Bloomberg BNA

Health IT Law & Industry Report™

VOL. 0, NO. 0 SEPTEMBER 24, 2012

Meaningful Use Stage 2 vs. Stage 1: Moving from Data Collection to Advanced Clinical Processes and Patient Engagement

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Introduction

On Aug. 23, 2012, the U.S. Department of Health and Human Services (''HHS'') issued the final rule on Stage 2 of the meaningful use incentive program for electronic health records (''EHRs''). In large part, Stage 2 attempts to employ objectives that foster patient access to their health information and more interoperable health information exchange. Farzad Mostashari, the National Coordinator for Health Information Technology within the Office of the National Coordinator for Health Information Technology of HHS (''ONC''), has asserted as much, calling the movement from Stage 1 from Stage 2 ''the big push . . . to move beyond data collection to improving care.''

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By way of background, it should be noted that the final rule has modified certain provisions of the proposed rule to account for comments and concerns lodged by various stakeholders.

First, timing for qualification has been extended to 2014.

Second, Stage 2 now offers additional flexibility to qualify for meaningful use through a batch reporting process that would allow groups to submit attestation information for all of their individual eligible professionals (''EPs'') in one file.

Third, CMS has modified timing of the 90-day period on which providers can report. Fourth, with regard to objectives, the final rule significantly reduces a number of thresholds.

Nonetheless, despite some of these reduced reporting and timing burdens, the technical burden remains

 ISSN 2151-2876

largely unchanged. Therefore, providers should fully evaluate the new reporting criteria, timing and associated costs of qualifying for meaningful use when pursuing qualification under Stage 2.

Here we address the highlights of Stage 2 reporting under the final rule and share some observations as to cost/benefit considerations relative to the Stage 2 requirements.

Stage 2 Core Objectives and Menu Objectives

Stage 2 reporting requirements retain the same structure as Stage 1 insofar as providers must still meet a combination of core and menu objectives. As discussed more fully below, some Stage 1 objectives were either combined or eliminated, but nearly all the Stage 1 core and menu objectives that were proposed have been included in some fashion in Stage 2 final rule. For many of these Stage 2 objectives retained from Stage 1, the threshold that providers must meet for the objective has also been raised.

Providers should fully evaluate the new reporting criteria, timing and associated costs of qualifying for meaningful use when pursuing qualification under Stage 2.

However, similar to Stage 1, flexibility exists in Stage 2 for providers to qualify for meaningful use incentive payments without having to meet objectives outside their normal scope of clinical practice. However, providers should note that a change from Stage 1 to Stage 2 is that claiming exclusions for Stage 2 menu objectives no longer counts toward the number of objectives satisfied.

The requirements to meet core objectives have been expanded since Stage 1 which required EPs to meet 15 core objectives and eligible hospitals as well as Critical Access Hospitals (''CAHs'') to meet 14 core objectives. Under Stage 2, EPs must meet 17 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 20 core objectives. Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 19 core objectives.

On the other hand, the menu objectives requirements have been reduced from Stage 1 to Stage 2. Particularly, Stage 1 required EPs, eligible hospitals and CAHs to meet 5 of 10 menu objectives, while Stage 2 requires EPs, eligible hospitals and CAHs to meet only 3 of 6 menu objectives. Tables attached as **Appendix A** (EPs – Comparison of Stage 1 vs. Stage 2 Core and Menu Objectives) and **Appendix B** (Eligible Hospitals and CAHs – Comparison of Stage 1 vs. Stage 2 Core and Menu Objectives) compare the core and menu objectives for Stage 2 to related Stage 1 objectives.

Some Significant Changes

Notable changes include eliminating the Stage 1 core objective for testing of ''exchange of key clinical information'' and adding a new, more robust ''transitions of care'' core objective in Stage 2. Specifically, this new Stage 2 core objective requires providers who transition or refer a patient to another care setting or provider to give a summary of care record for more than 50% of transitioned patients or referrals. Additionally, for more than 10% of transitioned patients and referrals, providers must provide a summary of care record electronically.

In an effort to promote interoperability among disparate EHR systems, the new Stage 2 core objective also requires providers to conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's or to conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period.

Additionally, the Stage 1 core objective to ''provide patients with an electronic copy of their health information'' was eliminated and replaced by the Stage 2 ''electronic/online access'' core objective. Specifically for EPs, this new Stage 2 core objective requires providing patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP. For eligible hospitals and CAHs, the new Stage 2 core objective requires providing patients the ability to view online, download and transmit their health information within 36 hours after discharge from the hospital.

