MU MONTHLY

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MU Meaningful Use
Indian Health Service
Improving Health Care within the Indian Health System

IMMUNIZATION REGISTRIES AND SYNDROMIC SURVEILLANCE

Ongoing Submission

In MU Stage 1, both EPs and EHs are required to test at least once their EHR's capacity to send electronic data to an immunization registry and syndromic surveillance to a public health agency. In Stage 2, however, EPs and EHs will be expected to demonstrate ongoing submission of such data.

In addition, immunization registry has been made into a core item for both EPs and EHs in Stage 2. The measure reads as follows:

> Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.

Syndromic surveillance has also been made into a core item for EHs in MU Stage 2 but will remain a menu item for EPs. The measure reads as follows:

> Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.

EPs and EHs must attest YES to successful ongoing submission of electronic immunization data to an immunization information system (IIS), and/or to successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period. To meet MU for immunization registries and syndromic surveillance, an EP or an EH will have to meet one of the following criteria:

- Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period.

(Continued on p. 2)

Contents of This Issue

Immunization Registries and Syndromic Surveillance 1
Important Dates 1
Using RPMS to Submit Electronic Data 2
Syndromic Surveillance Patch 3
Tech Talk 4
NIHB Reaches 24% of Goal 4

If you'd like to see a specific topic covered, email coleen.maddy@ihs.gov with your suggestion.

IMPORTANT DATES

EHs

- **September 30, 2013:** FY 2013 reporting year ends
- **October 1, 2013:** FY 2014 reporting period begins (90 days for all EHs, regardless of stage)
- **November 30, 2013:** Last day to register and attest to receive an incentive payment for FY 2013

EPs

- **October 3, 2013:** Last day for EPs in their first year of Stage 1 to begin their 90-day reporting period for CY 2013 (EPs in their second or third participation year must demonstrate MU for the entire CY)
- **December 31, 2013:** CY 2013 reporting year ends
- **January 1, 2014:** CY 2014 reporting period begins (90 days for all EPs, regardless of stage)
- **February 28, 2014:** Last day to register and attest to receive an incentive payment for CY 2013

Note: 2014 is the last year that EPs can begin the Medicare EHR Incentive Program.

REGISTRIES AND SURVEILLANCE

(Continued from p. 1)

- Registration with the public health agency or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation.

The exclusions below are applicable to both measures for any EP or EH:

- Does not administer any immunizations to or collect syndromic surveillance data on their patients during the EHR reporting period.
- Operates in a jurisdiction for which no IIS or public health agency is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period for accepting immunization or syndromic surveillance data.
- Operates in a jurisdiction where no IIS or public health agency provides information timely on capability to receive immunization data or syndromic surveillance data.
- Operates in a jurisdiction for which no IIS or public health agency is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

Although both measures are similar in how they demonstrate MU, their technical requirements differ. The next two articles highlight some of those important variations.

USING RPMS TO SUBMIT ELECTRONIC DATA

Introducing IHS Interface: How It Works

Whether needed for a one-time test or for ongoing submission, RPMS users at federal, tribal and urban health facilities can use the IHS Immunization Interface Management software, often referred to simply as IHS Interface, to meet the immunization registries measure for both Stage 1 and Stage 2.

For IHS Interface to function properly, EPs and EHs must use the RPMS Immunization Module to record and track immunizations. Doing so allows IHS Interface to extract information from the Immunization Module and format it into HL7 2.5.1 immunization messages that meet all ONC certification and CMS attestation criteria.

In addition to using the RPMS Immunization Module, EPs and EHs must verify that their IIS can accept HL7 messages. Although each state is required to build its own IIS system, not all states or jurisdictions are at the same level of readiness. State IIS are usually located within the immunization program of the state health department.

Unfortunately, EPs and EHs that have begun this verification process have reported a long lag time from the initial Q & A to achieving ongoing submission. This is due, in part, to state-to-state variability in messaging specifications. Although all states build their messaging to meet the same standards, some jurisdictions carry requirements that others do not.

In acknowledgment of these circumstances, the RPMS EHR was built with one software package that addresses the basic needs of all states. The IHS Interface team then releases patches on a continual basis in response to unique state requirements as they emerge. However, this means that providers have to wait, often for months, from the time messaging needs are identified until that need is met in IHS Interface. In addition, a state may need to make programming changes in order to accept RPMS messages in accordance with the HL7 standard. This creates a waiting period as well.

USING RPMS

(Continued from p. 2)

Providers who have yet to engage in this process may question whether they will be able to achieve the immunizations registries measure in 2014. Rest assured that ongoing submission encompasses all stages of the process from registration, project initiation, testing and validation to production interfacing. Furthermore, providers may meet one of the several exclusions already listed (see p. 2).

Questions

Contact your area immunization coordinator or area data exchange team for more information. Contact Cecile Town, IHS interface coordinator, to learn more about the status of the software and how that impacts submission in a specific state.

