

Meaningful Use Workgroup

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Workgroup Membership

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Nemaha County Hospital
NY State Dept. of Health
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Pacific Business Group/Health
Center/Democracy & Technology
Carnegie Mellon University
Social Security Administration
CMS/HHS
CMS
Siemens
Rhode Island Department of Health and Human Services

Agenda

Stage 2 NPRM discussion items from April 4th HITPC meeting

Proposed changes to stage 1 in NPRM

Next steps

Improve quality safety, efficiency and reducing health disparities

- Is enough being done to reach domain goals, especially related to efficiencies?
- There seems to be little in the rule around disparities.

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Implement one CDS rule relevant to specialty or priority	Use CDS support - change certification criteria definition	1. Implement 5 CDS interventions related to five or more CQMs 2. Drug-drug and drug-allergy interaction checks enabled	<p>(1) The certification criteria should include the suggested clinical decision support attributes. (i) Enhance the source/citation criterion as a hyperlink to peer-reviewed literature, or as a name and funding source if it is internally developed. (ii) It should be configurable (see examples). (iii) Presented at relevant point in the clinical workflow, which is mentioned in the NPRM text. (iv) Presented to users who can act on them. (v) can be integrated into EHR (vs. standalone). (2) In addition to DDI, require an additional decision support function addressing efficiency such as reducing overuse of high-cost imaging or use of generic medications.</p> <p>Are the 5 attributes covered in the SCC NPRM?</p>
>30% patients with at least one medication order entered using CPOE	<p>Medications: 60% Lab: More than 60% have at least one lab order entered Radiology: At least one radiology test is ordered</p>	More than 60% of medication, laboratory, and radiology orders are recorded using CPOE	<p>(1) Clarify whether paper orders need to be counted. If counting paper orders is difficult, then we propose that the denominator be 1) medications on the med list, 2) resulted lab tests, and 3) resulted radiology tests. The numerator would be # of CPOE orders entered by the authorizing provider (the goal of CPOE). (2) As proposed, med, lab, & rad orders are lumped so that one could skip an order type completely. Recommend keeping percentage by order type (3) Recommend keeping definition requiring a licensed professional (no scribes). (4) Clarification-HITPC Proposal: only radiology was suggested as yes/no; laboratory was counted.</p> <ul style="list-style-type: none"> • Re denominator, issues of multiple results per panel, putting med on each other's list. • Detailed recommendations needed related to the issue of scribes. • How does this relate to the need for an objective related to progress notes (i.e., engagement of provider in actual use of EHR)? • There doesn't seem to be a way to measure who actually entered the order; instead recommend adding clarifying language to indicate that the person who enters the order needs to be the one to act upon decision support. Decision support needs to be at the point of sign-off. • Consider who carries the liability.

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Implement drug-drug and drug-allergy interaction checks	Employ drug interaction checking (drug-drug, drug-allergy) provider to refine DDI rules	Consolidated	<p>(1) We agree with the consolidation, especially because DDI is still separate in the consolidated objective. (2) We believe DDI deserves special attention because current commercial DDI databases are well known to have high false positives, which contribute to alert fatigue. Providers should be able to revise DDI rules.</p> <ul style="list-style-type: none"> • Need to understand what it means for providers to be able to revise DDI rules (First Databank supported provider customization in public comment). • Is this a temporary provision until the industry can produce DDI with fewer false positives? • More research needs to be done – there may be better practices.
EP only: Generate and transmit electronically > 40% of all prescriptions	EP: Increase threshold to 50% EH: Transmit 10% of discharge orders	>65% of all EP prescriptions and >10% of all hospital discharge orders for Rx are compared to at least one drug formulary and transmitted electronically	<p>65% may be high due to patient preference and pharmacy capabilities in certain geographies.</p> <p>IE WG preliminary: Concerned that the threshold may be high given the state of the market.</p> <ul style="list-style-type: none"> • Cautioned that setting the threshold too high can penalize the provider for things outside of control. • May be helpful to be consistent with what CMS did for eRx – Terry Cullen.

