Meaningful Use Stage 2 Modifications 2015-2017

IHS Office of Information Technology

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Modified Stage 2: 2015-2017

- Goals of the 2015-2017 Proposed Rule:
  - Simplify MU reporting requirements
    - Remove redundant and topped out objectives
  - Reduce program complexity
  - Align with other quality programs

Certified EHR Version

Version		Start Year	End Year
2011		2010	2014
2014		2014	2017
2015		2017 (optional) 2018 (not required)	?

Meaningful Use Stages

1st Year Demonstrating MU	Stage of MU 2015	Stage of MU 2016	Stage of MU 2017	Stage of MU 2018	Stage of MU 2019 & future years
2011	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2012	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2013	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2014	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2015	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2016	- NA -	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2017	-NA -	- NA -	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2018	-NA -	- NA -	- NA -	Stage 3	Stage 3
2019 and future years	- NA -	- NA -	- NA -	- NA -	Stage 3

EHR Reporting Period

Year	Reporting Timelines
2015	All EPs & EHs use the calendar year for MU reporting for a continuous 90 day reporting period.
2016	90 day reporting period for first time participants; Full year reporting period for participants beyond their first year of participation.
2017	90 day reporting period for first time participants 90 days for Stage 3 adopters Full year reporting period for participants beyond their first year of participation and new Medicare EPs

Modified Stage 2

- EPs and EHs in program year 2015 will report on Modified Stage 2 objectives and measures (2015-2017).
- Alternate exclusions added for Stage 1 EPs & EHs to meet Modified Stage 2 in 2015 and some for 2016.
  - Providers scheduled demonstrate Stage 1 may choose to use the alternate exclusions and specifications, but they **are not required** to use them.

Objective Removed from 2015

- Record Demographics
- Record Vital Signs
- Record Smoking Status
- Clinical Summaries
- Structured Lab Results
- Patient List
- Patient Reminders

- Summary of Care (Measure 1 & 3 Only)
- Electronic Notes
- Imaging Results
- Family Health History
- eMAR (Hospital Only)
- Advanced Directives (Hospital Only)
- Structured Labs to Ambulatory Providers

Demonstrating Modified Stage 2

Eligible Professionals

- 10 Objectives*
- 9 CQMs

Eligible Hospitals

- 9 Objectives*
- 16 CQMs

* Objectives may have multiple measures associated with them. Objectives also include the consolidated public health objective.

Modified Stage 2 Objectives

Eligible Providers

- CPOE
- eRx
- Clinical Decision Support
- Patient Electronic Access
- Protect Electronic Health Info
- Patient Specific Education
- Medication Reconciliation
- Summary of Care/HIE
- Secure Messaging

Eligible Hospitals

- CPOE
- eRx
- Clinical Decision Support
- Patient Electronic Access
- Protect Electronic Health Info
- Patient Specific Education
- Medication Reconciliation
- Summary of Care

Modified Stage 2

Objectives & Measures 2015-2017

Protect Electronic Health Information

Conduct or review a security risk analysis in accordance with the requirements in 45CFR 164.312(a)(2)(iv) and 45CFR 164.306 (d)(3), and implement security updates as necessary and correct identified deficiencies as part of the EP, EH or CAH's risk management process. **(Y/N)**

Stage 1 Alternate Exclusions and Specifications
N/A

Clinical Decision Support

Measure 1: Implement 5 clinical decision support interventions related to 4 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period.

Measure 2: The EP has ***enabled*** and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Stage 1 Alternate Exclusions and Specifications
For an EHR reporting period in 2015 only, an EP, eligible hospital or CAH who is scheduled to participate in Stage 1 in 2015 may implement one clinical decision support rule.

CPOE

> 60% of medication, 30% of laboratory and **30% of radiology** orders are created by the EP or the authorized provider of the Eligible Hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

Stage 1 Alternate Exclusions and Specifications
2015: Providers scheduled to demonstrate Stage 1 may report on >30% Medications orders. 2015 & 2016: Providers scheduled to demonstrate Stage 1 may claim an exclusion for Measure 2 (laboratory orders) and Measure 3 (radiology orders).

Electronic Prescribing (e-Rx)

EPs: *>50%* of all permissible prescriptions, or all prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

EHs: *>10%* of hospital discharge medication orders for permissible prescriptions (for new, changed and refilled prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.

Stage 1 Alternate Exclusions and Specifications
2015: EPs scheduled to demonstrate Stage 1 may report on >40% permissible prescriptions are transmitted electronically. 2015 & 2016: EHs that did not intend to select eRX may claim an exclusion. (eRX was a menu objective for Stage 2)

Health Information Exchange
aka: Summary of Care

The EP or EH that transitions or refers their patient to another setting of care or provider of care:

1. Uses CEHRT to create a summary of care record; **and**

2. Electronically transmits the summary to a receiving provider for **>10%** of transitions of care and referrals.

Stage 1 Alternate Exclusions and Specifications
2015: Providers may claim an exclusion if they were scheduled to demonstrate Stage 1.

Patient-Specific Education Resources

Patient specific education resources identified by CEHRT are provided to patients for **>10%** of all unique patients seen by the EP or discharged from the EH or CAH inpatient or emergency department during the EHR reporting period.

Stage 1 Alternate Exclusions and Specifications
2015: Providers may claim an exclusion if they were scheduled to demonstrate Stage 1, and did not intend to select the Patient Education menu objective.

Medication Reconciliation

The or EP, EH or CAH performs medication reconciliation for **>50%** of transitions of care in which the patient is transitioned into the care of the EP or admitted to the EH's inpatient or emergency department.

