

# “EHR Meaningful Use Guide”

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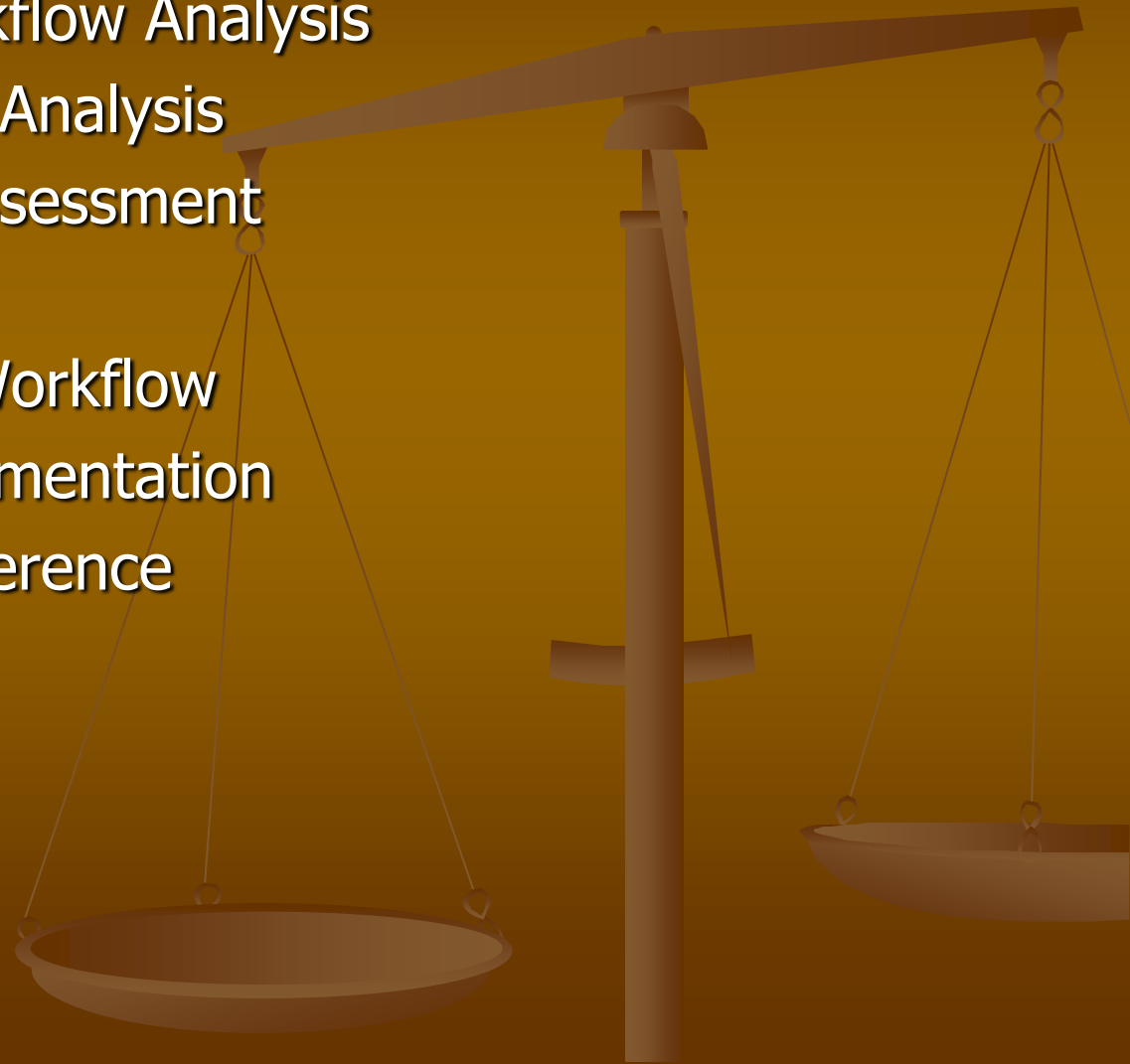
# Agenda

1. **EHR Readiness**
2. **Core Data Capture**
3. **Building a Meaningful Use Implementation Plan**



# EHR Readiness

- Practice Workflow Analysis
- Hardware/IT Analysis
- Staff Skills Assessment
- Gap Analysis
- Role-based Workflow
- Sample Documentation
- Provider Preference



# Practice Workflow & Skills Assessment



## PRACTICE WORKFLOW AND ASSESSMENT TOOL

### Appointment Scheduling

Who books appointments?

