MEDITECH Prepares You for Stage 2 of Meaningful Use: Eligible Hospitals

Eligible Providers please see the document: *MEDITECH Prepares You for Stage 2 of Meaningful Use: Eligible Professionals*.

Staying Up To Date

As our eligible hospitals and eligible providers successfully attest for Stage 1 of Meaningful Use, MEDITECH is actively preparing for Stage 2.

Congratulations are in order for our customers who have achieved Stage 1 Attestation for fiscal year 2011! As of this writing, there are over 200 customers who have successfully attested.

MEDITECH remains committed to ensuring our customers are ready to meet the demands of Meaningful Use Stage 2 and beyond. Currently, the Office of the National Coordinator (ONC) and Center for Medicare and Medicaid (CMS) continue to evaluate recommendations for Stage 2 requirements, which are slated to be finalized mid-2012. MEDITECH is participating in all Health IT Policy meetings and staying up-to-date on proposed Meaningful Use recommendations for criteria, standards, privacy and security, and certification for Stage 2.

We are taking a proactive approach to enhancing our applications based on what is predicted to be included in the Meaningful Use Stage 2 criteria. We are analyzing our applications and creating both new and updated Best Practices, so we're in a prime position to deliver materials to customers after the government announces the Final Ruling.

Our Recommendations for Stage 2: Eligible Hospitals

First, Continue Stage 1 Functionality Deployment

For eligible Hospitals, many of the Stage 2 requirements are increased utilization of functions that you began to roll out in Stage 1. So, continuing on your path to get more providers and other clinicians using these functions allows you to meet many of the proposed requirements for Stage 2. They include the following:

1. CPOE – Order Source use by licensed providers increased from 30% to 60%, Laboratory and Radiology orders now required in addition to medications.
2. Drug-Drug and Drug-Allergy as well as, Drug Formulary Checking, continue as in Stage 1.
3. Record Demographics increased from 50% to 80%.
4. Problem List on 80% of inpatients, continue with this threshold.
5. Active Medication List on 80% of patients, continue with this threshold.
6. Maintain Active Medication Allergy List on 80% of patients, continue with this threshold.
7. Growth Charts & Vital Signs increased from 50% to 80%.
8. Smoking Status increased from 50% to 80%.
9. Clinical Decision Support Rule – to improve performance on high-priority health conditions.
10. Clinical Quality Measures – see more detail information below.
11. Provide Patient with Health Record Upon Request for 50% of patient, continue with this threshold.
12. Discharge Instructions at discharge increased from 50% to 80%.
13. Perform a “test” with an health information exchange (Provide Summary of Care Record) increases from just “test” to demonstrate an actual exchange with another EMR or HIE (CCD Interoperability exchange suite).
14. Perform Protect Health Information - Security Audit.

Next, Menu Items from Stage 1 are Now Required Core Items

1. Immunization Reporting: Attest to at least one submission of data to immunization registries or immunization information systems.
2. Reportable Laboratory Results to Public Health Agency: Attest to at least one submission of reportable lab results to a public health agency.
3. Syndromic Surveillance: Attest to at least one submission of electronic syndromic surveillance data to a public health agency.
4. Patient Lists: Generate lists of patients by multiple specific parameters to use for quality improvement, reduction of disparities, research, or outreach.
5. Advanced Directives: Move to Core; For 50% of patients 65 years and older, record whether an advance directive exists (with date and timestamp of recording) and provide access to a copy of the directive itself if it exists.
6. Incorporate Laboratory Test Results: Incorporate clinical laboratory-tests results into certified EHR technology as structured data for more than 40% of all clinical laboratory tests results ordered whose results are either in a positive/negative or numerical format.
7. Patient Lists: Generate lists of patients by multiple specific parameters to use for quality improvement, reduction of disparities, research, or outreach.
8. Patient-Specific Education Resources: Use certified EHR technology to identify patient-specific educational resources and provide those resources to more than 10% of all unique patients (removed "if appropriate" – should be included with all patient encounters).
9. Medication Reconciliation: The eligible provider, eligible hospital, or critical access hospital who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
10. The eligible hospital or critical access hospital who transitions their patient to another setting of care, or provider of care, or refers their patient to another provider of care, should provide summary of care record for each transition of care or referral.

We are updating all affected Stage 1 Best Practices to reflect changes. Our target is to release new documentation in a staggered manner throughout Q1 of 2012.

Lastly, New Requirements for Stage 2

While we still work through and seek additional clarifications on new requirements, below is a summary of the current recommendations.

1. e-Prescribing: Generate and transmit 10% of all hospital discharge orders for permissible prescriptions electronically.
2. Clinician Notes (Physician, PA, NP): 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).
3. Electronic Medication Administration Record (eMAR): Medication orders automatically tracked via electronic medication administration record in-use in at least one hospital ward/unit ("automatically" implies "5 rights" are recorded without manual transcription and that this is done within the CEHRT).
4. Patient Portal: View and download discharge instructions and visit information. More than 10% of patients/families view and have the ability to download information about a hospital admission; information is made available within 36 hours of discharge.
5. Send Laboratory Test Results: Hospitals labs send (directly or indirectly) structured electronic clinical laboratory results to outpatient providers for more than 40% of electronic orders received.
6. Electronically transmit a summary of care record (CCD): New to be included in the CCD: • Eligible Providers & Eligible Hospitals: Record and provide (send) a summary of care record for more than 50% transitions of care for the referring eligible provider or eligible hospital. • Eligible Providers & Eligible Hospitals: Record care plan fields (goals and patient instructions) for more than 10% of all patients seen during the reporting period. • Eligible Providers & Eligible Hospitals: Record health team member (including PCP, if available) for more than 10% of all patients seen during the reporting period. • Eligible hospital: 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. • Use of portable media (e.g., USB, fax, CD, etc.) does not constitute electronic data exchange.

