Medweb Telemedicine
667 Folsom Street,
San Francisco, CA 94107
Phone: 415.541.9980 Fax: 415.541.9984
www.medweb.com

Meaningful Use

On July 16 2009, the ONC Policy Committee unanimously approved a revised definition of Meaningful Use prepared by the Meaningful Use Workgroup. The revisions reflect the comments by the ONC policy committee members on the initial draft, the feedback at "listening sessions" held by ONC, and 792 comments that had been submitted on the draft. These recommendations (after some minor clarifications based on the committee discussion) were forwarded to the Centers for Medicare & Medicaid Services (CMS) and legalized.

The Meaningful Use requirements are staged with certain criteria and measures required to receive Meaningful Use payments in 2011 and 2012, and additional requirements that must be met to receive incentive payments in 2013 and 2014, and even more in 2015. The staging of requirements was based on a balance between their importance and the ability of the industry to implement them. The working group focused on the definitions for 2011/12 and most of the changes to the initial draft involve moving requirements forward in time. The two biggest changes (and the areas where there were the greatest number of comments) are: that the measure for computerized physician order entry (CPOE) in 2011/12 is that 10 percent of all orders be entered by the provider using CPOE (the percentage was not specified in the original draft); and that incentive payments will be suspended if a provider has been found in violation of HIPAA and has not remedied the problem. The previous draft specified that payments would be suspended if a provider was reported to have violated HIPAA.

The requirements for privacy and security were also clarified. CMS will require compliance with Federal regulations and state Medicaid programs will be encouraged to also require compliance with state laws to receive the Medicaid incentive payments. The committee will also recommend to CMS that the 2011/12 requirements be required for the first adoption year (which could be later than 2011 or 2012.) However, since the incentive payment level decreases over time, to receive the maximum payment, an organization would still need to meet the 2011/12 criteria by 2012.

Organizations that meet the initial set of criteria in 2011 will receive about 70 percent of their total Medicare incentive payments in 2011 and 2012. We believe that Meaningful Use of an EMR system achieves the goals of increased quality and safety, improved efficiency and transparency, and an enhanced ability to provide patient-centered care. That should be the goal. Every organization will want to meet the specific requirements to receive their reimbursement incentive, but Meaningful Use doesn't start or stop there. The proposed draft requirements are consistent with this philosophy; proposed Meaningful Use requirements and measures are tied to the national goals of:

- Improving quality, safety and efficiency
- Engaging patients in their care
- Increasing coordination of care
- Improving the health status of the population
- Ensuring privacy and security

During the comment period, many people strongly endorsed this overall approach to defining Meaningful Use.

Industry Impact

The financial incentives in the stimulus bill provide an opportunity for eligible organizations and professionals who desire a fully integrated EHR but struggle with funding and with barriers to sharing information effectively. For eligible organizations the important question now remains, "How do we achieve Meaningful Use of an EMR?"

Five key requirements:

1. Setting the right EMR goals
2. Purchasing the right EMR product

3. The right implementation of the EMR
4. The right use of the EMR by caregivers
5. Delivering the right outcomes with the EMR product

The Right Goals

The goal in implementing an EMR is to improve patient care. This is a major undertaking involving massive changes that will touch everyone in the organization. Busy providers will rally around the cause of safer, more efficient care. At best, they are willing to "go along with" a change that provides an extra payment to the hospital. This is especially true of community physicians who need to take time away from their practice (and their income) to lead the change, receive training, and optimize use.

The Right Product

Purchasing the right EMR product is an essential requirement for achieving Meaningful Use. The product must provide the applications and features to meet the quality and efficiency goals, and it must be designed to be useable by physicians. For example, if an EMR does not provide the capability to check orders for the right dose based on renal function, then use of computerized physician order entry (CPOE) will not address one of the top ten causes of preventable adverse drug events. If there is no capability to check for possible duplicate tests, then savings can't accrue from reducing unnecessary tests. If data are not easily captured and coded, nurses will still spend time extracting the data required for quality reporting and the availability of data for quality improvement will be limited. If the system is not used because it creates inefficiencies, no benefits will accrue.