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
>50% of all unique patients seen have demographics recorded	increase to 80%	More than 80 % of all patients seen have demographics recorded	Agree with 80%. Would recommend adoption of CDC demographic standards, which are more granular (but can be mapped to) 1997 OMB standards. How are demographics being used to address disparities?
Maintain an up-to-date problem list for >80% of all patients	No change	Consolidated with summary of care	We recommend keeping these 3 lists as separate objectives for the following reasons: 1) they were and still will be important motivators for clinicians to enter and maintain accurate lists; 2) the stage 1 requirement is very minimal; we were planning to add more rigorous capabilities to facilitate maintaining complete and accurate lists 3) just having these elements in a transition of care document (which may be difficult or impossible for clinicians to access) does not give the information the visibility it deserves; 4) removing the objectives sends a signal that these 3 items are less important than other items like demographics and vital signs. Is the MU WG suggesting that a quality measure should be proposed for Stage 3? The more we teach to this, there will be positive feedback. Stage 3, ways to facilitate more accurate lists.
Maintain active medication list >80% of all patients	No change	Consolidated with summary of care	
Maintain active medication allergy list for >80% of all patients	No change	Consolidated with summary of care	

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
>50% of vital signs recorded: <ul style="list-style-type: none"> • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI 	80% of vital signs recorded: <ul style="list-style-type: none"> • Height • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI 	80% of vital signs recorded: <ul style="list-style-type: none"> • Height/Length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI 	Agree.
Smoking status for patients 13 & older for >50%	Increase threshold to 80%	> 80% of patients 13 and older	Agree.
MENU: Implement drug-formulary checks with access to at least one drug formulary	Drug formulary checks according to local needs (internal/external formulary, generic substitution)	Consolidated - include within eRX core objective	Agree.
Report ambulatory and hospital clinical quality measures to CMS or States	No change	Removed - Objective is incorporated directly into the definition of a meaningful user	Agree. Re Group Reporting <ul style="list-style-type: none"> • Team-based care: first answer how group shares patients, then address reporting

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
EH MENU: Record advanced directives for > 50% patients 65 or older	Record an advance directive exists for EP: at least 25 patients and provide access to a copy EH: >50% of patients 65 years and older and provide access to a copy	EH Menu - >50% of all unique patients 65 or older a have an indication of an advance directive status recorded as structured data.	EP: We recommend adding a Menu requirement - More than 10% of patients who are 65 or older. Strongly recommend moving to core for Stage 3. EH: This is an important objective and we recommend the original stage 1 objective should be moved to core for hospitals.
MENU: Incorporate clinical lab test results into certified EHR for more than 40% of all clinical lab tests results ordered with a +/- or # format	Incorporate >40% of all clinical lab tests	EP/EH: >55% of all clinical lab tests results ordered whose results are in a +/- or # format	Agree. Okay to count individual tests.
MENU: Generate lists of patients by specific conditions	Generate lists of patients by multiple specific conditions	Generate at least one report listing patients of the EP, EH/CAH with a specific condition.	Agree. We had suggested multiple specific conditions, to ensure that EHRs were certified to handle more than one variable. To ensure adequately achieving priority goals, additional guidance should be provided

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
EP MENU: Send reminders to >20% of all patients 65+ or 5 or younger	>10% of all active patients are sent a clinical reminder (existing appointment does not count)	>10% of all patients w/in 24 months prior to the EHR reporting period were sent a reminder, per patient preference	Agree. It may require exclusions for some specialists, such as surgeons who do not require follow up after the initial post-op visit or manage preventive services.
N/A	EH: Medication orders automatically tracked via electronic medication administration record in-use in at least one hospital ward/unit	EH: >10% of medication orders created by authorized providers are tracked using eMAR.	Agree.
N/A	N/A	NEW MENU - >40% of all scans and tests whose result is an image ordered are incorporated into or accessible in EHR	(1) We agree with the proposed objective, but would recommend a 10% threshold with an exclusion if they have no access to electronic images (e.g., local imaging centers do not offer electronic access). (2) Re: question about a <i>potential</i> measure requiring exchanging images for 10%. While we agree with the spirit of the potential measure, we but believe that Stage 2 may be too soon to expect EPs and EHs to share images with outside providers.
N/A	N/A	NEW MENU: >20 % have a structured entry for one or more first-degree relatives or an indication that family health Hx has been reviewed	Although we support the spirit of this objective, we are not aware of adopted standards in this area, and we have concerns about the cost/benefit of the information as currently captured (e.g., FH is dependent on the clinical condition).

