Health Information Technology Policy Committee Recommendations for Stage 2 Meaningful Use

July 7, 2011

Health Outcomes Policy Priority	Stage 1 Final Rule		Stage 2 Proposed by HITPC		Stage 3 Comments
	Eligible Professionals	**Eligible Hospitals**	**Eligible Professionals**	**Eligible Hospitals**	
Improve quality, safety, efficiency, and reduce health disparities	**Medication only**: More than 30% of unique patients seen during the reporting period with at least one medication in their medication list have at least one medication order entered using CPOE		**Medications**: Increase threshold to **60%** **Lab:** More than 60% of unique patients seen during the reporting period with at least one lab test resultreturned during the reporting period have at least one lab order entered during the reporting period using CPOE **Radiology**: At least one radiology test is ordered using CPOE (unless no radiology test is ordered)		
	Implement drug-drug and drug-allergy interaction checks		Employ drug interaction checking (drug-drug, drug-allergy) with the ability for the provider to refine DDI rules		The goal is to have nationally endorsed lists of DDI with higher positive predictive value and ability to record reason for overriding alert
	Generate and transmit more than 40% of all permissible prescriptions electronically	N/A	Increase threshold to **50%**	Generate and transmit more than 10% of all hospital discharge orders for permissible prescriptions electronically	

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	Record demographics as structured data for more than 50% of all unique patients: • Preferred language • Gender • Race • Ethnicity • Date of Birth	Record demographics as structured data for more than 50% of all unique patients: • Preferred language • Gender • Race • Ethnicity • Date of Birth • Date of preliminary cause of death in the event of mortality	Record demographics for more than **80%** of all unique patients seen during the reporting period with the ability to use the data to produce stratified quality reports		Use more granular demographic categories per IOM report (HITSC needs to work on standards for granular demographics)
	Maintain an up-to-date problem list of current and active diagnoses for more than 80% of all unique patients: have at least one entry or an indication that no problems are known for patient recorded as structured data		No change		
	Maintain active medication list: more than 80% of all unique patients have at least one entry recorded as structured data (or indication that the patient is on no meds)		No change		
	Maintain active medication allergy list: More than 80% of all unique patients seen during the reporting period have at least one entry (or indication that the patient has no known medication allergies) recorded as structured data		No change		

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	Record and chart changes in vital signs: more than 50% of all unique patients age 2 and over have vital signs recorded as structured data • Height • Weight • Blood Pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI		Record and chart vital signs: more than 80% of all unique patients seen during the reporting period age 2 and over have vital signs recorded as structured data: • height • weight • blood pressure (for patients 3 and older) • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI		
	Record smoking status for patients 13 years old and older: more than 50% of all unique patients seen during the reporting period 13 years or older have smoking status recorded as structured data		Increase threshold to **80%**		Add new field in certification for secondhand smoke
	Implement one clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance with that rule	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Use clinical decision support **HITSC**: Suggest changing certification criteria definition as indicated on comment summary: 1. Display source/citation of CDS 2. Configurable based on patient context (e.g., inpatient, outpatient, problems, meds, allergies, lab results) 3. Presented at a relevant point in clinical workflow 4. Alerts presented to users who can act on alert (e.g., licensed professionals) 5. Can be integrated with EHR		

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	MENU: Implement drug-formulary checks with access to at least one drug formulary		Implement drug-formulary checks according to local needs (e.g., may use internal or external formulary, which may include generic substitution as a "formulary check")		
	Report ambulatory clinical quality measures to CMS or States	Report hospital clinical quality measures to CMS or the States	No change	No change	
	N/A	**MENU:** Record advanced directives for more than 50% patients 65 years old or older	Record whether an advance directive exists (with date and timestamp of recording) for at least 25 unique patients seen during the reporting period and provide access to a copy of the directive itself if it exists	Record whether an advance directive exists (with date and timestamp of recording) for more than 50% of patients 65 years and older and provide access to a copy of the directive itself if it exists	Signal ability to store and retrieve a copy of the current AD for Stage 3
	MENU: Incorporate clinical lab test results into certified EHR technology as structured data for more than 40% of all clinical lab tests results ordered whose results are either in a positive/negative or numerical format		Incorporate clinical lab test results into certified EHR technology as structured data for more than 40% of all clinical lab tests ordered whose results are either in a positive/negative or numerical format **HITSC:** Use LOINC where available		