Are there certain appointments that can only be scheduled by nursing?

What is your scheduling policy? Is everyone adhering to this policy?

Does your practice use scheduling guidelines based on diagnosis or condition?

What is your scheduling methodology?

How are patients assigned to a provider?

How do you actually schedule an appointment? (DIAGRAM OUT)


Does the process vary when the patient walks in to schedule an appointment?

How are foreign-language/handicapped patient needs addressed?

Is there a telephone scheduling section separate from the front desk staff?

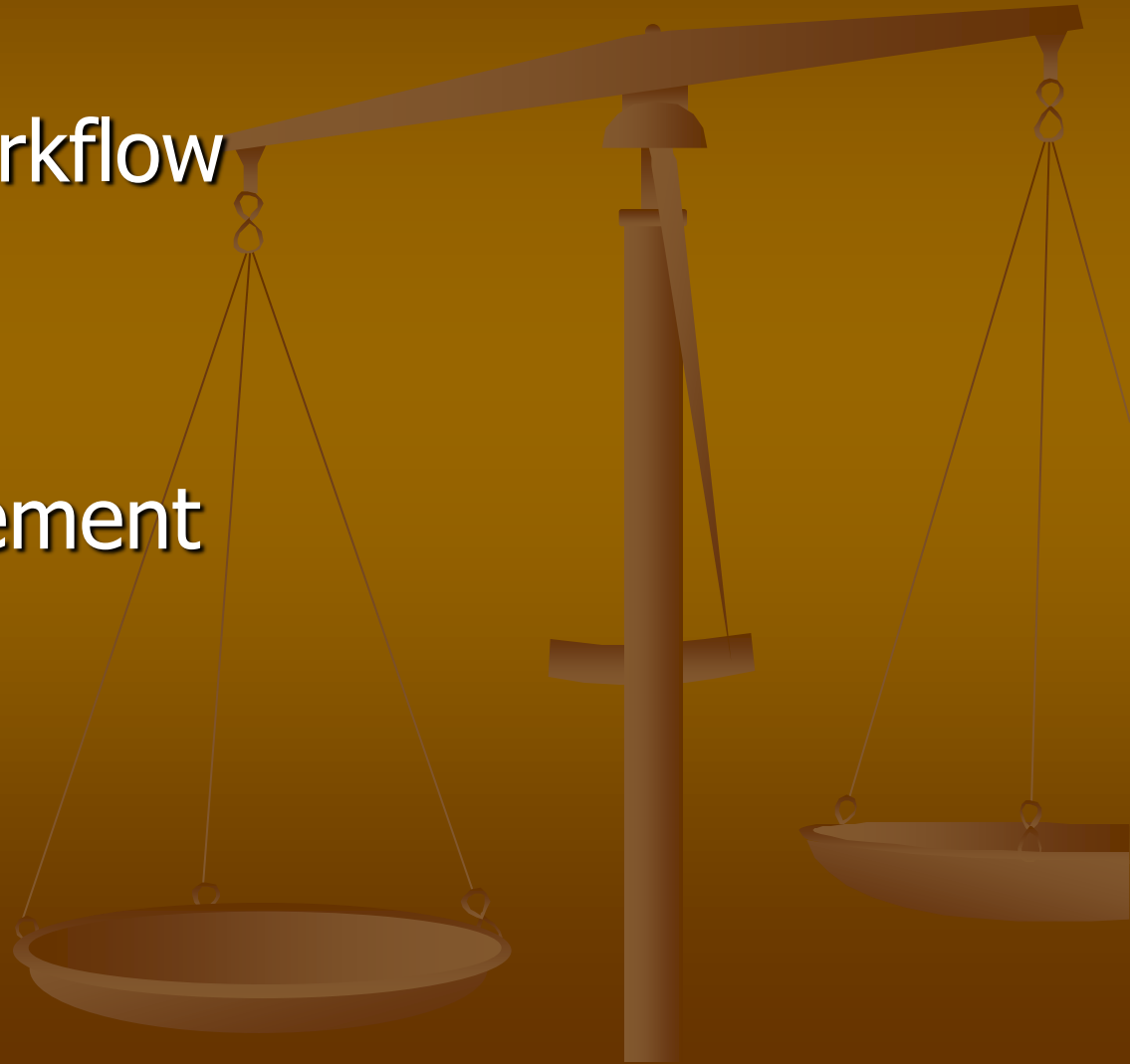
Are referral requirements addressed at the time of appointment scheduling?