Objectives not included - Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	Enter at least one electronic note for > 30% of visits (non-searchable, scanned notes do not qualify)	N/A Record electronic notes in patient records for >30 % of office visits.	Agree with adding text-searchable notes to certification. Because some certified EHRs do not have clinical documentation, and we believe that having a complete record, including progress notes, is required to deliver high quality, efficient care, we recommend that provision for recording progress notes should be a meaningful use objective.
N/A	Hospital labs send (directly or indirectly) structured results to outpatient providers for >40% of electronic lab orders received.	N/A Hospital labs send structured electronic results to outpatient providers for >40% of electronic lab orders received.	The providers depend upon hospital labs which are about 40% of the market. IE WG recommendation: Unanimous approval to restore HITPC recommended requirement for hospitals to send structured labs

Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Provide >50% with an electronic copy of their health information	Combined with other objectives	Replaced	Agree.
Provide >50% with discharge instructions	Combined with other objectives	Replaced	Agree.
>10% of unique patients timely electronic access to their health information	>10% view and have the ability to download EP: available w/in 24 hrs (or 4 days after available) EH: available w/in 36 hrs	Replaced	Agree, with improved timeliness to 2 business days for EPs.

Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	N/A	<p>NEW Measure</p> <p>1. > 50% provided online access EP 4 business days EH w/in 36 hrs</p> <p>2. >10 % of patients view, download, or transmit to a 3rd party</p>	<p>We appreciate and agree with the intent to keep the timeliness criterion simple (1 timeline). However, we believe there is value in providing the patient with prompt access to the summary of an encounter (which we define as an office visit or other contact in which an order is generated). We propose that a single timeliness criterion be applied, and that it be shortened to "within two business days of information becoming available to the EP."</p> <p>The MU WG is divided about the threshold for patients seen who have actually viewed, downloaded, or transmitted during the reporting period.</p> <p>NB: Discharge instructions were available at discharge in stage 1, and in NPRM that goes to 36 hrs</p> <p>Important that what is given to the patient speaks to both the provider and patient.</p> <ul style="list-style-type: none"> • Concerned about specifying %, as this is beyond the control of the provider. • May need to revisit work done to identify exclusions (Christine) • Suggestion to adjust denominator (e.g., could use patient preferences) • Some commented 10% too high (GH), others 2 days too long (LW) <p>IE Workgroup</p> <ul style="list-style-type: none"> • Concern about tying physician achievement of objectives to patient actions that they may not be able to control • Recognition of and appreciation for the policy aims that underlie the objective • Anecdotal evidence from WG members that provider promotion of electronic patient tools is the biggest driver of patient utilization, and therefore, a WG view that provider promotion (either through promoting registration of portal/PHR or routinely using secure messaging themselves) is what should be directly measured and counted. <p>Preliminary WG recommendation: Change measure to be more than 10% of patients have "registered" for portal or 3rd party PHR service. Still have to work through what the measure would be in years 2 and beyond since "registration" is a one-time event and don't want to give credit for the same action in successive years. Perhaps grow the requirement (10% in year 1, 15% in year 2, to a cap of 30% or so)</p>

Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Clinical summaries for >50% of all office visits within 3 business days	Provide clinical summaries to >50% within 24 hours; available within 4 days	EP: Clinical summaries provided to patients within 24 hrs for >50 % of office visits.	The NPRM says that HITPC recommended that for clinical summaries information be made available within 24 hrs or within 4 <i>business</i> days of info becoming available. The HITPC actually recommended that for clinical summaries information be made available within 24 hrs or within 4 (calendar) days of becoming available. That is consistent with our new recommendation to use 2 business days overall to achieve a single timeline for all data.
MENU: Use certified EHR to identify patient-specific educational resources for >10% of all patients	Identify educational resources and provide to >10%	Patient-specific education resources are provided to patients for >10% of all office visits	Agree.
N/A	Offer secure online messaging to patients: at least 25 patients	A secure message was sent using the electronic messaging function for > 10 % of patients	<p>We are concerned about 10% being too high to achieve by Stage 2. We recommend lowering the threshold to 5% (which is 10% of the necessary 50% with portal access) for patient-initiated messages. The patient-initiated message could be a response to a provider message.</p> <p>Asked to consider a two part requirement 1) provider sends the message 2) add a timeliness requirement for responses to any messages that the provider receives back from patients. Must respond to message received within 2 business days. This would make it more useful for patients</p> <p>IE Workgroup: Very preliminary recommendation on secure messaging: Change measure to include provider-generated messages to patients with some type of verification that patients have received the message (perhaps “read receipts” or notifications sent to patient-designated unsecured email or some other type of electronic acknowledgement).</p>

Objective not included - Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	Record preferences for communication for >20%	<p>N/A</p> <p>EP: Record preferences for communication for >20%</p>	<p>HITPC's intent was to capture a patient's preferred communication method in order for the system to use that media for future non-urgent communication. This respects the patient's wishes and is more efficient for the provider. We recommend that the preferred communication field support multiple message types (e.g., non-urgent clinical, administrative) and preferred media (e.g., electronic, phone, SMS message).</p>

Improve Care Coordination

- This is the most important domain and is the weakest link when thinking about how to incorporate different vendor records, certification standards will be crucial.

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Perform at least one test of the capability to exchange key clinical information	HIE test eliminated in favor of use objectives	Removed for an actual use case	<p>We agree with eliminating the test. For Stage 1, we suggested option 4 (actual electronic transmission of a summary of care document).</p> <p><i>IE WG recommendation: Unanimous approval to remove test for Stage 1 with no replacement (Option 1)</i></p> <p>Need to verify that it is okay to defer to the IE WG for final recommendation. Need appropriate onramp and escalator. [Stage 1 continues indefinitely for new EPs; e.g., consider option 4 for 2014. (CB)]</p>
MENU: Perform medication reconciliation for >50% of transitions	Move to core.	Performs medication reconciliation for >65% of transitions	<p>The certification criteria should support the reconciliation process (e.g., comparing multiple medication lists and resolving differences). In order to support the measure, the provider needs to capture the fact that a transition has occurred. Because detection of the occurrence of a transition must be captured manually, we recommend that the threshold remain at 50%.</p> <p><i>IE WG preliminary: Concerned that 65% might be too high for some specialties as a core measure.</i></p>

Improve Care Coordination

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
<p>MENU: Provide a summary of care record for >50% of all transitions and referrals of car</p>	<p>1. Record and provide (by paper or electronically) a summary of care record for >50% of transitions of care for the referring EP or EH 2. Record care plan goals and patient instructions in the care plan for >10% of all active patients</p>	<p>Summary of care record provided for >65% of transitions of care and referrals. Electronically for >10% of transitions (outside organization and other EHR vendor).</p>	<p>Care plan section of the summary of care document should include the reason(s) for referral or transition and the results of the referral (recommendations). To support the measure, the provider needs to capture the fact that a transition is about to occur. We agree with the requirement for measure 2 that the transmitted summary of care document should cross organizational barriers. However, we believe that while it is essential that the exchange of information comply with prescribed standards, we believe that requiring that the transmission occur between different vendor systems may cause unintended consequences in some geographic regions where a few vendors may have a dominant market share. The group was divided on countable number vs. percent.</p> <p><i>IE WG recommendation: Remove requirement for cross-vendor exchange to meet 10% electronic exchange threshold</i></p> <ul style="list-style-type: none"> • Critical to think about the technical capability to merge fields into a different EHR. • Need to facilitate communication among all relevant providers. Seem to be imposing artificial constraints on what it means to supply the info. Direct should count. The rule talks about certified EHR technology, consider broadening. • Need to do more than just receive a document, unhappy with the slow adoption of smart receipt. • Need to be able to send to non-MU EP and have the transmission count.

