

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

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

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.

We would like to take a moment to congratulate those customers who have achieved Stage 1 Attestation for calendar year 2011, as well as those still planning to attest before the end of the year.

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 Professionals

Stage 1 required the use of robust tools within the MEDITECH Ambulatory solution (Medical and Practice Management) that continue to be required for Stage 2:

- A certified release of Medical and Practice Management utilizing the scheduling, clinical, and billing applications.
- DrFirst E-prescribing.
- Patient Portal (LSS Portal - Stage 1*).
- Syndromic Surveillance Interface.
- Immunization Interface.

Note: The Patient Portal, the Syndromic Surveillance Interface, and the Immunization Interface can be either Medical and Practice Management or modularly certified from another vendor.

New Ambulatory Requirements

Although the final rule may change requirements, the following ambulatory items would be required based on our initial review of the current recommendations:

- Patient Portal (MEDITECH's Patient and Consumer Health Portal - Stage 2*).
- Patient Education Interface: MEDITECH plans to allow customers to utilize the same patient education vendors as the acute environment. Customers may also continue to use their own education materials.
- Reportable Cancer Conditions Interface (under consideration by CMS, but not yet a recommendation).

**Note: The LSS Patient Portal may be utilized to help customers achieve Stage 1 Meaningful Use. Stage 2 requires the use of MEDITECH's new Patient and Consumer Health Portal.*

Continuing Stage 1 Functionality Deployment

For eligible professionals, many of the Stage 2 requirements are increased utilization of functions that you began to roll out in Stage 1. Additionally, all menu items in Stage 1 become core requirements in Stage 2, many with increased thresholds. These changed and continued items include:

1. CPOE: Increase from 30% to 60% and now includes laboratory orders. At least one Radiology test is ordered using CPOE.
2. Drug-Drug and Drug-Allergy Interaction Checks: Including the ability to refine DDI rules.
3. e-prescribing: Increase from 40% to 50%.
4. Record Demographics: Increase from 50% to 80% with the ability to use the data to produce stratified quality reports.
5. Growth Charts & Vital Signs: Increase from 50% to 80%.
6. Smoking Status: Increase from 50% to 80%.
7. 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 medications).
8. 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.
9. Problem List: Containing 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 the patient recorded as structured data.
10. Medication Reconciliation: For more than 50% of transitions of care in which the patient is transitioned into the care of the eligible provider, eligible hospital, or critical access hospital.
11. Clinical Decision Support Rule: Use clinical decision support to improve performance on high priority health conditions.
12. Drug-Formulary Checks: Implemented according to local needs.
13. Patient Reminders: For Stage 1, 20% of patients 65+ years old or 5 years old and younger. For Stage 2, 10% of all active patients are sent a clinical reminder (a reminder for an existing appointment does not count).
14. Patient Lists: Generate lists of patients by multiple specific parameters to use for quality improvement, reduction of disparities, research, or outreach.
15. Clinical Summaries: Provide clinical summaries to patients for more than 50% of all office visits, increased from within 3 business days to within 24 hours, pending information such as laboratory results, which should be available to patients within 4 days of becoming available to eligible providers.
16. Timely Access: In Stage 1, provide more than 10% of all unique patients timely electronic access to their health information. In Stage 2, 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 the eligible provider).
17. Incorporate Laboratory Results into the Electronic Medical Record: Incorporate clinical lab-tests 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, using LOINC when available.
18. Provide Patient with Patient Education Materials: 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).
19. Report ambulatory clinical quality measures (see section "A Larger Impact of Stage 2: Clinical Quality Measures").
20. Immunization Registries: Attest to at least one submission of data to immunization registries or immunization information systems.
21. Syndromic Surveillance: Attest to at least one submission of electronic syndromic surveillance data to a public health agency.
22. Risk Assessment: Perform or update security risk assessment and address deficiencies. Address encryption for data at rest.

New Ambulatory Measures for Stage 2

While we are still working through and seeking additional clarifications on new requirements, below is a summary of the current recommendations:

1. Advance Directives: 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 if it exists.
2. Electronic Notes: 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).
3. Secure Messaging: Offer secure online messaging to patients; at least 25 patients have sent secure messages online.
4. Patient Communications: Record patient preferences for communication medium for more than 20% of all unique patients seen during the reporting period.
5. Provide Summary of Care Record: <ul style="list-style-type: none"> • Record and provide (by paper or electronically) a summary of care record for more than 50% transitions of care for the referring eligible provider or eligible hospital. • Record care plan goals and patient instructions in the care plan for more than 10% of patients seen during the reporting period. • Record health care team members (including at a minimum the PCP, if available) for more than 10% of all patients seen during the reporting period. • 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.
6. Submit Reportable Cancer Conditions: Attest to at least one submission in accordance with applicable law and practice.

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. MEDITECH has reviewed all 113 measures and is developing Best Practices and Reporting Tools for each measure.

Preparing New Releases

At this time, MEDITECH is targeting MAGIC 5.66, Client/Server 5.66, and 6.08 for Stage 2 Certification for the Ambulatory solution.

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