate in CDC-led vendor calls
- Inform CDC of issues identified

What is NPCR Doing to Help?

Technical Assistance

- Review and analysis of cancer CDA reports
- Detailed feedback on CDA reports to send to provider and/or EHR vendor
- Training on CDA, eMaRC Plus, and CDA Validation Plus
- Respond to MU questions; coordinate responses with ONC, CDC, and EHR Public Health Task Force

Coordinated Communication with EHR Vendors

- Monthly or bi-monthly calls with registries and individual EHR vendors
  - Please inform us of any additional vendors you would like to work with
  - Please request to join calls if interested
- Monthly Collaboration call with state cancer registries and EHR vendors
- Ad hoc communications with additional EHR vendors as needed
- Work collaboratively to identify solutions to specific EHR issues identified

What is NPCR Doing to Help?

Software Development and Enhancement

- Ongoing requirements gathering for enhancements to eMaRC Plus
- Enhancements to CDA Validation Plus
- Software updates for bugs identified by states and NPCR

Participation in Other MU Activities

- Bi-monthly State Cancer Registry Physician Reporting WG
- NPCR Meaningful Use web site updated as needed
- Participation in Stage 2 and Stage 3 MU Task Forces
- Information dissemination to registries

Lessons Learned

- **Validation and testing by state cancer registries is resource intensive**
  - Not all registries have resources needed
  - Significant assistance is needed to understand how to interpret validation findings
  - Very slow, labor intensive process, frequent back and forth between states and providers, providers and vendors, and states and vendors
- **Communication with vendors is key**
  - Finding the right person can be a challenge
  - Once the right person is found, vendors have been very receptive to fixing issues
- **Communication/coordination with state programs**
  - Avoids duplication of effort by states
  - Provides single, coordinated communication with vendors

What's next?

Modification Years and Meaningful Use Stage 3

- 2015-2017 (Modification Years): Cancer reporting by EPs under Specialized Registries objective
- 2018 (Stage 3): Cancer reporting by EPs under Public Health Registry Reporting
- 2015 Edition Health Information Technology Certification Criteria
  - *HL7 Implementation Guide for CDA© Release 2: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers Release 1.1* (Referred to as "HL7 IG Release 1.1")
- Declaration of readiness for Stage 3 must be done 6 months in advance (by July 1, 2016 to receive Stage 3 reports on January 1, 2017)

Q: Which IG should be used?

A: The August 2012 Implementation Guide (IG) is the version cited in the 2014 Certification Edition and April 2015 IG is the version cited in the 2015 Certification Edition. Which one is used is only determined by the Stage the provider is in. If they are in Stage 2, they must use the August 2012 version and if they are in Stage 3 they must use the April 2015 version.

Q: Must states declare readiness separately for Stage 3 than their Stage 2 declaration?

A: Yes, you should have a separate declaration that clearly states what is required for Stage 3 (i.e., identify the standard and certification requirements).

Q: When do states need to declare readiness for Stage 3?

A: Six months before you plan to accept Stage 3 reporting.

Q: During the modification years, cancer falls under the "Specialized Registry" option. Does the cancer report need to comply with the IG format?

A: Yes. EPs still must use Certified EHR Technology (CEHRT) for cancer reporting, which means using the required IG and HL7 CDA standard cited in the applicable certification rule (see above).

Q: Is cancer reporting an option for providers that are treating patients with cancer but not treating them for cancer directly (e.g., they might be managing pain or acting as the primary care physician)?

A: No. Specialized Registry Reporting—Exclusions: "Any EP…may be excluded…if the EP…does not diagnose or treat any disease or condition".

Cancer case reporting is expected from physicians who either diagnose or directly treat cancer. "Directly treat cancer" means treatment to reduce or prevent growth of the tumor (surgery, chemo, radiation, hormone therapy, immunotherapy and watchful waiting).

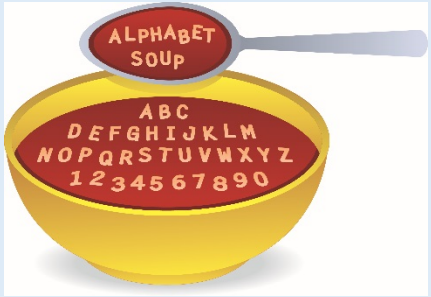
2015 Testing and Certification

- Cancer Report Validator (CRV): New validation tool for Stage 3 IG
- http://cda-validation.nist.gov/cda-validation/muCRV.html
- Lessons learned from Stage 2 resulted in significant improvements to tool
- Includes content and context specific testing
- Available now for EHR vendors

Meaningful Use (MU) Public Health (PH) Reporting Requirements Task Force

- Develops consensus guidance around the new process requirements for Modified Stage 2 Stage 3.
- Modified MU Stage 2 & Stage 3 PHA Readiness Guidance Recommendations Handbook. Version 3.1 available on website.
- http://www.cdc.gov/ehrmeaningfuluse/meaningful-use-mu-public-health-ph-reporting-requirements-task-force.html

MACRA, MIPS & APMs



- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a new program to incorporate multiple CMS quality reporting programs for Medicare clinicians into a single payment adjustment structure called the Quality Payment Program
- On April 27, 2016, CMS issued a Notice of Proposed Rulemaking (NPRM) to put in place key parts of MACRA. The proposed rule would make these changes through a single framework called the "Quality Payment Program". The Program has two paths:
  - The Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)
- In MIPS, providers will be paid for their performance in 4 categories relating to quality, the use of certified EHR technology (advancing clinical information), clinical practice improvement and resource use.
  - Advancing Clinical Information: This category represents 25 percent of total score in year 1; and replaces the Medicare EHR Incentive Program for physicians, also known as “Meaningful Use”.

Fast Healthcare Interoperability Resources (FHIR)

- Standard for exchanging healthcare information electronically
- Developed by HL7
- The basic building block in FHIR is a Resource; resources all share these characteristics:
  - A common way to define and represent them, building them from data types that define common reusable patterns of elements
  - A common set of metadata
  - A human readable part
- Possible uses
  - New format for physician cancer reporting
  - Structured Data Capture (SDC) for ePath and physician reporting

Structured Data Capture (SDC)

- Standards and specifications for SDC:
  - HL7 Fast Healthcare Interoperability Resources (FHIR)
  - Integrating the Healthcare Enterprise (IHE)
- Identify data needed and available data sources
- Develop SDC Form to capture standard data from source (physician EHR, Laboratory, etc.)
- EHR systems auto-populate the SDC Form and allow for manual data entry, if needed
- Participate in testing and demonstrations with EHRs and other healthcare vendors at IHE, HL7, and HIMSS
- Could address some of the data quality and workflow issues

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