The Right Product with Essential Capabilities: Hospital Setting

The essential capabilities have been specified in the requirements for achieving Meaningful Use. In addition to the changes mentioned previously for 2011, the workgroup added a requirement for one clinical decision support rule for a specialty or clinical priority (a reminder or alert), and added requirements for electronic eligibility checking, submitting claims electronically, and for providing ambulatory patients with electronic access to health information and providing inpatients an electronic copy of discharge instructions. Proposed requirements for meeting hospital incentive payment requirements for Meaningful Use of an EHR for 2011 include:

- Provider use of CPOE for at least 10 percent of orders
- Drug-drug, drug allergy, and drug formulary checking
- Implementation of one clinical decision rule
- Maintaining up-to-date problem, medication, and medication allergy lists
- Vital signs
- Lab test results
- Reminders for follow-up care
- Medication reconciliation at relevant encounters
- Providing patients with electronic copies or electronic access to their records upon request (electronic access to test results, problems, medications and allergies for ambulatory patients, and electronic copy of discharge instructions and procedures for inpatients)
- Providing patient-specific educational resources
- Providing the patient a summary of each encounter
- Exchanging "key clinical information" among providers
- Submitting electronic information to immunization registries and public health agencies
- Compliance with HIPAA and state laws for privacy and security
- Data sharing in accordance with the Nationwide Privacy and Security

Framework Act

In 2013 some of the additional requirements that would need to be met for Meaningful Use include:

- Clinical (nursing) documentation
- Closed loop medication management
- Evidence-based order sets
- Specialist reporting to external disease registries
- More complete decision support at the point of care
- Management of chronic conditions using patient lists and decision support
- Barcode for medication administration
- Documentation of family medical history
- Medication reconciliation at each transition of care
- Retrieve and act on prescription fill information
- Produce and share an electronic summary care record at every transition in care

Integration with inpatient medical devices would not be required until 2015.

The Right Product with Essential Capabilities: Ambulatory Setting

The proposed requirements for receiving the physician office incentive payment for Meaningful Use of an EMR in 2011 are the same as those for inpatient care.

Additional requirements include:

- ePrescribing
- Generating lists of patients with specific conditions
- Progress notes

In 2013, reporting by specialists to disease registries, offering secure messaging for patient-provider communication, access to a PHR populated with clinical information in real time and integration of data from home monitoring devices would be required. Providing access to tools for patient self-management would be required in 2015.

Right Implementation

Organizations satisfying Meaningful Use requirements must implement qualified EHRs in such a way that the staff can make full use of its capabilities, such as implementing:

- Full interoperability (of key features or applications, such as lab results, allergies, problem lists, medications/e-prescribing and other necessary information to promote care continuity between providers),
- Patient safety and quality reporting (clinical decision support and other functions that will improve medication safety and support population management activities),
    - Clinical documentation for physicians and the rest of the clinical team that includes coded data capture for reporting purposes, and
    - Training and ongoing technical assistance to physicians and the clinical team to promote optimal exchange of information.
    - The right implementation involves setting goals for benefits and adjusting processes and organizational governance to achieve those goals. It is essential to recognize that achieving Meaningful Use of an EMR system is a large-scale clinical change project that must be clinician-led.

Right Use

To meet the Meaningful Use requirements, all organizations must implement an EHR so that it is incorporated into the routine care process. This key area speaks to the effective use by clinical professionals for the purpose of delivering quality care and service.

The recommendation of the “right use” of a qualified EMR is demonstrated by the following levels of adoption:

- Equal to or greater than 90 percent of care-related electronic tasks are completed by clinical professionals utilizing the EMR (e.g., entering medication orders and/or documenting progress notes)

Direct evidence of role-based use by clinicians (e.g., physician order entry, e-prescribing, registered nurses documenting medication administration, pharmacist electronically sending pharmacy alerts to physician team, or respiratory therapist electronically entering and reporting ventilator bundle checks each shift, etc.)

