Stage 2
Eligible Professional
Meaningful Use Menu Set Measures
Measure 5 of 6

Date issued: October, 2012

Report Cancer Cases	
Objective	Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.
Measure	Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.
Exclusion	Any EP that meets at least 1 of the following criteria may be excluded from this objective: (1) The EP does not diagnose or directly treat cancer; (2) The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period; (3) The EP operates in a jurisdiction where no PHA provides information timely on capability to receive electronic cancer case information; or (4) The EP operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period can enroll additional EPs.

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Definition of Terms

None.

Attestation Requirements

YES/NO

EPs must attest YES to successful ongoing submission of cancer case information from certified electronic health record technology (CEHRT) to a public health central cancer registry for the entire EHR reporting period.

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

EXCLUSIONS: Any EP that meets at least 1 of the following criteria may be excluded from this objective:

(1) The EP does not diagnose or directly treat cancer;
(2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period;
(3) the EP operates in a jurisdiction where no PHA provides information timely on capability to receive electronic cancer case information; or
(4) the EP operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period can enroll additional EPs.

Additional Information

- Legislation requiring cancer reporting by EPs exists in 49 states with some variation in specific requirements, per the 2010 Council of State and Territorial Epidemiologists (CSTE) State Reportable Conditions Assessment (SRCA) (http://www.cste.org/dnn/ProgramsandActivities/PublicHealthInformatics/StateReportableConditionsQueryResults/tabid/261/Default.aspx).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT 45 CFR 170.314 (f)(5), and (f)(6).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§ 170.314(f)(5) Cancer case information	Enable a user to electronically record, change, and access cancer case information.
§ 170.314(f)(6) Transmission to cancer registries	EHR technology must be able to electronically create cancer case information for electronic transmission in accordance with: (i) The standard (and applicable implementation specifications) specified in § 170.205(i); and (ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and (c)(2).

Standards Criteria	
§ 170.205(i) Cancer information & Implementation specifications	HL7 Clinical Document Architecture (CDA), Release 2.0, Normative Edition (incorporated by reference in § 170.299). Implementation Guide for Ambulatory Healthcare Provider Reporting to Central Cancer Registries, HL7 Clinical Document Architecture (CDA), (incorporated by reference in § 170.299).
§ 170.207(a)(3)	IHTSDO SNOMED CT® International Release July 2012 (incorporated by reference in § 170.299) and US Extension to SNOMED CT® March 2012 Release (incorporated by reference in § 170.299).
§ 170.207(c)(2)	Logical Observation Identifiers Names and Codes (LOINC®) Database version 2.40, a universal code system for identifying laboratory and clinical observations produced by the Regenstrief Institute, Inc. (incorporated by reference in § 170.299).