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A New Day in Healthcare for You and For us
Part VI: Meaningful Use
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Your Life Your Health
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On February 17, 2009, President Obama signed the *American Recovery and Reinvestment Act* **(**ARRA**)**. The HITECH (Health Information Technology for Economic and Clinical Health) Act is part of this legislation and is designed to encourage physicians and other healthcare organizations to adopt and use (in a meaningful way) Electronic Health Records (EHR).

In the August 26, 2010, Your Life Your Health, we discussed the requirement that healthcare providers use a "certified EHR" in order to quality for "meaningful use," which is a description of the use of an EHR which will contribute to patient safety and improved quality of care.

In a February, 2010, *Health Leaders Magazine* published an article on "meaning use" *(the link to this article can be found at www.jameslhollymd.com* under *About Us, "In-the-news"*) the following was stated:

> "Based on the 2011 meaningful use criteria defined by the Centers for Medicare & Medicaid Services on December 30, 2009, for example, providers have to improve quality, safety, efficiency, and reduce health disparities by using computerized physician order entry, e-prescribing, and maintaining an active medication list and up-to-date problem list of current and active diagnoses. Providers will also have to engage patients and families by providing patients with an electronic copy of their health information, including diagnostic test results, medication lists, and problem lists, and to improve care coordination by having the capability to exchange key clinical information among care providers. In addition, providers will have to improve population health management by having the capability to submit electronic data to immunization registries and public health agencies—all while ensuring adequate privacy and security protection for personal health information created or maintained in the EHR.
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> "That is just a snapshot of the technologies organizations need to have in place for the 2011 guidelines. Each year the thresholds and expectations will increase. The proposed rule only defined the 2011 meaningful use criteria, but it did provide insight into where organizations will need to be by 2015. For instance, organizations should be able to achieve minimum levels of performance on national quality, safety, and efficiency measures; use clinical decision support for national high-priority conditions; give patients access to self-management tools and comprehensive health data; and not only capture data in electronic formats, but also be able to exchange both transmission and receipt of that data in an increasingly structured format. The goal by 2015 is to have a patient-centric, interoperable health information exchange across provider organizations regardless of providers' business affiliations or EHR platform.

> "It's a tall order with a lot of moving parts. But to improve outcomes beyond the meaningful use guidelines, senior leaders can't lose sight of what the technology will have to be capable of years from now. Healthcare providers will need to be able to process in a timely manner all of the data being generated to provide the type of clinical decision support and coordinated care that physicians want and patients and payers will demand."

Meaningful use Core and Menu Objectives

The final rule which has not been published, established the following criteria for a physician or group of physicians to achieve "meaningful use" and to quality for payments from CMS. There are two sets of functions required. The first is called an "core set" and all of these must be met. The second is called "menu set" and only five of those must be met in 2011 but one of those five must be one of the measures marked by an double asterisks.

Core SET Objectives and Measures

1. Record patient demographic, (sex, race, ethnicity, date of birth and preferred language) . More than 50% of patients' demographic data records as structured fields.
2. Record vital signs (height, weight and blood pressure for age 2 and higher. More than 50% of patients 2 years of age or older have height, weight and blood pressure recorded as structured data.
3. Maintain up-to-date problem list of current and active diagnoses. More than 80% of patients have at least one entry recorded as structured data or an indication that they have no problems.
4. Maintain active medication list. More than 80% of patients have at least one entry recorded as structured data or an indication they are on no medications.
5. Maintain active medication allergy list. More than 80% of patients have at least one entry recorded as structured data or an indication that they have no allergies.
6. Record smoking status for patients 13 years of age or older. More than 50% of patients 13 years or older have smoking status recorded as structured data.
7. Provide patients with clinical summary for each office visit. Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.
8. On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and medication allergies. More than 50% of requesting patients receive electronic copy within 3 business days.
9. Generate and transmit permissible prescriptions electronically. Moe than 40% of permissible prescriptions are transmitted electronically using certified EHR technology.
10. Computer provider order entry (CPOE) for medication orders. More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE.

11. Implement drug-drug and drug-allergy interaction checks. Functuality is enabled for these checks for the entire reporting period.
12. Implement capability to electronically exchange key clinical information among providers and patient-authorized entities. Perform at least one test of EHR's capacity to electronically exchange information.
13. Implement one clinical decision support rule and ability to track compliance with the rule. One clinical decision support rule implemented.
14. Implement systems to protect privacy and security of patient's data in the EHR. Conduct or review a security risk analysis, implement security updates as necessary and correctly indentified security deficiencies.
15. Report clinical quality measure to CMS or states. For 2011, provide aggregate numerator and denominator through attestation for 2012 electronically submit measures.

