Achieving Meaningful Use

Chapter FastFACTS

1. **Designating a project manager is a crucial first step to selecting an EHR.**
2. **Some pre-HITECH EHRs can't be meaningfully used because they don't record patient information in a way that makes it easy to analyze.**
3. **Each physician has to submit data on three of six core measures of quality of care and on at least three others from a menu of 38.**
4. **To receive HITECH money, you need to register at the CMS Website and meet attestation requirements.**
5. **Incentive requirements will toughen and expand for Stage 2, which will take effect in the professional's third payment year under Medicare.**

The overall intent of federal meaningful use regulations is simple: to induce the healthcare system to use electronic records in ways that can improve quality and reduce cost. But that's the only simple thing about the regulations. Their details are complex and confusing, and in many cases they are still changing as the program unfolds.

To keep up with the changes and updates that may affect the content of this chapter, go to Websites from the CMS, your Regional Extension Center (REC), and your professional societies. If you're researching answers to specific meaningful use questions, carefully note the dates of any publications, blog

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Leticia Mussa knows that it takes a village to raise a child.

Leticia Mussa has been a Traditional Birth Attendant (TBA) for 16 years. Leticia has no training other than the knowledge and skills she got from her grandmother 16 years ago. She is aware of the danger of getting HIV during delivery but she is not properly prepared to avoid it. When she delivers babies she has no gloves so she is forced to use nylon bags. Leticia knows that she needs proper training and supplies but she can't deny helping women in the village.

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posts, or other resources. Stage 1 meaningful use regulations were announced in mid-July 2010 and published in the Federal Register of July 28, 2010. Any commentary dated earlier is of historical value only and is almost certainly outdated.

Basics of System Selection

Selecting a system is a matter of getting a good fit for your practice in terms of cost, capabilities, and the content accompanying the system, says Dr. Morris of the consulting firm Deloitte. "Make sure the kinds of forms and templates you use are offered by the vendor and you're not just getting a blank slate."

"Don't attest to something that you can't prove. Don't think [CMS is] not going to come back and ask."

Cindy Dunn, RN, FACMPE
Principal
MGMA Health Care Consulting Group
Englewood, Colo.

A crucial first step is to put someone in charge. "A lot of practices don't assign a project manager, and [EHR acquisition and implementation] is project management at its finest," says Cindy Dunn, RN, principal with the MGMA Health Care Consulting Group in Englewood, Colo. "You've really got to have someone focused on this, and it's got to be a clinical person—a nurse, a lab technician, a physical therapist—not an IT person," because only someone who works directly with patients can evaluate whether an EHR will hinder or help that process.

Based on the research, the project manager should narrow the field to two or three—at most—federally certified EHR products that might meet your needs. Then, along with one or more other clinicians, the project manager should visit current users of the systems under consideration and observe the products in action, especially in tasks relating to your practice's typical patient encounters. Given the complexities of picking the right system, the project manager should engage help from a consulting firm

or your REC (see Chapter 5) at the beginning of the selection process. In addition, he or she should line up an attorney with experience in information system contracts (ideally in healthcare information systems) to help you negotiate and finalize a contract with the selected vendor.

Once you've signed the contract, you're on your way toward qualifying for federal EHR incentive payments. Now comes the hard part: adapting the product to the way your practice works—and vice versa. (For an example see "One Practice's EHR Journey.") While systems can be customized to some degree, the EHR you choose is probably not going to fit your practice perfectly. "It doesn't matter how many site visits you do. When you bring [the EHR] home, you realize that some form you use all the time can't be created. There are pieces that don't work the way you thought they would," Ms. Dunn says. Every practice that adopts an EHR has to adapt itself to the product in some ways.

The Meaning of 'Meaningful' Use

What distinguishes meaningful use from regular use? It's mostly a matter of "structured data"—i.e., putting information into the record in a way that makes it easy for the computer to retrieve it. If electronic records are set up to enter data in structured forms like checkboxes, pull-down menus, or "radio buttons," rather than in paragraphs of notes (or what IT experts call "free text"), they can perform such valuable tasks as generating a list of patients whose immunizations aren't up to date, including which ones they need, or preventing a physician from prescribing penicillin for a patient who's allergic to it. They can also compile reports on how well the practice is doing on certain quality targets, a function required for meaningful use and helpful for participating in any pay-for-performance programs. They also can share data with other EHRs that use a compatible structure.

Some pre-HITECH EHRs simply can't be meaningfully used

One Practice's EHR Journey

Even before the HITECH incentives, Valley Medical Group, a four-site, 40-physician multispecialty group in western Massachusetts, saw a financial win from its now two-year-old EHR system: The practice was able to reduce its medical records staff from 30 employees to five, no longer has to order paper and medical record jackets, and has converted one of its record rooms to a pharmacy.