What You Need for Stage 2

Although the final rule may change requirements, we want to ensure our customers that we are taking a very practical and also cautious approach in forecasting additional applications for Stage 2. From our initial review of the current list of requirements from CMS/ONC, we recommend the following applications be considered for Stage 2:

- A Patient Portal.
- e-Prescribing interfaces, including both MEDITECH applications in conjunction with DrFirst.
- Deployment of an Electronic Medication Administration Record, MEDITECH's recommendation is that Bedside Verification also be implemented along with this effort.
- Scanning and Archiving for data not electronically collected, specifically for Advanced Directives.
- Interfaces for Orders In and Results Out for Laboratory Orders between acute and ambulatory environments.
- Use of standards for Quality Reports requires a subscription to Intelligent Medical Objects (IMO) for nomenclature support. More information on pricing and packaging to follow.

A Larger Impact of Stage 2: Clinical Quality Measures

As of 11/21/11, the HIT Policy Committee has proposed 113 Clinical Quality Measures for Meaningful Use Stage 2. These measures are applicable to both acute and ambulatory settings. We have reviewed all 113 measures and are developing Best Practices and Reporting Tools for each measure.

An important part of the Clinical Quality Measures includes mapping standard nomenclatures within the electronic health record. National and international standards are becoming a necessity for exchanging data for Interoperability and for Quality Reporting. For Stage 1, MEDITECH designed an infrastructure to support nomenclatures such as SNOMED, LOINC, and RxNorm. Stage 2 requirements for supporting additional standard nomenclatures into our EHR are far greater than those of Stage 1. The existing infrastructure needs to be robust and accommodate frequent updates and changes needed to support the evolution of standard nomenclature adoption.

The key areas to include as standard nomenclature maps are: Problems, Orders, Procedures, Queries, Group Responses, Laboratory Tests, Laboratory Results, Imaging Exams, Operating Room Procedures, Patient Locations, Medications, Interventions, Problems, Allergens, and Chief Complaints.

MEDITECH is currently working with a third-party vendor, Intelligent Medical Objects (IMO), as well as other nomenclature developers across the industry to incorporate these standards into our EHR. These enhancements are a part of your Stage 2 update. Pricing and packaging for the content subscription should be provided soon.

Preparing New Releases

At this time, MEDITECH is targeting MAGIC 5.66, Client/Server 5.66 and 6.07 for Stage 2 certification. Customers need a new release for the following reasons:

1) A New Patient Portal

2) Additional Privacy & Security Requirements

- Standardized encryption of all connections to SSL/TLS.
- Encryption of downloads - CD, USB, and data provenance tracking.
- Enhanced patient centric audit logs in MIS.

3) Increased Standard Nomenclature Requirements

- Logical Observation Identifiers Names and Codes (LOINC) – Laboratory.
- Systematized Nomenclature of Medicine (SNOMED) - Problem List.
- ICD-9 and ICD-10 - Problem List.
- RxNorm – medications.
- CVX Codes - vaccines administered.

4) Clinical Quality Reporting Requirements

- Value sets use vocabularies not used widely in EHRs.
- Stage 2 currently has 113 proposed Clinical Quality Measures specific for Meaningful Use. Data capture must be in discrete fields and includes over 65,000 data sets that must be accounted for.

We are currently evaluating all update schedules to provide timely access to the certified Stage 2 releases in order to meet your goals. Your coordinators should be in touch with you regarding your ARRA Stage 2 planning and timing. MEDITECH will announce further updates following the proposed rule being released at the end of 2011.

As a reminder the following MEDITECH products/applications are still required for Stage 2:

- Admissions.
- Health Information Management.
- Management Information System.
- Pharmacy.
- Laboratory and Microbiology.
- Departmental or Imaging and Therapeutic Services.
- Order Entry/Order Management.
- Patient Care Inquiry/Enterprise Medical Record.
- Nursing/Patient Care Systems.
- Physician Care Manager.

Applications below can be either MEDITECH or modularly certified from another vendor:

- Emergency Department.
- Data Repository - for clinical quality reporting (if not using another vendor product or reporting service).
- CCD/CCR Interoperability Interfaces.
- Interoperability Interfaces for Public Health.
- Syndromic Surveillance Interface.
- Immunization Interface.
- Reportable Labs Interface.
- Patient Discharge Instructions (your own, Thomson Reuters, or EBSCO Publishing).

Resources

http://www.meditech.com/interoperability/ehrhome.htm

http://www.lssdata.com/govt/

https://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage

https://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp#TopOfPage

http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__federal_advisory_committees_%28facas%29/1149