Objectives not included - Improve Care Coordination

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	Record health care team members for >10% of all patients; this information can be unstructured	N/A Record health care team members for >10% of all patients.	Okay to leave as part of the summary of care document.
N/A	Send care summary (with care plan and care team) electronically to the receiving provider EP : at least 25 pts. with transition of care. EH : for >10% of discharges	N/A Record care plan goals and patient instructions in the care plan for >10% of patients seen during the reporting period.	Okay to leave as part of the summary of care document.

Improve population and public health

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
<p>MENU: Perform at least one test of the capability to submit electronic data to immunization registries</p>	<p>Attest to at least one submission of data in accordance with applicable law and practice</p>	<p>Successful ongoing submission of electronic immunization data to an immunization registry or except where prohibited, and in accordance with applicable law and practice</p>	<p>We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority.</p> <p>Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited".</p> <p>IE WG preliminary:</p> <ul style="list-style-type: none"> • Concern that too much discretion left to state and local public health agencies. • Lack of definition of ongoing successful submission. There appears to be significant optionality allowed in the standards, which may not align with other information exchange objectives such, e.g. transitions of care. <p>Need one standard to communicate with registries, maybe we can get there by stage 3.</p>
<p>Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies</p>	<p>Attest to submitting to at least one organization in accordance with applicable law and practice</p>	<p>NEW Measure: Successful ongoing submission of electronic laboratory results in accordance with applicable State law and practice, except where prohibited</p>	<p>As above.</p> <p>IE WG preliminary:</p> <ul style="list-style-type: none"> • Concern that too much discretion left to state and local public health agencies. • Lack of definition of ongoing successful submission. There appears to be significant optionality allowed in the standards, which may not align with other information exchange objectives such, e.g. transitions of care.

Improve population and public health

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies	Attest to at least one submission in accordance with applicable law and practice	EP MENU/EH Core - Successful ongoing submission of electronic syndromic surveillance data to a public health agency except where prohibited and in accordance with applicable law and practice	As above. IE WG preliminary: <ul style="list-style-type: none"> • Concern that too much discretion left to state and local public health agencies. • Lack of definition of ongoing successful submission. There appears to be significant optionality allowed in the standards, which may not align with other information exchange objectives such, e.g. transitions of care.
N/A	N/A	NEW MENU - Successful ongoing submission of cancer case information except where prohibited, and in accordance with applicable law and practice.	Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited". Further clarification is needed regarding what is an acceptable registry. IE WG preliminary: More specificity is needed on the definition of what would be qualifying registries. • Need to take a step back to figure out what makes sense in the long term. What is the basis for selecting cancer registry?

Improve population and public health

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	N/A	<p>New MENU - Successful ongoing submission of specific case information to specialty registries except where prohibited, and in accordance with applicable law and practice.</p>	<p>We are in agreement with the objective. Need to consider whether sufficient standards are available to support the interfaces between EHRs and registries. Panelists at our hearing also expressed concern about the proprietary nature of some registries, which affects the costs to participate, and in some cases places contractual restrictions on use of data and ability to participate in other registries. Concern about requiring all EHRs to interface all data with all registries. Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited". Further clarification is needed regarding what is an acceptable registry.</p> <p>IE WG preliminary:</p> <p>More specificity is needed on the definition of what would be qualifying registries.</p> <ul style="list-style-type: none"> • May not be paying enough attention to gov't registries. • There is no standard to describe data elements of registries. If turn to certification would have to require EHRs to work with all registries. • Advanced Directive registry in Maryland was provided as an example. • Need to take a step back to figure out what makes sense in the long term longer, selecting cancer registry is a disservice. • Other countries looking at US for standards. This will set the example for other countries to follow. • More feedback is needed.