New menu objectives were also added in Stage 2 including the following: record electronic notes in patient records, imaging results accessible through EHR, record patient family health history, identify and report cancer cases to a State cancer registry (for EPs only), identify and report specific cases to a specialized registry (other than a cancer registry) (for EPs only), generate and transmit permissible discharge prescriptions electronically (''eRx'') (new for eligible hospitals and CAHs only), and provide structured electronic lab results to ambulatory providers (for eligible hospitals and CAHs only).

Changes in Timing and Periods of Reporting

The final rule makes it clear that providers seeking incentive payments under Stage 2 will not need to meet Stage 2 requirements until 2014 at the earliest. This timing has been expanded since the original 2013 deadline set forth under the 2009 American Recovery and Reinvestment Act (''ARRA''). The table below indicates the progression of meaningful use stages since the inception of the incentive program.

Reporting periods for the meaningful use criteria have also changed from Stage 1 to Stage 2. For Stage 1, providers are free to choose the 90-day interval as long as it occurs prior to the close of the calendar or fiscal year. For Stage 2, providers must choose from a list of fixed 90-day periods set forth in the final rule.

EPs can choose from the following periods: January 1, 2014, through March 31, 2014; April 1, 2014, through June 30, 2014; July 1, 2014, through September 30, 2014; or October 1, 2014, through December 31, 2014. Eligible hospitals and CAHs can choose from the following periods: October 1, 2013, through December 31, 2013; January 1, 2014, through March 31, 2014; April 1, 2014, through June 30, 2014; or July 1, 2014, through September 30, 2014.

Several Reduced Thresholds

A number of thresholds have been reduced in response to overwhelming concern about meeting pro-

   ISSN 2151-2876

posed targets. Notably, the ''transitions of care'' core objective, requiring providing a summary of care document at transition, dropped to 50% from 65%.

Even more dramatically, the eligible hospital ''ePrescribing'' threshold for the eRx menu objective was reduced from 50% to 10%. Likewise, the ''image results'' threshold was reduced from 40% to 10%. Even the threshold for patients utilizing view, download, and transmit functionality under the Stage 2 ''electronic/online access'' core objective was reduced from 10% to 5%.

Data Privacy and Security

Despite easing some burden on providers by lowering certain thresholds for various core and menu objectives, certain objectives may create additional burden. Most notably, providers must encrypt HIPAA data at rest to properly secure health care information under Stage 2. The final rule presents guidance on encryption of data from EHRs, but such guidance suggests providers must encrypt all temp files, cookies or other types of data caches.

Reporting on Clinical Quality Measures (CQMs)

The Stage 2 final rule also requires that providers report on a minimum number of CQMs. CQMs are no longer a core objective beginning in 2014, but all providers are required to report on CQMs in order to demonstrate meaningful use.

Specifically, EPs must report on 9 out of 64 total CQMs while eligible hospitals and CAHs must report on 16 out of 29 total CQMs. Additionally, all providers must select CQMs from at least 3 of the 6 key health care policy domains from the HHS National Quality Strategy including: Patient and Family Engagement; Patient Safety; Care Coordination; Population and Public Health; Efficient Use of Healthcare Resources; and Clinical Processes/Effectiveness.

Observations as to Impact

During a time when physicians are being challenged by fee reductions, additional checks on the care plans that they develop and the capital and operating expenses associated with health information technology, it would be sensible for each new regulatory requirement imposed to be ''lean and mean.'' In other words, new reporting requirements should be closely linked to fundamental policy goals.

Also, new regulatory burdens should be tested against a standard that asks whether their benefits clearly outweigh the costs of complying because the aggregate burden of costs being borne in the sector is not insignificant and it has material impacts on the number of persons able to practice independently and even on the willingness of talent to enter the field. Ultimately, the attainment of public policy health access goals will be impacted by the availability of health care personnel and the costs they incur in education, training and in attempting to be in practice.

Many of the Stage 2 ''objectives'' and ''measures'' are extensions of those in Stage 1. Where they are, perhaps the burden of proof might be deemed to be lower insofar as physicians seeking incentive payments at this stage will already have incurred some of the set up costs associated with attaining Stage 1 measures. There is one new core objective – with measures that must be attained to earn the incentive payment in contrast to several new menu objectives from which attainment of only 3 of the 6 is required.