Stage 1 Alternate Exclusions and Specifications
2015: Providers may claim an exclusion if they were scheduled to demonstrate Stage 1, and did not intend to select Medication Reconciliation menu objective.

Patient Electronic Access
(View, Download, Transmit)

Measure 1: ***>50%*** of all unique patients seen by the EP or discharged from the inpatient or emergency departments of the EH or CAH during the EHR reporting period are provided timely online access to their health information (within 4 business days after the information is available to the EP or 36 hours of discharge).

Patient Electronic Access (cont.)

(View, Download, Transmit)

Measure 2 (VDT):

2015 & 2016: - At least **1** patient seen by the EP or discharged from the inpatient or emergency department views, downloads or transmit their health information during the EHR reporting period.

2017: **>5%** of unique patients seen by the EP or discharged from the inpatient or emergency department views, downloads or transmit their health information during the EHR reporting period.

Alternate Measure or Exclusions
2015: Providers may claim an exclusion for measure 2 (VDT) if they were scheduled to demonstrate Stage 1.

Secure Messaging

2015: The capability for patients to send and receive a secure electronic message with the EP was **fully enabled** during the EHR reporting period. **(Y/N)**

2016: At least **1 patient** 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 the patient-authorized representative) during the EHR reporting period.

2017: **>5%** of 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 the patient-authorized representative) during the EHR reporting period.

Alternate Measure or Exclusions
2015: Providers may claim an exclusion for Secure Messaging if they were scheduled to demonstrate Stage 1.

Public Health Reporting

EPs must meet 2 of 3 measures; eligible hospitals/CAHs must meet 3 of 4 measures:

Measure 1 -Immunization Registry Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit immunization data.

Measure 2–Syndromic Surveillance Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit syndromic surveillance data.

Measure 3–Specialized Registry Reporting: The EP, eligible hospital, or CAH is in active engagement to submit data to a specialized registry.

Measure 4 – Electronic Reportable Laboratory Result Reporting (for EHs/CAHs only): The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory (ELR) results.

Alternate Measure or Exclusions
2015: An EP scheduled to be in Stage 1 in 2015 may meet 1 measure and an eligible hospital or CAH scheduled to be in Stage 1 in 2015 may meet two measures.

Clinical Quality Measures

Clinical Quality Measures Reporting

- EPs: Report on 9 CQMS from 3 of the 6 domains

- EHs: Report on 16 CQMs from 3 of the 6 domains

- 2015: Continuous 90 day reporting period

National Quality Strategy Domains

- Patient and Family Engagement

- Patient Safety

- Care Coordination

- Population/Public Health

- Efficient Use of Healthcare Resources

- Clinical Processes/Effectiveness

Adult Ambulatory CQMs

Adult Ambulatory Clinical Quality Measures
1. Controlling High Blood Pressure
2. Use of high Risk Medications in the Elderly
3. Preventive Care & screening: Tobacco use screening & cessation intervention
4. Use of imaging studies for low back pain
5. Preventive care & screening for clinical depression and follow-up plan
6. Documentation of current medications in the medical record
7. Preventive care & screening: Body Mass Index (BMI screening & follow-up)
8. Closing the referral loop: receipt of specialist report.
9. Functional status assessment for complex chronic conditions

Pediatric Ambulatory CQMs

Pediatric Ambulatory Clinical Quality Measures
1. Appropriate testing for children with pharyngitis
2. Weight assessment & counseling for nutrition and physical activity
3. Chlamydia screening for women
4. Use of appropriate medications for asthma
5. Childhood immunization status
6. Appropriate treatment for children with upper respiratory infection (URI)
7. Follow-up care for children prescribed attention-deficit/hyperactivity disorder   (ADHD)
8. Preventive care & screening for clinical depression and follow-up plan
9. Children who have dental decay or cavities

Hospital Clinical Quality Measures

Hospital Clinical Quality Measures
1. ED-2: Emergency Department Throughput: Admitted patients – Admit decision time to ED department time for admitted patients.
2. ED-3: Median time from ED arrival to ED departure for discharged ED patients.
3. Stroke-2: Ischemic Stroke: Discharged on anti-thrombotic therapy.
4. Stroke-3: Ischemic Stroke: Anticoagulation therapy for atrial fibrillation/flutter.
5. Stroke-4: Ischemic Stroke: Thrombolytic therapy.
6. Stroke-5: Ischemic Stroke: Antithrombotic therapy by end of hospital day two.
7. VTE-3: VTE patients with anticoagulation overlap therapy.
8. AMI-7a: Fibrinolytic therapy received within 30 minutes of hospital arrival.
9. AMI-10: Statin prescribed at discharge.

Hospital Clinical Quality Measures (cont.)

Hospital Clinical Quality Measures
10. Exclusive breast milk feeding.
11. EHDI 1a: Hearing screening prior to hospital discharge.
12. Stroke-8: Ischemic or hemorrhagic stroke – stroke education.
13. Home Management Plan of Care (HMPC): Document given to patient or caregiver.
14. VTE-5: VTE discharge instructions.
15. Healthy-term newborn.

Stage 3

- Begins in 2018 (Optional in 2017)

- 2015 Certified Technology

- Full year reporting period

- 8 Objectives

Stage 3 Objectives

- Protect Electronic Health Information

- Electronic Prescribing

- Clinical Decision Support

- Computerized Provider Order Entry

- Patient Electronic Access

- Coordination of Care through Patient Engagement

- Health Information Exchange

- Public Health Reporting

Questions?