- Direct evidence of quality reporting fed by electronic clinical documentation
- A close eye is maintained on the revenue cycle process, e.g., appropriate interfaces must be established and documentation should feed charge capture rather than requiring a separate electronic step in the charging process
- Evidence of benefit, for example, the number of alerts that result in a change in orders, the number of nursing hours spent in compiling quality data, the number of chronic care patients that meet the criteria for appropriate care.

Meaningful Use in Radiology

The Office of the National Coordinator for Health Information Technology (ONCHIT) received a mandate from the Federal government to create guidelines for the meaningful use of IT in healthcare. Via certain requirements, the intent of what has become known as "Meaningful Use" is to radically improve healthcare through the use of IT. The requirements are directly tied to reimbursement incentives for all healthcare providers who are successful "meaningful users" of IT in healthcare.

There are timelines commensurate to complying with such requirements, and any eligible providers ("EP's"), who do not meet the MU standards by 2015 will face penalties via reductions in Medicare/paid reimbursements.

Meaningful Use consists of five goals:

1) Improve healthcare quality, safety, and efficiency
2) Engage patients and their families in patient care
3) Improve care coordination
4) Improve public health and reduce health disparities
5) Ensure privacy and security protections for patients

How to qualify in Radiology?

Any radiologist who receives Medicare payments of at least $24,000 per year is eligible up to $44,000 in bonus payments over the next five years. Medicaid offers a program whereby radiologists, and any EP's, can receive $64,000 per physician over a five-year period. In addition to the above criteria, EP's must be practicing at a federally-qualified and have a minimum of thirty percent of payments attributable to needy individuals paying via Medicaid. To qualify for either program, radiologists must:

1) Provide 10 percent of services in an outpatient setting which includes urgent care facilities, independent clinics and offices defined by the CMS (Centers of Medicaid and Medicare Services) "place of service" codes.
2) The radiologist must either own a Certified Ambulatory Electronic Health Record system or have full-time usage of one at the outpatient setting, with a dedicated log-on in play if the EHR is not owned.
3) The radiologist must either own a Certified Ambulatory Electronic Health Record system or have full-time usage of one at the outpatient setting, with a dedicated log-on in play if the EHR is not owned.
4) Use a complete Certified (I.e. Drummond, CCHIT) EHR. Despite the fact that radiologists are exempt from the e-prescribing clinical objective of MU, since they clearly write fewer than 100 prescriptions per year, they still must document that they are using a complete Certified EHR.
5) Enter "vitals" on patient, which become a part of the EHR record.

How has MU compliance in Radiology become easier in 2011?
Radiologists have long expressed the view that they have been overlooked in the Meaningful Use environment. In terms of digital storage and display of imaging studies, launching web-viewer of images and reports from EMR, accepting outside imaging studies into PACS and the ability to create annotated image libraries, radiologist have been using advanced IT long before most PCP's did. As Meaningful Use was initially rolled out, many radiologists were concerned that they were being asked to adopt technology and workflows that did not benefit their patients or apply to the practice of radiology.

Prior to mid-2011, radiologists "place of service" had to own e-prescribing technology, even though the radiologist was exempt from using it. While the ownership of e-prescribing technology is still mandated, there is now a logical approach to radiologists qualifying for MU. Namely, radiologists can document the meeting of Meaningful Use criteria in radiology workflow by stating patient vitals as a part of the intake into the EHR supply-chain workflow.

In an August 2011 article with *Diagnostic Radiology*, the American College of Radiology estimated that 90 percent of radiologists will be eligible for these CMS incentives. The key aspect though is not the actual receipt of the funds but what comes after, namely the radiologist's ability and desire to adopt and integrate new technology and practice workflows.

The last day to begin using certified technology to qualify for full payment is October 1st, 2012. After this date, incentives drop. Penalties go into effect October 1st, 2015.