The new ''electronic/online access'' core measure requires that 5% of patients seeing the applicant eligible professional have sent a message to the professional using secure messaging capability. This requirement can be criticized for several reasons.

First, it saddles physicians with a patient encounter that, under many payor programs, the physician will not be reimbursed for.

Second, it places the physician seeking to obtain the Stage 2 incentive payment in the awkward position of needing to incent her patients to utilize email transmissions. While one would expect that this communication pathway would develop over time, it is not certain why physicians should be punished should their patients not take advantage of it at this juncture.

The new menu objectives, while offering choice, also raise questions from a cost/benefit perspective. For the most part, these objectives pertain to developing a more robust medical record—requiring the practitioner to use the EHR for progress notes (for 30% of patients), to access scans (for 20% of patients), and for family histories. We have to hope that the benefit of these components of the EHR outweigh the issues created as to ease of use of various systems with concomitant impact on productivity.

A similar critique might be raised with respect to those menu objectives that relate to utilization of registries. Submission of cancer cases to a cancer registry and other cases to appropriate registries is no doubt laudable. However, would a failure to be able to do so merit withholding EHR stimulus dollars otherwise earned? Are these objectives fundamental to the care coordination and quality goals of the meaningful use program?

Table 1: Meaningful Use Staging by Year

1ST Year	Stage of Meaningful Use										
	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	1	2	2	3

Turning back to the core objective measures, we again acknowledge that the ''hurdle'' posed by these measures is not new and thus that the burden of proof for their acceptance is conceptually lower. For the most part, these measures merely increase the percentage of cases that must satisfy a measure (e.g. a higher percentage of scripts being placed through computerized auto experts). However, one could argue that a number of these measures are not ''core'' to the public policy goals around facilitating care management and transitions.

It is an interesting commentary on the prospects for near term success of information exchange that the objective of exchange of clinical information, with its accompanying measure around certifying the EHR, has been eliminated from Stage 1 and not extended to Stage 2.

One might speculate that the exchange goals were too high given current technical limitations and note that the drafters have instead concentrated their hopes on facilitating patients' access to records on line. It is also interesting to note that those patients will have the option of merely viewing or downloading the info—transmission of the data is something that is facilitated not required.

An additional metric addresses the provision of clinical summaries to 50% of patients within 4 days of the service being rendered. Thus, the final Stage 2 rules suggest that the high goal of electronic data ''exchange'' is giving way to ''access''. The target has moved from incentivizing physicians to exchange to incentivizing them to give access to electronic data.

A final way to critique the Stage 2 measures is to review them for consistency with other policy direction. One measure may be found wanting by this standard—the measure suggesting the Stage 2 security risk analysis address, among other topics, ''the encryption/security of data at rest.''

Risk analysis is indeed appropriate under HIPAA and applicable NIST standards. However, such standards also do not compel encryption of data at rest. Data that is not web facing can be secured by means of physical safeguards to the point where an analysis would suggest foreseeable risk has been adequately addressed. One might be concerned, however, that the phrasing of this measure will lead certain meaningful use applicants to adopt a control for data at rest that is not cost-effective and may lead to degradation of performance of the EHR. As was noted above, given the demands on physician practice capital, no extraneous demands should be placed on those funds by this rule.

Conclusion

The final rule for Stage 2 meaningful use has been modified since Stage 1 in a number of significant ways. From a policy perspective, the new objectives seek greater patient engagement and empowerment through promoting access and education. Further, the new objectives seek to transition providers from an EHR capability ''testing'' phase under certain Stage 1 requirements to more robust and active use of those EHR functions under Stage 2.

Stage 2 objectives also generally ramp up reporting thresholds significantly when compared to corresponding Stage 1 objectives. However, it should be noted that some of the thresholds under the Stage 2 proposed rule have been significantly reduced in the final rule as described above. In addition to the greater rigor with regard to Stage 2 objectives, the Stage 2 final rule makes clear that, while some flexibility still exists with regard to qualifying for meaningful use, some of that leniency in Stage 1 has been reduced in Stage 2.

In light of these changes, providers need to fully evaluate the cost-benefit of pursuing Stage 2 meaningful use in 2014 or beyond.