# Gap Analysis

		<b>Meaningful Use Gap Analysis and Readiness Assessment</b>								
<b>Practice Name:</b> Date Completed:						<b>Product:</b> Current Release:				
To achieve Stage 1 Meaningful Use, you must meet 20 Objectives. These include 15 mandatory objectives from the Core Set and your selection of 5 objectives from a menu set of 10 objectives.										
							<b>Scoring:</b> 1 = Functionality not available in EHR 2 = Not being used but available in EHR 3 = In use but request workflow redesign 4 = In use, process documented & optimal			
Meaningful Use Core Objectives: Must Meet 100%	Measure	Related EHR Feature	MU Reference	Exclusion (if applicable)	Pre Upgrade Score	Post Upgrade Score	Action Plan/Notes			
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.	More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	Medication Tab	Does the provider enter medications into the medications section or is the nurse or MA assisting? Does the provider prescribe any injectible medications that are given in the office? (ex. Rocephin)	Any EP who writes fewer than 100 prescriptions during the EHR reporting year.						
2) Implement drug-drug/drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period.	Clinical Tools	Does the site have a subscription to clinical tools, and if so is their drug interactions up to date?	Any EP who writes fewer than 100 prescriptions during the EHR reporting year.						
3) Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	Medication Tab	Has the site implemented SureScripts, and if so is the provider using it?	Any EP who writes fewer than 100 prescriptions during the EHR reporting year.						
4) Record demographics • preferred language ____ • gender ____ • race ____ • ethnicity ____ • date of birth ____	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.		Is the practice capturing GENDER, DATE OF BIRTH, RACE, and ETHNICITY? Does the practice have an area where they are currently capturing Preferred Language? What is the check-in procedure for checking demographics? Does the site	None						

# Role-based Workflow

- Skill Specific
- Redesign of Workflow
- Considerations
- Reassignment
- Change Management



