

Meaningful Use
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February 29th, 2012 is the last day for eligible professionals to register and attest to receive an incentive payment for calendar year 2011.

At first I thought that Meaningful use was limited to the Electronic Records and their ability to capture data in a specific format. Then I realized that there was more to it. For example, the fact that the system can capture and produce data means nothing if the EPs don't enter the data in the correct fields in the correct format. Furthermore, there is more than data requirements such as the requirement to have a Security Audit Risk Analysis and the requirement to give each patient a summary of each visit.

When everything is considered Meaningful use includes both a core set and a menu set of objectives that are specific to eligible professionals. Specifically speaking there are a total of 25 meaningful use objectives. To qualify for an incentive payment, EPs must meet the 15 core objectives and 5 of 10 "optional objectives" for a total of 20 objectives.

For your benefit I have enclosed a summary of the 15 core objectives and a brief list of the 10 optional objectives.

1. Use 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.
Objective: 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.
Measure: More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
Requirement: NUMERATOR / DENOMINATOR / EXCLUSION
Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
2. Implement drug-drug and drug-allergy interaction checks.
Objective: Implement drug-drug and drug-allergy interaction checks.
Measure: The EP has enabled this functionality for the entire EHR reporting period.
Requirement: YES / NO Attestation
Exclusion: No exclusion.
3. Maintain an up-to-date problem list of current and active diagnoses.
Objective: Maintain an up-to-date problem list of current and active diagnoses.
Measure: More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Requirement: NUMERATOR / DENOMINATOR
Exclusion: No exclusion.
4. Generate and transmit permissible prescriptions electronically (eRx).
Objective: Generate and transmit permissible prescriptions electronically (eRx).
Measure: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Requirement: NUMERATOR / DENOMINATOR/EXCLUSION
Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
5. Maintain active medication list.
Objective: Maintain active medication list.
Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Requirement: NUMERATOR / DENOMINATOR

Exclusion: No exclusion.

6. Maintain active medication allergy list.

Objective: Maintain active medication allergy list.

Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

Requirement: NUMERATOR / DENOMINATOR

Exclusion: No exclusion.

7. Record specific demographic information.

Objective: Record Preferred language, Gender, Race, Ethnicity, Date of birth.

Measure: More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.

Requirement: NUMERATOR / DENOMINATOR

Exclusion: No exclusion.

8. Record and chart vital sign changes.

Objective: Record and chart Height, Weight, Blood pressure, Calculate and display body mass index (BMI), Plot and display growth charts for children 2-20 years, including BMI

Measure: For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.

Requirement: NUMERATOR / DENOMINATOR / EXCLUSION

Exclusion: Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.

9. Record smoking status for patients 13 years old or older.

Objective: Record smoking status for patients 13 years old or older.

Measure: More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Requirement: NUMERATOR / DENOMINATOR / EXCLUSION

Exclusion: Any EP who sees no patients 13 years or older.

10. Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States. In order to report clinical quality measures (CQMs) from an electronic health record (EHR), electronic specifications must be developed that include the data elements, logic and definitions for that measure in a format that can be captured or stored in the EHR so that the data can be sent or shared electronically with other entities in a structured, standardized format, and unaltered.

These electronic specifications are derived from certified EHRs. As part of the criteria for satisfying meaningful use, CQM results (numerators, denominators, and exclusions) must be reported to CMS. Eligible professionals must report from the table of 44 clinical quality measures which includes, 3 Core, 3 Alternate Core, and 38 additional CQMs.

- Core CQMs - EPs must report on 3 required core CQMs, and if the denominator of 1 or more of the required core measures is 0, then EPs are required to report results for up to 3 alternate core measures.

- EPs also must also select 3 additional CQMs from a set of 38 CQMs (excluding the core/alternate core measures). It is acceptable to have a '0' denominator provided the EP does not have an applicable population.

In sum, EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures. A maximum of 9 measures would be reported if the EP needed to attest to the 3 required core, the three alternate core, and the 3 additional measures.

Objective: Report ambulatory clinical quality measures to CMS.

Measure: Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS.

Requirement: YES / NO Attestation

Exclusion: No exclusion.

11. Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule. CMS will not issue additional guidance on the selection of appropriate clinical decision support rules for Stage 1 Meaningful Use. This determination is best left to the EP taking into account their workflow, patient population, and quality improvement efforts.

CMS describes this application as “HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.” In addition, CMS states that “We purposefully used a description that would allow a provider significant leeway in determining the clinical decision support rules that are more relevant to their scope of practice.”

HIMSS offers more of an interpretation by describing this application as “CDS provides the right information to the right person at the right time to assist in the process of delivering quality and safe care. Aside from alerts and reminders, CDS may include templates, order sets, data display that highlights important information, reference information, and other tools to support optimal care within the clinical workflow. CDS interventions can:

- Gather and present clinical and other relevant data needed for clinical decision making;
- Detect potential safety and quality problems and help prevent them;
- Foster the greater use of evidence-based medicine principles and guidelines;
- Safeguard against inappropriate utilization of services, medications, and supplies;
- Organize, optimize and help operationalize the details of a plan of care;
- Help keep track of the simple things that we sometimes forget, such as adjusting medication doses for altered renal function, or remembering to complete Advanced Directives for an admitted patient; and
- Ensure that the best clinical knowledge and recommendations are utilized to improve health management decisions by clinicians and patients.”

Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.

Measure: Implement one clinical decision support rule.

Requirement: Yes/No Attestation

Exclusion: No exclusion.

12. Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.

Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.

Measure: More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.

Requirement: Any EP that has no requests from patients or their agents for an electronic

Exclusion: NUMERATOR / DENOMINATOR / EXCLUSION (EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement).

13. Provide clinical summaries for patients for each office visit.

Objective: Provide clinical summaries for patients for each office visit.

Measure: Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.

Requirement: NUMERATOR / DENOMINATOR / EXCLUSION

Exclusion: Any EP who has no office visits during the EHR reporting period.

Resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

14. Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically. While attestation is simply, yes or no answer, the EP must conduct an electronic exchange of key clinical information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. Actual patient information is not required and a test patient may be used to satisfy this objective as long as the test information is identical in form to what would be sent about an actual patient.

Objective. Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.

Measure. Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

Requirement: YES / NO Attestation

Exclusion. No exclusion.

15. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. EPs must conduct or review a security risk analysis of certified EHR technology and implement updates as necessary at least once prior to the end of the EHR reporting period and attest to that conduct or review. The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period.

Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

Requirement: YES / NO Attestation

Exclusion: No exclusion.

The remaining 5 objectives may be chosen from the list of 10 menu set objectives.

1. Implement drug formulary checks.
2. Incorporate clinical lab-test results into EHR as structured data.
3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
4. Send patient reminders per patient preference for preventive/follow-up care.
5. Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
6. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

7. The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
8. 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 care record for each transition of care or referral
9. Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice
10. Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

Please remember that the information above is simply a summary and that in case of questions you should consider contacting Taino Consultants Inc.

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