The EHR has already been invaluable for patient outreach, says Martha Mastroberti, manager of healthcare informatics. "It allows you to leverage what you know about your patients," she says. For example, it can identify all diabetic patients whose hemoglobin A1c levels are over 9, so that the practice can summon them for an office visit. The product includes a patient portal that enables physicians to share information with patients without an office visit or phone call. "If a patient gets blood drawn in the morning, our providers often have results before lunch and can send them directly to the patient with their comments attached," she says.

While the practice was motivated to have a high-level EHR system in order to qualify as a Level III patient-centered medical home as recognized by the NCQA—which it achieved in 2009—it's now working to ensure its system meets meaningful use requirements. The vendor, Athenahealth of Watertown, Mass., has guaranteed that its Web-based product, properly used, will qualify its clients for the payments, Ms. Mastroberti says, but she sees a challenge in meeting definitions that are not always clear cut.

For example, the "patient demographics" criterion requires an entry for ethnicity. This can often be difficult to define even when you ask the patient directly, which can sometimes be awkward in itself, she says. "It turns out to be hard to say to someone, 'What ethnicity are you?'" Ms. Mastroberti says. "I understand why it would be useful to know, but it's complicated in practice."

according to the federal definition, because they were set up to mirror the way physicians have traditionally recorded information: Rather than writing paragraphs with a pen, the user types paragraphs into a computer. While this has the advantage of legibility, most of the data remain so inaccessible that the records might as well be on paper. Such outmoded systems can't pass the certification tests described in Chapter 2. If your practice has such a system, it will probably have to be replaced or upgraded significantly in order to accommodate structured data.

The EHR itself will help you standardize, but it won't do the whole job. For your practice to reap the full benefits of an EHR and fulfill federal meaningful use requirements, information must be entered the same way by each person in the practice every time. To make that happen, all clinicians have to agree on where and how to record each piece of information.

"When we implemented our EHR, I assumed everything would be standardized within a few months," says Dr. Manjunath of Whitney Young Health Center in Albany, which at press time was upgrading its 4-year-old EHR to a federally certified meaningful use version. "But an EHR doesn't guarantee standardization, because you can use it like a word processor or a paper chart. You can note a patient's blood pressure or tobacco use anywhere you want."

Quality Reporting

Many of the Stage 1 meaningful use requirements are incremental: for example, 30% of patients must have at least one medication ordered through the EHR's order entry system. There's one prominent exception: reporting key clinical quality measures to CMS. Each physician has to submit data on three of six core measures of quality of care; specific choices depend on his or her patient population. Each physician must also report on at least three additional measures from a menu of 38. All the measures represent common screening and treatment processes and have been drawn from either the National Committee for Quality Assurance (NCQA) or the AMA's Physician Consortium for Performance Improvement.

To be certified for meaningful use, software must demonstrate the ability to extract data for the core measures, the alternate core measures, and at least three of the "menu" measures. The core measures are these:

- Hypertension: Blood Pressure Measurement
- Preventive Care and Screening Pair:
  - Tobacco Use Assessment
  - Tobacco Cessation Intervention
- Adult Weight Screening and Follow-up

Alternate core measures (in case any of the core measures aren't appropriate for your practice) are these:

- Weight Assessment and Counseling for Children and Adolescents
- Influenza Immunization for Patients 50 and Older
- Childhood Immunization Status

Because many of the 38 items (from which you can pick three) target the same group of patients, you can fulfill the Stage 1 meaningful use quality reporting by focusing on one type of patient. There are nine measures for diabetes, five for cancer, four each for ischemic vascular disease and ob/gyn screening, and three each for heart failure, coronary artery disease, and asthma. There is one measure for each of the following: immunizations, depression, glaucoma, pediatric pharyngitis, smoking, drug/alcohol dependence, and back pain.

Computing the quality measures is trickier than it looks, Dr. Waldren says. The object is to use the EHR to measure how many of your patients have received a given test, assessment, or intervention, as a percentage of the number of patients who were eligible to receive it. Not only must you record the relevant data for each patient in the correct spot on the chart, but you (or your EHR) must compute both a numerator (the number of patients for whom the information was recorded) and a denominator (the number of patients for whom it could have been recorded).

New Pitfalls

Prepare for several challenges as you transition from paper to an EHR. The first is transferring at least some information from paper to the new system. Some practices make the transfer for all patients at once, while others gradually enter or scan old information into the new record at each patient visit. Either way, lapses can occur. Dr. Troxel cites an example in which an abnormal Pap smear from a paper lab report was mistakenly put into the wrong spot in the EHR. The physician who ordered the test

didn't notice the result, and neither did another physician who saw the patient a year later. The patient subsequently developed cervical cancer.

