Aligning "Meaningful Use," Safety and EHR Strategies

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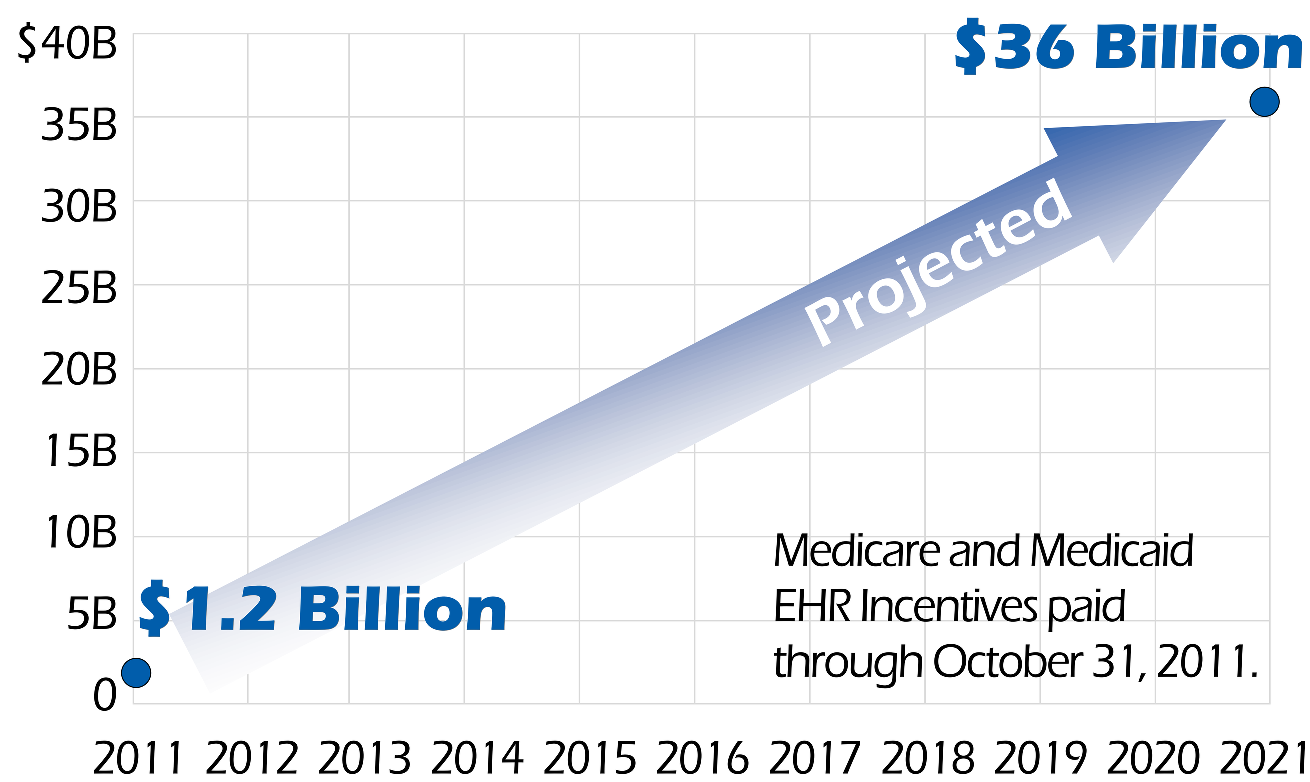
History

- The Health Information Technology for Economic and Clinical Health (HITECH) Act—Part of the American Recovery and Reinvestment Act (ARRA) of 2009 earmarked significant incentive funds for Electronic Health Record (EHR) adoption.
- Congress did not simply want adoption of EHRs – they wanted to ensure that there would be **"meaningful use"** of EHRs.
- Meaningful Use Objectives will be released in Stages—Stage 1 Objectives are presently in place. The Final Rule for Stage 2 is anticipated in June 2012.

Economic Impact

$1.2 billion[1] of a projected $36 billion[2] in incentive payments have been paid to date.



Analyze

- Review objectives with an eye to those that hold the potential to have a "high impact" on safety within your organization.
- Analyze both Core and Menu Objectives.

Example List of Identified *"High Impact" Core Objectives*

- Maintain active medication list
- Maintain active medication allergy list
- Implement drug-drug and drug-allergy interaction checks
- Maintain up-to-date problem list
- Provide patients with an electronic copy of their discharge instructions

Align

- Align your organization's investment in attaining meaningful use objectives with its patient safety process improvement programs.

