Analyzing Stage 1 and Stage 2 Meaningful Use Differences

Save to myBoK

By Allison Viola, MBA, RHIA

The summer of 2012 ended with a bang when the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC) issued final regulations outlining requirements for the stage 2 "meaningful use" EHR Incentive Program. The stage 2 final regulation did not include any major surprises, or greatly diverge from what was issued within the proposed regulation. However, there are key differences between stage 1 and stage 2 of the program.

Stage 2 Increases Measure Difficulty

In order to determine who is a "meaningful user" of EHRs in stage 2 of the incentive program, CMS retained the system of using "core" and "menu" set objectives and measures similar to stage 1. Clinical quality measures (CQM) were also once again included in stage 2. However, one difference in stage 2 was the removal of CQMs from the core and menu set. The CQMs now stand on their own as separate objectives. This approach becomes effective in 2014 when all CQMs are to be electronically submitted to CMS.
For eligible hospitals (EHs) and eligible professionals (EPs) taking part in the stage 2 meaningful use program, CMS ramped up many of the measure thresholds in order to continue challenging participants as they advance through the program stages. For example, the CPOE objective added laboratory and radiology to the required medication entry, and raised the specific threshold assigned to it. In stage 1 eligible hospitals needed to have at least one medication entered using CPOE for 30 percent of patients. However in stage 2 more than 60 percent of medication orders, 30 percent of laboratory orders, and 30 percent of radiology orders now need to be completed using CPOE in order to meet the measure.

The objectives that call for providers to record patient demographics, changes in the record and chart for patient vital signs, and smoking status for patients all increased from 50 percent of patients in stage 1 to 80 percent of patients in stage 2.

Merging Measures

The objectives requiring eligible providers to maintain an up-to-date problem list of current and active diagnoses, maintain active medication lists, and maintain active medication allergy lists are no longer separate objectives in stage 2-as they were in stage 1. These measures have been incorporated into one measure-"Summary of Care Document at Transitions of Care and Referrals." Serving as the anchor to this newly aligned objective is the "Common Meaningful Use Data Set." Established by ONC, this set of 16 common data elements for reporting was developed to reduce data collection burden and redundancy for program participants. This data set didn't exist in stage 1, and providers were often confused on which specific data elements to collect for various program measures.

Changes in Release of Information Measures

Another set of objectives that experienced a significant makeover from stage 1 to stage 2 was the ability to provide patients with a copy of their health information. The makeover did not come without challenges for HIM professionals, however, since eligible physicians and eligible hospitals must now give patients the ability to view online, download, and transmit their health information to a third party within four days for physicians and 36 hours for hospitals. This would likely involve implementing a patient portal.

Moreover, just copying health information to a CD or a USB drive and handing the device to a third party does not meet the requirement of "transmission," as it did in stage 1.

Stage 1 vs. Stage 2 Meaningful Use Comparison Table-Hospitals and CAHs

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines	More than 30 percent of unique patients with at least one medication in their medication list admitted to the eligible hospital's or critical access hospital's (CAH) inpatient or emergency department have at least one medication order entered using CPOE	Use CPOE for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines	More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department during the EHR reporting period are recorded using CPOE
Record demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth • Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 50 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department have demographics recorded as structured data	Record following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth • Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department have demographics recorded as structured data
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 percent of all patients of the inpatient or emergency departments of the eligible hospital or CAH who request an electronic copy of their health information are provided it within 3 business days	Provide patients the ability to view online, download and transmit their health information within 36 hours after discharge from the hospital	More than 50 percent of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period are provided timely (available to the patient within 36 hours after discharge from the hospital) online access

			to their health information
Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	More than 50 percent of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department and who request an electronic copy of their discharge instructions are provided it	This objective is eliminated from Stage 1 in 2014 and is no longer a separate objective for Stage 2	This measure has been incorporated into the View, Download, and Transmit objective for Stage 2
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 a summary of care record for each transition of care or referral	The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care 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	The eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals

Source: Centers for Medicare and Medicaid Services, August 2012. Full table available at www.cms.gov.

Menu Set Makeover

Eligible hospitals saw a few new objectives inserted into the menu set since most former menu objectives migrated to the core objectives. The advance directive measure held steady in the menu set as CMS believed further analysis needed to be conducted to determine the best approach for meeting the measure. Eligible physicians experienced similar changes to their menu set in stage 2, though CMS also held off on creating an advanced directives objective for this group.

The measure requiring the submission of syndromic surveillance data to public health agencies was also held back since CMS found in stage 1 that "very few public health agencies have the ability to accept non-emergency or non-urgent care ambulatory syndromic surveillance data electronically, and those that do are less likely to support EPs (eligible physicians) than hospitals," according to the stage 2 final rule.

Therefore CMS said it does not believe that current infrastructure supports moving this objective to the core set for eligible physicians.

Allison Viola is the former director of federal relations at AHIMA.

Article citation:
Viola, Allison F.. "Analyzing Stage 1 and Stage 2 Meaningful Use Differences" *Journal of AHIMA*

83, no.11 (November 2012): 52-53.

Driving the Power of Knowledge

Copyright 2022 by The American Health Information Management Association. All Rights Reserved.