  HITR ISSN 2151-2876

APPENDIX A
EPs – Comparison of Stage 1 vs. Stage 2 Core and Menu Objectives

Stage 2 Objective	Objective Type	Measure	Related Stage 1 Objective	Measure	Change
Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders	Core	More than 60% of medication, 30% of laboratory, and 30% of radiology orders	Use CPOE for medication orders	More than 30% of unique patients with at least one medication	Increased reporting threshold Introduced new reporting types
Generate and transmit permissible prescriptions electronically (eRx)	Core	More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically	Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically	Increased reporting threshold
Record demographic information	Core	More than 80% of all unique patients seen by the EP have demographics recorded as structured data	Record demographic information	More than 50% of all unique patients seen by the EP have demographics recorded as structured data	Increased reporting threshold
Record and chart changes in vital signs	Core	More than 80% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data	Record and chart changes in vital signs	For more than 50% of all unique patients age 2 and over seen by the EP, blood pressure, height and weight are recorded as structured data	Increased reporting threshold Change in age baseline
Record smoking status for patients 13 years old or older	Core	More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data	Increased reporting threshold
Use clinical decision support to improve performance on high-priority health conditions	Core	1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. 2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule	Implement one clinical decision support rule	Increased clinical decision support tool use required Introduced drug-drug interaction checks

Stage 2 Objective	Objective Type	Measure	Related Stage 1 Objective	Measure	Change
Provide patients the ability to view online, download and transmit their health information	Core	1. More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information 2. More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days	Timing of providing access enlarged, and new threshold introduced
Provide clinical summaries for patients for each office visit	Core	Clinical summaries provided to patients within one business day for more than 50% of office visits	Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	Time period for providing clinical summaries shortened
Protect electronic health information created or maintained by the Certified EHR Technology	Core	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 and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	Introduced required encryption for data at rest
Incorporate clinical lab-test results into Certified EHR Technology	Core	More than 55% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated as structured data	Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated as structured data	Increased reporting threshold
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Core	Generate at least one report listing patients of the EP with a specific condition	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the EP with a specific condition	No Change
Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care	Core	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period	Use clinically relevant information to identify patients who should receive reminders for preventive/ follow-up care	Use EHR to identify and provide reminders for preventive/follow-up care for more than 10% of patients with two or more office visits in the last 2 years	Increase reporting threshold

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Stage 2 Objective	Objective Type	Measure	Related Stage 1 Objective	Measure	Change
Use certified EHR technology to identify patient-specific education resources	Core	More than 10% of all unique patients seen by the EP are provided patient-specific education resources indentified by EHR	Use certified EHR technology to identify and provide patient-specific education resources	More than 10% of all unique patients seen by the EP are provided patient-specific education resources indentified by EHR	No change
Perform medication reconciliation	Core	Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	Perform medication reconciliation	Perform medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	Includes transition to another EP within transition of care
Provide summary of care record for each transition of care or referral	Core	1. Provide a summary of care record for more than 50% of transitions of care and referrals 2. Provide a summary of care record either a) electronically to a recipient using CEHRT or b) via exchange facilitated by NwHIN or a ONC-validated mechanism to facilitate exchange for 10% of transitions and referrals 3. Either a) conduct one or more electronic exchanges between different EHRs or b) conduct one or more tests with the CMS-designated test EHR	The EP 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	Provide a summary of care record for more than 50% of transitions of care and referrals	No change to reporting threshold Introduced required provider to provider electronic exchange
Submit electronic data to immunization registries	Core	Successful ongoing submission of electronic immunization data to an immunization registry or immunization information system for the entire EHR reporting period	Capability to submit data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice	Performed at least one test of EHR capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)	Increased reporting threshold
Use secure electronic messaging to communicate with patients on relevant health information	Core	A secure message was sent using the electronic messaging function by more than 5% of unique patients seen during the EHR reporting period	No related Stage 1 measure	N/A	New core objective

Stage 2 Objective	Objective Type	Measure	Related Stage 1 Objective	Measure	Change
Submit electronic syndromic surveillance data to public health agencies	Menu	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	Performed at least one test of EHR capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Increased reporting threshold
Record electronic notes in patient records	Menu	Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patients	No related Stage 1 measure	N/A	New menu objective
Imaging results accessible through CEHRT	Menu	More than 20% of all scans and tests whose result is an image ordered by the EP for patients seen during the EHR reporting period are incorporated into or accessible through Certified EHR Technology	No related Stage 1 measure	N/A	New menu objective
Record patient family health history	Menu	More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been	No related Stage 1 measure	N/A	New menu objective
Identify and report cancer cases to a State cancer registry	Menu	Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period	No related Stage 1 measure	N/A	New menu objective
Identify and report specific cases to a specialized registry (other than a cancer registry)	Menu	Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period	No related Stage 1 measure	N/A	New menu objective