Meaningful Use Objectives

- Eligible Providers (Stage 1 Objectives)
  - 25 Objectives
    - 15 are required ("core objectives")
    - 5 of the remaining 10 may be deferred ("menu objectives")
- Hospitals (Stage 1 Objectives)
  - 24 Objectives
    - 14 are required ("core objectives")
    - 5 of the remaining 10 may be deferred ("menu objectives")

Summary Overview of Meaningful Use Objectives.*

Objective	Measure
Core set of objectives to be achieved by all eligible professionals, hospitals, and critical access hospitals to qualify for incentive payments	
Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause in the event of death)	Over 50% of patients' demographic data recorded as structured data
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)	Over 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data
Maintain up-to-date problem list of current and active diagnoses	Over 80% of patients have at least one entry recorded as structured data
Maintain active medication list	Over 80% of patients have at least one entry recorded as structured data
Maintain active medication allergy list	Over 80% of patients have at least one entry recorded as structured data
Record smoking status for patients 13 years of age or older	Over 50% of patients 13 years of age or older have smoking status recorded as structured data
For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request	Clinical summaries provided to patients for over 50% of all office visits within 3 business days; over 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided with it
On request, provide patients with an electronic copy of their health information (including diagnostic-test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures)	Over 50% of requesting patients receive electronic copy within 3 business days
Generate and transmit permissible prescriptions electronically (does not apply to hospitals)	Over 40% are transmitted electronically using certified EHR technology
Computer provider order entry (CPOE) for medication orders	Over 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE
Implement drug–drug and drug–allergy interaction checks	Functionality is enabled for these checks for the entire reporting period
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
Implement one clinical decision support rule and ability to track compliance with the rule	One clinical decision support rule implemented
Implement systems to protect privacy and security of patient data in the EHR	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies
Report clinical quality measures to CMS or states	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures
Eligible professionals, hospitals, and critical access hospitals may select any five choices from the menu set	
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
Incorporate clinical laboratory test results into EHRs as structured data	Over 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one listing of patients with a specific condition
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate	Over 10% of patients are provided patient-specific education resources
Perform medication reconciliation between care settings	Medication reconciliation is performed for over 50% of transitions of care
Provide summary of care record for patients referred or transitioned to another provider or setting	Summary of care record is provided for over 50% of patient transitions or referrals
Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions)
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)
Additional choices for hospitals and critical access hospitals	
Record advance directives for patients 65 years of age or older	Over 50% of patients 65 years of age or older have an indication of an advance-directive status recorded
Submit electronic data on reportable laboratory results to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Additional choices for eligible professionals	
Send reminders to patients (per patient preference) for preventive and follow-up care	Over 20% of patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)	Over 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR

Source: *NEJM*[3]

Conclusion

If an organization's EHR strategies align attainment of "Meaningful Use" objectives with its safety initiatives, the ultimate impact on patient safety will be enhanced. Further, the organization's focus on patient-centered care aligns with the ACO requirements of the Medicare Shared Savings Program component of the Affordable Care Act.

Case Study Example

- Meaningful Use Objective
  - Patient provided with an electronic copy of the discharge instructions
- Implementation
  - Use an automated informed consent solution (iMedConsent™, Dialog Medical, Atlanta, GA) in concert with the EHR (VistA CPRS, Department of Veterans Affairs)
- Key Safety Factors
  - Discharge instructions are accessible via the EHR (to the on-call nurse)
- Results
  - Observed a 270% reduction in the 14-day readmission rate[4]

Discharge instructions are detailed and procedure-specific.

Instructions are saved to the EHR.

Patient and nurse sign the discharge instructions.

References

[1] CMS. EHR Incentive Programs. Spotlight and Upcoming Events. http://www.cms.gov/EHRIncentivePrograms/50_Spotlight.asp. Accessed December 1, 2011.

[2] Rock and a hard place: An analysis of the $36 billion impact from health IT stimulus funding. *Price Waterhouse Coopers*. April 2009.

[3] Blumenthal D and Tavenner M. *The New England Journal of Medicine* 2010;363(6):501-504.

[4] Boast P and Potts C. *Patient Safety & Quality Healthcare* 2010;7:14-16.

Presented at the 23rd Annual Institute for Healthcare Improvement (IHI) National Forum
December 4-7, 2011   Orlando, FL