SYNDROMIC SURVEILLANCE PATCH

One of the positive outcomes of the H1N1 influenza pandemic in 2009-10 was a rapid, proactive response by IHS to monitor influenza-like illness (ILI) and influenza vaccinations throughout Indian Country. The RPMS Program Management Office in OIT and the Office of Public Health Support's Division of Epidemiology and Disease Prevention (DEDP) partnered to develop an RPMS patch that accumulates targeted ILI and influenza vaccination data at the local site and securely exports the information daily to DEDP. Because DEDP is recognized as a public health agency by CMS, local sites are able to meet MU Stage 1 and Stage 2 requirements for syndromic surveillance simply by using this patch and providing daily export files to DEDP.

What's New in MU Stage 2

Although the Stage 2 requirements for syndromic surveillance have increased from Stage 1 (see p. 1), the impact on local sites continues to be minimal as long as the RPMS patch is installed and implemented. A new version of the patch, APCL v3 Patch 29, is expected to roll out later this summer and will incorporate all of the requirements necessary for facilities to meet both the Stage 1 and Stage 2 measures for syndromic surveillance.

Reports and Documentation

Another positive outcome of the pandemic has been that DEDP consolidates and aggregates the ILI and influenza vaccination data into reports. These reports provide national and IHS area overviews and comparisons for ILI trends since the pandemic; weekly percentages of ILI visits by IHS area; influenza vaccine coverage by age and high-risk groups (such as asthma and diabetes); and counts of the specific influenza vaccines administered. This information has been used by national program administrators as well as IHS areas, service units, and facilities to monitor ILI and influenza vaccine coverage on a weekly basis.

Individuals interested in viewing reports created from the daily export files can look through the weekly list at IHS Influenza Surveillance Reports. More detailed reports for a specific area, service unit, or facility can be obtained by contacting the appropriate area representative. In addition, a new report distribution method that uses a web browser is about to be implemented. This process will allow individuals to obtain reports directly and will inform area representatives when reports are available.

Non-RPMS sites, such as NextGen and CERNER sites, can also take advantage of this system by using the documentation available for the patch as a guideline for creating NextGen and CERNER patches. Although news about patch documentation for non-RPMS sites has been fairly informal in the past, documentation for Patch 29 will be posted under Guidance Documents on the Facility Data Exports & Reports web page.

Email any questions about creating a non-RPMS patch to HQ_OPHS_Disease_Surveillance@ihs.gov.

TECH TALK

In preparation for MU2, all federal/tribal/urban sites will need to install Ensemble 2012 as part of the certification requirements. Beta testing was completed in June, and upgrades for all sites are currently being scheduled. See below for several frequently asked questions.

1. What OS is necessary to upgrade to Ensemble 2012?

Windows 2008 R2 (recommended) or AIX 6.1 or higher

2. How long does it take to upgrade?

Duration depends on the database size, but the average upgrade lasts approximately three to four hours.

3. Is assistance available for the upgrade?

Absolutely. Reach out to the contacts at the end of this article to initiate the discussion.

4. Does AIX 5.3 OS need to be updated prior to installing Ensemble 2012?

Yes. Assistance is available with the documentation and configuration for the upgrade to AIX 6.1 or 7.1.

5. Can the system be upgraded remotely?

Yes, but onsite personnel are required in the event of a hardware failure and the need to roll back the upgrade because of an unforeseen error.

Contact either Todd Romero (***todd.romero@ihs.gov***), Federal Lead, or Ryan Cooper (***ryan.cooper@ihs.gov***), project manager, with questions or to schedule the upgrade.

NIHB REACHES 24% OF GOAL

As of July 1, National Indian Health Board (NIHB) Regional Extension Center's (REC) field teams have verified that 654 of 2,700 primary care providers (24 percent) registered with the REC have met the CMS MU Stage 1 measure requirements.

As of June 2013, the NIHB REC has allocated approximately $10M to its sub-recipient organizations to deliver "boots-on-the-ground" EHR and MU services to IHS providers. The NIHB REC's sub-recipients (United South and Eastern Tribes, Alaska Native Tribal Health Consortium, California Rural Indian Health Board, and Northwest Portland Area Indian Health Board) have used these funds to acquire the EHR and MU services of health IT professionals.

To date, the NIHB REC has registered 3,153 primary care providers working in Indian health system facilities to receive its REC health IT services. As of April 30, CMS reported $17,903,368 in total CMS EHR incentive payments to providers signed up with the NIHB REC.

Significant progress has been made in health IT outreach and education efforts throughout the Indian health system. MU report processes in federal, tribal and urban Indian health facilities are improving substantially and indicate that a significant number of providers are moving toward meeting MU Stage 1 requirements. However, more time and effort is required to develop a full working knowledge of the intent and benefits of demonstrating MU.

Staff from federal, tribal, and urban Indian health facilities contribute the central role toward ensuring that MU Stage 1 efforts in Indian Country succeed. Each facility is encouraged to produce ongoing MU reports for its providers to monitor their progress in meeting the MU Stage 1 requirements. If specific measures are not being met, staff is encouraged to contact NIHB REC field teams to request technical support.

MU resources provided by the NIHB REC Core and Sub-Recipient Teams are available at the following links:

NIHB HITECH Resource Center:
http://www.nihb.org/hitech/
USET REC Team:
http://www.usetinc.net/ehr/default.aspx
CRIHB REC Team:
http://www.crihb.org/rec/
NPAIHB REC Team:
http://www.npaihb.org/programs/ehr
ANTHC REC Team:
http://www.anthctoday.org/