

How Hospitals Can Achieve Meaningful Use

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Meaningful Use - Core Set

1. Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause of death in the event of mortality). More than 50% of patients' demographic data must be recorded as structured data

Meaningful Use - Core Set

2. Record vital signs and chart changes (height, weight, blood pressure, body mass index, growth charts for children). More than 50% of patients 2 years of age or older must 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 must have at least one entry recorded as structured data.

Meaningful Use - Core Set

4. Maintain an active medication list. More than 80% of patients have at least one entry recorded as structured data.
5. Maintain an active medication allergy list. More than 80% of patients have at least one entry recorded as structured data.
6. Record smoking status for patients 13 and older. More than 50% of patients age 13 or older have smoking status recorded as structured data.

Meaningful Use - Core Set

7. For professionals, provide patients with clinical summaries for each office visit; for hospitals provide an electronic copy of hospital discharge instructions upon request.
 - Clinical summaries provided to patients for more than 50% of all visits within 3 business days.
 - More than 50% of all patients who are discharged from an inpatient or ED of a hospital who request an electronic copy of their discharge instructions must be provided with it.

Meaningful Use - Core Set

8. Upon request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication list, medication allergies, and for hospitals discharge summary and procedures).
 - More than 50% of requesting patients must receive an electronic copy within 3 business days.

Meaningful Use - Core Set

9. Generate and transmit permissible prescriptions electronically (does not apply to hospitals).
 - More than 40% must be transmitted electronically using certified EHR technology.
10. Computerized Provider Order Entry for Medication Orders.
 - More than 30% of patients with at least one medication in their medication list must have at least one medication ordered through CPOE

Meaningful Use - Core Set

11. Implement drug-drug and drug-allergy interaction checks. Functionality must be enabled for these checks for the entire reporting period.
12. Implement capability to electronically exchange key clinical information among providers and patient-authorized entities. Must perform at least one test of the EHR's capacity to electronically exchange information.

Meaningful Use - Core Set

13. Implement one clinical decision support rule and track compliance with that rule. One rule must be implemented.
14. Implement systems to protect privacy and security of patient data in the EHR. Must conduct or review a security risk analysis, implement security updates as necessary and correct identified security deficiencies.

Meaningful Use - Core Set

15. Report clinical quality measures to CMS or states.
 - For 2011, provide aggregate numerator and denominator through attestation. For 2012, electronically submit measures.
 - Core Measures
 - Hypertension: Blood Pressure Measurement
 - Tobacco Use Assessment and Tobacco Cessation Intervention
 - Adult Weight Screening and Follow-up
 - Alternate Core Measures
 - Weight Assessment and Counseling for Children and Adolescents
 - Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
 - Childhood Immunization Status

Meaningful Use - Menu Set

- Implement drug formulary checks. Drug formulary check system must be implemented and access at least one internal or external drug formulary during the reporting period.
- Incorporate clinical laboratory test results into EHRs as structured data.
 - More than 40% of clinical laboratory test results are in positive/negative or numerical format and are incorporated into EHRs as structured data

Meaningful Use - Menu Set

- Generate lists of patients by specific conditions for use for quality improvement, reduction of disparities, research or outreach. Must generate 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. More than 10% of patients are provided patient specific education resources

Meaningful Use - Menu Set

- Perform Medication reconciliation between care settings. Medication reconciliation must be performed for more than 50% of transitions of care.
- Provide summary of care record for patients referred or transitioned to another provider or setting. Summary of care record must be provided for more than 50% of patient transitions or referrals

Meaningful Use - Menu Set

- Submission of electronic immunization data to immunization registries or immunization information systems.
 - Must perform at least one test of data submission and followup submission (where registries can accept electronic submissions)
- Submission of electronic syndromic surveillance data to public health agencies.
 - Must perform at least one test of data submission and followup submission (where public health agencies can accept electronic data)

Meaningful Use - Menu Set

- For hospitals - record advanced directives for patients 65 years or older.
 - More than 50% of patients aged 65 or older must have an indication of an advanced directive status recorded.
- For hospitals - submission of electronic data on reportable laboratory results to public health agencies. Perform at least one test of data submission and followup submission (where public health agencies can accept electronic data)

Meaningful Use - Menu Set

- For professionals - Send reminders to patients (per patient preference) for preventative and followup care. More than 20% of patients aged 65 or older or age 5 or younger must be sent appropriate reminders.
- For professionals - Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication list, medication allergies). More than 10% of patients must be provided with electronic access to information within 4 days of its being updated in the EHR.

Meaningful Use Data Exchanges

Core Set

1. Provide patients an electronic copy of their ambulatory, ED or inpatient summary of care record record
2. Transmit prescriptions
3. Capability to exchange key clinical information among care providers and patient authorized entities
4. Report clinical quality measures

Menu Set

5. Incorporate clinical lab tests results into EHRs as structured data
6. Provide summary of care record for patients referred or transition to another provider or setting
7. Capability to submit data to immunization registries, provide syndromic surveillance and lab data to public health agencies

Questions?

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