# Sample Documentation

- Super Bill
- Progress Notes
- Order Slips
- Patient Education
- Letters



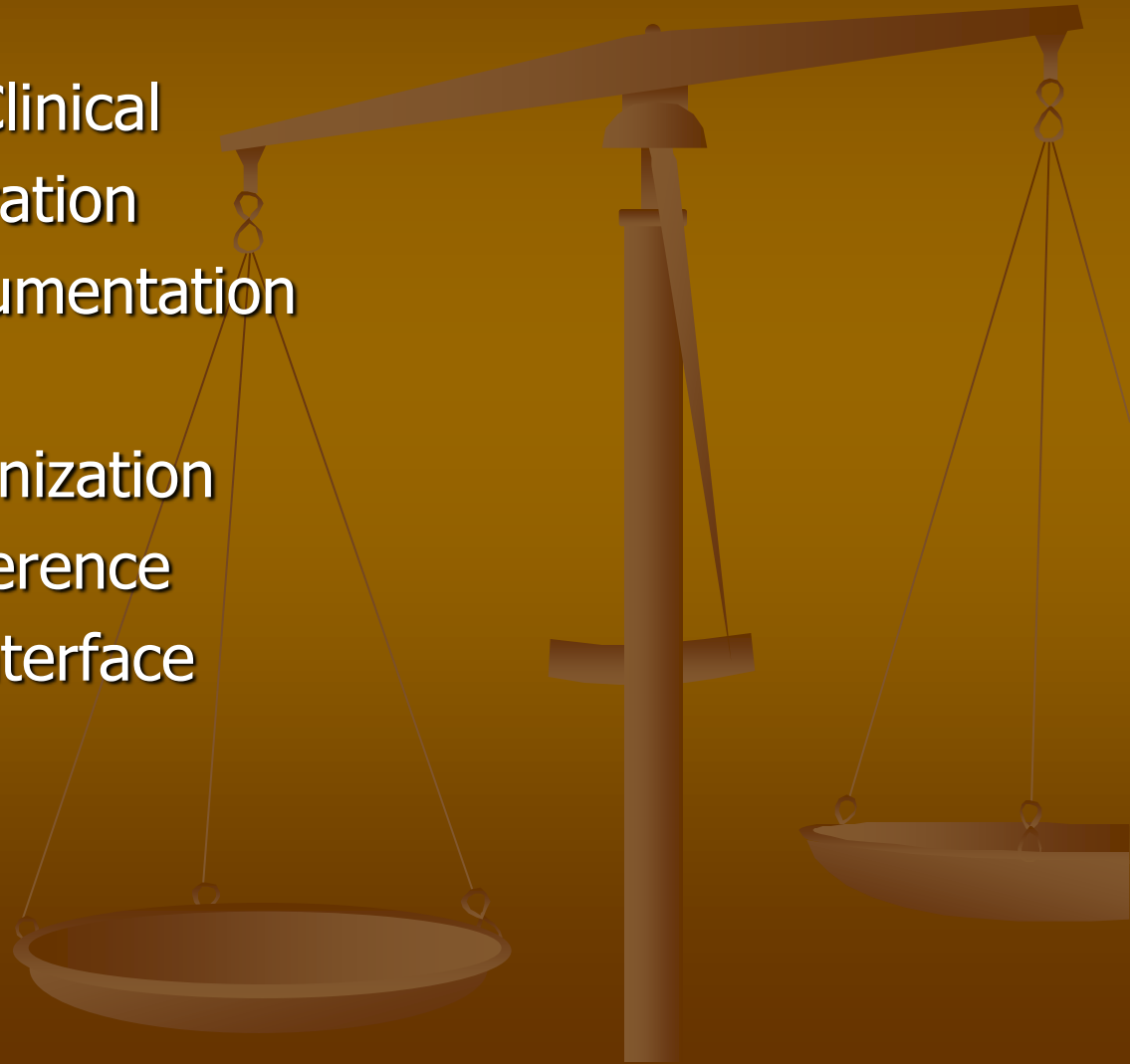
# Provider Preference

- Typing
- Transcription
- Voice Recognition
- Keyboard/Mouse
- Hybrid



# Core Data Capture

- Front office
- Mid office – Clinical
- Device Integration
- Provider Documentation
- Templates
- Data Synchronization
- Provider Preference
- Manual vs. Interface