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	N/A			Hospital labs send (directly or indirectly) structured electronic clinical lab results to outpatient providers for more than 40% of electronic lab orders received **HITSC:** Use LOINC where available	
	MENU: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach		Generate lists of patients by *multiple* specific parametersto use for quality improvement, reduction of disparities, research or outreach		
	MENU: Send preventive or follow-up reminders to more than 20% of all unique patients 65+ years old or 5 years old or younger		More than 10% of all active patients are sent a clinical reminder (reminder for an existing appointment does not count)		
	N/A		Enter at least one electronic note, broadly defined, by a physician, physician assistant, or nurse practitioner for more than 30% of unique visits during the reporting period (non-searchable, scanned notes do not qualify)	Enter at least one electronic note, broadly defined, by a physician, physician assistant, or nurse practitioner for more than 30% of eligible hospital days (non-searchable, scanned notes do not qualify)	

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	N/A	N/A	N/A	Medication orders automatically tracked via electronic medication administration record in-use in at least one hospital ward/unit (“automatically” implies “5 rights” recorded without manual transcription)	
	N/A		N/A		Record family history (seek HITSC input on appropriate standards)
Engage patients and families in their care	Provide more than 50% of all patients with an electronic copy of their health information upon request	N/A	Access to health information incorporated into view and download	N/A	
	N/A	Provide more than 50% of all patients with an electronic copy of their discharge instructions at the time of discharge upon request	N/A	Discharge instructions incorporated into view and download	

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	Provide more than 10% of all unique patients timely electronic access to their health information subject to the EP's discretion to withhold certain information	N/A	More than 10% of patients and families view and have the ability to download their longitudinal health information; information is available to all patients within 24 hours of an encounter (or within 4 days after the information is available to EPs)	More than 10% of patients and families view and have the ability to download information about a hospital admission; information is made available within 36 hours of discharge. Information available for view and download should include discharge instructions, which are available immediately upon discharge	
	Provide clinical summaries for more than 50% of all office visits within 3 business days	N/A	Provide clinical summaries to patients for more than 50% of all office visits within 24 hours; pending information, such as lab results, should be available to patients within 4 days of becoming available to EPs; (electronically accessible for viewing counts)	N/A	

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	MENU: Use certified EHR technology to identify patient-specific educational resources for more than 10% of all unique patients and provide those resources to the patient if appropriate		Use certified EHR technology to identify patient-specific educational resources and provide those to more than 10% of all unique patients		
	N/A	N/A	Offer secure online messaging to patients: at least 25 patients have sent secure messages online	N/A	
	N/A	N/A	Record patient preferences for communication medium for more than 20% of all unique patients seen during the reporting period	N/A	
	N/A	N/A	N/A	N/A	Provide mechanism for patient-entered data (supply list); consider "information reconciliation" to correct errors

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Improve Care Coordination	Perform at least one test of the capability to exchange key clinical information among providers of care and patient authorized entities electronically		HIE test eliminated in favor of objectives that use HIE		
	MENU: Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP, eligible hospital, or CAH		No change (moves to core with all menu items)		
	MENU: Provide a summary of care record for more than 50% of all transitions and referrals of care		Record and provide (by paper or electronically) a summary of care record for more than 50% of transitions of care for the referring EP or EH		
	N/A		Record care plan goals and patient instructions in the care plan for more than 10% of patients seen during the reporting period		
	N/A		Record health care team members (including at a minimum PCP, if available) for more than 10% of all patients seen during the reporting period; this information can be unstructured		Record health care team members (including at a minimum PCP, if available) using NPI for more than 10% of all patients seen during the reporting period

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	N/A		Electronically transmit a summary of care record (including care plan and care team if available) to the receiving provider for at least 25 patients undergoing a transition of care	Electronically transmit a summary of care record(including care plan and care team if available) to the receiving provider or post-acute care facility for more than 10% of all discharges	
Improve population and public health	MENU: Perform at least one test of the capability to submit electronic data to immunization registries or Immunization Information systems and actual submission in accordance with applicable law and practice		Attest to at least one submission of data to immunization registries or immunization information systems in accordance with applicable law and practice		View cumulative immunization record and recommendations
	N/A	MENU: Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies and actual submission in accordance with applicable law and practice	N/A	Attest to at least one submission of reportable lab results to apublic health agency in accordance with applicable law and practice	
	MENU: Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice		Attest to at least one submission of electronic syndromic surveillance data to a public health agencyin accordance with applicable law and practice		

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	N/A		N/A		Patient-generated data submitted to public health agencies
Ensure adequate privacy and security protections for personal health information	Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of the its risk management process		Perform, or update, security risk assessment and address deficiencies		
	N/A		Address encryption of data at rest		
	N/A		N/A		Signal that Stage 3 may require meeting conditions of participation in NWHIN

Note: In the proposed stage 2 objectives, **all objectives are considered core** (i.e., there are no “menu” items proposed).