ISSN 2151-2876

APPENDIX B
Eligible Hospitals and CAHs –Comparison of Stage 1 vs. Stage 2 Core and Menu Objectives

Stage 2 Objective	Objective Type	Measure	Related Stage 1 Objective	Measure	Change
Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders	Core	More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE	Use CPOE for medication orders	More than 30% of unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE	Increased reporting threshold and new types of reporting
Record demographic information	Core	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data	Record demographic information	More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data	Increased reporting threshold
Record and chart changes in vital signs	Core	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data	Record and chart changes in vital signs	More than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), blood pressure height and weight are recorded as structured data	Increased reporting threshold
Record smoking status for patients 13 years old or older	Core	More than 80% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	Increased reporting threshold
Use clinical decision support to improve performance on high-priority health conditions	Core	1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. 2. The eligible hospital or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule	Implement one clinical decision support rule	Increased clinical decision support tool use required Introduced drug-drug interaction checks

Stage 2 Objective	Objective Type	Measure	Related Stage 1 Objective	Measure	Change
Provide patients the ability to view online, download and transmit their health information within 36 hours after discharge from the hospital	Core	Provide online access to health information for more than 50% with more than 5% actually accessing	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	More than 50% of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days	New core objective incorporate Stage 1 objectives for providing patients electronic copies of health records
Protect electronic health information created or maintained by the Certified EHR Technology	Core	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 and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	Introduced required encryption for data at rest
Incorporate clinical lab-test results into Certified EHR Technology	Core	More than 55% of all clinical lab tests results ordered by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data	Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	Increased reporting threshold
Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	Core	Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized, and in accordance with applicable State law and practice	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Increased reporting threshold
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Core	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition	No Change

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Stage 2 Objective	Objective Type	Measure	Related Stage 1 Objective	Measure	Change
Use certified EHR technology to identify patient-specific education resources	Core	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient and emergency departments (POS 21 and 23) are provided patient- specific education resources	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources	No change
Perform medication reconciliation	Core	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)	Perform medication reconciliation	Perform medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	No change
Provide summary of care record for each transition of care or referral	Core	1. Provide a summary of care record for more than 50% of transitions of care and referrals 2. Provide a summary of care record either a) electronically to a recipient using CEHRT or b) via exchange facilitated by NwHIN or a ONC-validated mechanism to facilitate exchange for 10% of transitions and referrals	The eligible hospital or CAH that 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	Provide a summary of care record for more than 50% of transitions of care and referrals	No change to reporting threshold Introduced required provider to provider electronic exchange
Submit electronic data to immunization registries	Core	Successful ongoing submission of electronic immunization data to an immunization registry or immunization information system for the entire EHR reporting period	Capability to submit data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice	Performed at least one test of EHR capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Increased reporting threshold
Submit electronic syndromic surveillance data to public health agencies	Core	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Increased reporting threshold

Stage 2 Objective	Objective Type	Measure	Related Stage 1 Objective	Measure	Change
Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)	Core	More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked are tracked using eMAR	No related Stage 1 objective	N/A	New core objective
Record whether a patient 65 years old or older has an advance directive	Menu	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data	Record advance directives for patients 65 years old or older	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded	No change
Record electronic notes in patient records	Menu	Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patients	No related Stage 1 measure	N/A	New menu objective
Imaging results accessible through CEHRT	Menu	More than 20% of all scans and tests whose result is an image ordered by the EP for patients seen during the EHR reporting period are incorporated into or accessible through Certified EHR Technology	No related Stage 1 measure	N/A	New menu objective
Record patient family health history	Menu	More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been recorded	No related Stage 1 measure	N/A	New menu objective
Generate and transmit permissible prescriptions electronically (eRx)	Menu	More than 10% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology	No related Stage 1 measure	N/A	New menu objective
Provide structured electronic lab results to ambulatory providers	Menu	Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20% of electronic lab orders received	No related Stage 1 objective	N/A	New menu objective

HITR ISSN 2151-2876