Menu Set Objectives and Measures
(Must select five measures and
one must be one of those identified with a double asterisk.)

1. Implement drug formulary checks. Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period.
2. Incorporate clinical laboratory results into EHRs as structured data. More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data.
3. Generate lists of patients by specific conditions to sue for quality improvement, reduction of disparities, research or outreach. Generate at least one listing of patients with a specific condition.
4. Use EHR technology to identify patient/specific education resources and provide those to the patient as appropriate. More than 10% of patients are provided patient-specific education resources.
5. Perform medication reconciliation between care settings. Medication reconciliation is performed for more than 50% of transitions of care.
6. Provide Summary of care record for patients referred to or transitioned another provider or setting. Summary of care record is provided for more than 50% of patient transitions or referrals.
7. Submit electronic immunization data to immunization registries or immunization information systems.**
8. Submit electronic syndromic surveillance data to public health agencies. Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data.**

9. Send reminds to patients (per patient preference) for preventive and follow-up care. More than 20% or patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders.
10. Provide patients with timely electronic access to their health information (including laboratory results, problem lists, medication lists, medication allergies). More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR.

Intent

If physicians demonstrate "meaningful use" in 2011, 2012, 2013, and 2014, they will receive a payment in the form of increased Medicare or Medicare reimbursement. If physicians ignore EHRs and meaningful use, in 2015, penalties are accessed so that the physicians will be paid less than those who are using an EHR meaningfully. The problem is that the penalties are relatively low and may not be enough to motivate EHR adoption.

The intent of this bill and of the incentive payments is both to encourage the adoption of EHRs and to encourage the expansion of their use in order to improve patient safety and quality outcomes. The Federal Government anticipates that 420,000 physicians will qualify for meaningful use payments in 2010. There is a potential for this not happening. In fact, the number qualifying for meaningful use for 2011 may be significantly lower, maybe by as much as 90% lower.

Potential

None of the core or menu functionalities required for meaningful use are inappropriate. The problem is how many providers will be able to perform at that level in the short term. There is no question that SETMA meets most of these standards and the two that we do not currently meet; we will meet by January 2011. But, SETMA has been implementing an EHR since 1998. It would be frightening to us if we did not presently use an EHR at all, and knew that by the end of 2011, we would have to be using it to the level described in the meaningful use rules..

Furthermore, the cost of implementing an EHR is much higher than the funds being offered in this incentive. SETMA has spend and paid for over $6,000,000 for EHR and related technologies over the past 12 years. Many providers may decide that it is cheaper to accept the penalties which are relatively small, than to implement the technology. If that happens, then it is possible that this bill, designed to promote the adoption of EHRs, may in fact have the opposite effect.

Solution

Providers can quickly buy an inexpensive EHR, which provides the basic functions required for meaningful use. The problem with this is that it may be a short term solution with longer term limitations on obtaining the maximum patient-care benefit from electronic patient management.

Some solo and small group physicians may seek out medical groups who have already achieved meaningful use and join forces with them. This has benefit for both as long as the new physicians are prepared to learn and use the electronic system to its maximum benefit.

Conclusion

Since the publication of the August article on certified EHRs, two agencies have been granted the authority to review EHR vendors' products for whether they meet meaningful use standards. The only problem is that the specifics of that standard have not yet been published.

There is not doubt that the concept of meaningful use is a good one. The problem will come in both the government's inability to fulfill its part of the process effectively and the time table – a three year phase in – may be too aggressive. The desire to get it done and to get in done right now may slow the process of adoption of EHRs rather than speed it up. We shall see.

It had been my hope that healthcare providers who had qualified as patient-centered medical homes could be granted meaningful use standards without further qualifying requirements. This hope was particularly related to those who had qualified for NCQA's Tier (Level) III PC-MH recognition. Now that SETMA has achieved NCQA Tier III recognition, and as we have revived the requirements for meaningful use, it is obvious that that will not happen. Less than 0.3% of medical practices in the United States have qualified as a medical home and only about 70% of those who qualify do so at the Tier III level. And, while all of the meaningful use requirements of NCQA PC-MH, it is possible to become a Tier III medical home without achieving all of the elements of meaningful use. We will have to qualify for meaningful sue in addition to receiving medical home recognition.

Note: On September 29, 11:00 AM CDT, Dr. Holly will be conducting a national webcast sponsored by IBM. The subject title is "Business Intelligence and Reporting at SETMA: Improving Quality, Outcomes and Clinical Practices." You can get information on how to register at no cost for the presentation by checking SETMA's website or by calling SETMA after Tuesday, September 21, 2010.