Another potential problem is "alert fatigue"—which happens when physicians ignore, turn off, or override the alerts and decision-support tools built into certified EHRs. Alert fatigue could not only harm the patient but also result in legal problems. "There are multiple practice guidelines for everything, so ignoring that particular one might be the right thing to do," Dr. Troxel says. "But our concern is that if you do ignore it and the patient has an adverse outcome, the plaintiff's attorney will see that you overrode the warning and will argue that that constitutes negligence." To avoid this problem, he urges understanding the sources of the recommendations that come with your EHR and making sure they are consistent with the way you practice. Finally, while it's tempting to assume that your EHR software works correctly, that's not always the case. (See "New Way to Report EHR Safety Problems.")

The Red Tape

Once you've implemented your EHR and fulfilled all the measures of meaningful use, how do you go about getting your money? The HITECH program requires each physician in the practice to perform two steps for 2011 benefits. The first is to register at the CMS Website, available as of January 3.

The second is to attest that you are a meaningful user of an EHR. Attestation requirements are different for Medicaid and Medicare. For Medicaid benefits, first-year participants have to attest that they have acquired an EHR. Once you start collecting the Medicaid money, you have to show meaningful use by the second year. Check with your state Medicaid program to find out the attestation procedure.

For Medicare, you have to attest that you achieved 90 consecutive days of meaningful use during 2011. You must also provide specific information on the number of patients for whom you fulfilled each of the criteria (the numerator), and the number of patients for whom you could have fulfilled the criteria (the denominator), to demonstrate that you've achieved the meaningful use thresholds. The denominator must be drawn from your entire patient panel—not just Medicare patients and, in some cases, not just patients who have an electronic record. That requirement gives practices a strong incentive to get all their patients onto the electronic system as soon as they can to make it easier to compile the necessary numbers.

The exact format for Medicare attestation was scheduled to be available this April, the earliest date on which anyone would be eligible to collect Medicare HITECH incentive money. Attestation is similar in spirit to signing an income tax return: It means you're prepared to back up your statement if the government decides to audit you. CMS is likely to do spot checks to assure the accuracy of participants' attestations, just as the IRS does with taxpayers, Ms. Dunn says. "Don't attest to something that you can't prove," she says. "Don't think they're not going to come back and ask."

Raising the Stakes

The meaningful use criteria announced last summer were only for Stage 1 of the program, which is one reason they're relatively relaxed. To keep those incentive payments coming, providers will have to become even more diligent in 2013 for Stage 2 and again in 2015 for Stage 3. The current requirements will become more stringent for Stage 2, and the only question is how much more, Dr. Zaroukian says. "Right now there are some optional items, and those will probably all become core items in 2013. People will have to show habitual, rather than occasional, use." For example, the order entry requirement, currently at 30%, might increase to 80%, he says.

New requirements could be added as well, Dr. Zaroukian says, although it depends on how rapidly healthcare providers are achieving Stage 1 meaningful use. "Stage 1 is about data capture and sharing, and Stage 2 will be about advancing clinical

New Way to Report EHR Safety Problems

EHRs are supposed to reduce errors; but like any other system devised by humans, they can also introduce them. Badly designed user interfaces can make it easy for physicians to enter information in the wrong place, or even in the wrong record. Software bugs can crop up in even the most meticulously tested system. Users should always report software problems to their vendor, but a confidential online tool unveiled last fall also lets them tell others. *EHRevent.org* is a site sponsored by the iHealth Alliance, a consortium of professional societies and malpractice insurers that's also been active in collecting drug safety information. It's operated by PDR Network, the company that produces the *Physicians' Desk Reference*. *EHRevent.org* allows providers to file safety event reports on the following:

Incident: An EHR event that reached a patient, whether or not the patient was harmed.

Near Miss: An EHR event that is not believed to have impacted a patient.

Non-Patient Issue: An incident or near miss that impacted staff, employee(s), or visitor(s).

Unsafe Condition: A circumstance that increases the probability of an EHR event.

Parties reporting a problem must identify both themselves and the product they're using, although they can request that their identity be kept confidential. To comply with HIPAA requirements, reports must not include information that could identify specific patients.

The information will be compiled into reports shared with government agencies, iHealth Alliance member organizations, the federal RECs charged with helping practices pick EHR vendors and systems, the vendors of the systems that have problems reported about them, and the users that have reported problems. To encourage vendor cooperation, the program won't name names or warn customers away from certain products, but even general information about EHR errors should be useful.

processes and using decision-support rules," he predicts. "If we only have 30% meaningful users by 2013, that might have an impact on the overall level of expectations, but not on the types of expectations or the general approach."