Privacy and security protections for personal

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
<p>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</p>	<p>1. Perform, or update, security risk assessment and address deficiencies 2. Address encryption of data at rest</p>	<p>Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3),and implement security updates as necessary and correct identified security deficiencies as part of its risk management process</p>	<p>Privacy and Security Tiger Team</p>

Agenda

Stage 2 NPRM discussion items from April 4th HITPC meeting

Proposed changes to stage 1 in NPRM

Next steps

Stage 1 Proposed Changes - Improve quality safety, efficiency and reducing health disparities

Type	Measure	Change
Core	CPOE	<p>Current denominator: the number of unique patients with at least one medication in their medication list seen by an EP/EH during the EHR reporting period.</p> <p>New denominator: the number of medication orders created by the EP/EH during the EHR reporting period</p>
Core	e-prescribing	None
Core	Drug-drug & drug allergy checks	None
Core	Medication list	None
Core	Allergy list	None
Core	Problem list	None
Core	Decision support	None
Core	Record demographics	None
Core	Smoking status	None

Stage 1 Proposed Changes - Improve quality safety, efficiency and reducing health disparities

Type	Measure	Change
Core	Vital signs	<p>Age changes: Blood pressure (for patients age 3 and over only) and height and weight (for all ages)</p> <p>Exclusions changes: Any EP who (1) Sees no patients 3 years or older is excluded from recording BP; (2) Believes that all three vital signs of height, weight, and BP have no relevance to their scope of practice is excluded from recording them; (3) Believes that height and weight are relevant to their scope of practice, but BP is not, is excluded from recording BP; or (4) Believes that BP is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.</p>
Core	Clinical quality measures	Removed: Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6
Menu	Incorporate clinical labs	None
Menu	Implement drug-formulary checks	None
Menu	Patient reminder	None
Menu	Generate patient list	None

Author's Notes:
 Improve quality safety
 Improve quality safety

Stage 1 Proposed Changes - Engage patients and families

Type	Measure	Change
Core	Clinical summaries to patient	None
Core	Health info to patients	Two objectives become one CORE objective
Menu (EP only)	Patient electronic access	<p>Objective: Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP or 36 hours after discharge from the hospital.</p> <p>Measure: Measure: 1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP or 36 hours after discharge from the hospital)</p> <p>2. More than 10 % of all unique patients seen by the EP or discharged from EH during the reporting period, view, download, or transmit to a third party their health information</p>
Menu	Patient-specific education	None

Stage 1 Proposed Changes – Care Coordination

Type	Measure	Change
Core	Electronic exchange	<p>Removed for an actual use case in Stage 2, but asking for comment on 4 different options:</p> <ol style="list-style-type: none"> 1) Remove objective <i>(IE WG recommendation)</i> 2) Require that the test be successful. 3) Eliminate, but require that providers select either Stage 1 medication reconciliation or summary of care at transitions of care and referrals from the menu set. This would preserve the domain of care coordination for Stage 1. 4) Move from a test to one case of actual electronic transmission of a summary of care document for a real patient either to another provider of care at a transition or referral or to a patient authorized entity.
Menu	Medication reconciliation	None
Menu	Summary of care record	None

Stage 1 Proposed Changes – Public Health and Privacy and Security

Type	Measure	Change
Menu	Submit electronic data to immunization registry	Addition of "except where prohibited" to the objective
Menu	Submit electronic syndromic surveillance data	Addition of "except where prohibited" to the objective
Core	Protect health information	None

Proposed Timeline Changes

Stage of Meaningful Use Criteria by Payment Years as Finalized in 2010					
First Payment Year	2011	2012	2013	2014	2015
2011	1	1	2	2	TBD
2012		1	1	2	TBD
2013			1	1	TBD
2014				1	TBD
2015					
2016					
2017					

Proposed Timeline Updates - Stage of Meaningful use Criteria by First Payment Year											
First Payment Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017								1	2	2	3

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Next steps

Next Steps

- Next MU workgroup meeting is scheduled for May 1st, 10:00-12:00
- HITPC meeting May 2nd