# Mid Office Clinical

Vital Signs: Stein, Richard

Template: **Vitals**

	09/29/11	07/08/11	06/13/11	06/13/11	05/17/11	04/21/11	10/07/10	03/17/10	02/09/07	03/14/06	03/03/06	04/07/05	11/25/03
Height	5'9"			5'9"	5'9"	5'9"	5'9"	5'9"	5'9"			5'9"	5'9"
Weight	167 lbs			190 lbs	190 lbs	184 lbs	178 lbs	169 lbs	167 lbs	165 lbs	166 lbs	168 lbs	167 lbs
BMI	24.68 kg/m <sup>2</sup>		28.08 kg/m <sup>2</sup>	28.08 kg/m <sup>2</sup>	28.08 kg/m <sup>2</sup>	27.20 kg/m <sup>2</sup>	26.31 kg/m <sup>2</sup>	24.98 kg/m <sup>2</sup>	24.68 kg/m <sup>2</sup>	24.39 kg/m <sup>2</sup>	24.54 kg/m <sup>2</sup>	24.83 kg/m <sup>2</sup>	24.68 kg/m <sup>2</sup>
DFC													
Temperature								98.4 F	98.8 F	99.4 F	100.6 F	98.8 F	98.8 F
Pulse	76	78		78		74	76	84	86	78	98	90	86
Respirations								14		14	16		
Systolic	122	122		122	156	155	123	134	135	142	148	138	135
Diastolic	76	85		76	78	82	75	88	86	96	98	80	86
Oximetry								95 %		98 %	92 %		97 %
(Your text here)													
(Your text here)													
(Your text here)													
Smoking										Current Smoke	Current Smoke	Current Smoke	Current Smoke
Pain Level													
Peak Flow						400 Liters/min					280 Liters/min		440 Liters/min

How is this handled?

# Device Integration

The image shows a software interface window titled "Device Integration" overlaid on a background of a balance scale. The window contains several input fields and buttons. A red arrow points to the "Acquire" button, which is circled in green. The text "Direct Vitals Acquisition" is written in large red letters over the window.

(Your text here)	<input type="text"/>	
(Your text here)	<input type="text"/>	
(Your text here)	<input type="text"/>	
Smoking	<input type="text"/>	Packs Per Day <input type="text"/>
Pain Level	<input type="text"/>	
Peak Flow	<input type="text"/>	
Diastolic - Large Cup	<input type="text"/>	
Systolic - Large Cup	<input type="text"/>	

Buttons: OK, Cancel, **Acquire**, Help

**Direct Vitals Acquisition**



# Templates

Providers: «\*» : «\*»

Insert Vitals from today (BP, Pulse):  
Insert Vitals from today (Temp, Height, Weight):  
Insert BMI from today: ||BODY\_MASS\_INDEX||

## **Subjective:**

This «\*age\*» old «\*sex\*» presents for «f/u» «CC...» «CC:system...» **TC1**.

«S-...»

«ROS»

«Insert Past Medical History»  
«Insert Social History»  
«Insert Family History»  
«Insert Current Medications»  
«Insert Allergies»

## **Objective:**

«PEMale»  
«PEFemale»

## **Assessment:**

«DXType»  
«DXTop50»

## **Plan:**

«P-...»  
Laboratory: «DEL» «Lab#...» **ID1**  
X-Rays: «DEL» «XRay...» **ID2**  
Medications: «DEL»  
Immunizations: «DEL» «PlanImm...» **ID3**  
Procedures: «DEL»

## **Patient Education:**

«Diet»  
«Exercise»  
«Smoking»  
«Alcohol»

Other: «DEL»

Follow-up: «DEL» «F/U...»

**Configured to  
Meaningful Use  
Objectives**





# Provider Preference

**John Child** Notes  
ID: 123456 Age: 12 years 8 months DOB: 02/01/1999

**Date:** 09/29/11 12:57pm  
**Title:** OFFICE VISIT

**SUBJECTIVE :**

John is a 12-year-old male who is being seen today for pain in his left ear. His mother states that he was swimming in the local lake. She states that he has not been listening to her as well as in the past. She also states that John is due for his flu shot today.

**TODAY'S VITALS SIGNS**  
Bp: 114/67, Left Arm, Pulse: 78  
Height: 5'1", Weight: 89 lbs

**PHYSICAL EXAMINATION**

Vital signs are stable. Afebrile.  
Patient appears well-developed, well-nourished, in no acute distress.  
**HEENT:** Left ear canal inflamed. Tympanic membrane color: Red.  
**Neck:** Supple, no adenopathy.  
**Heart:** Regular rate and rhythm, no murmurs, rubs, or gallops.  
**Lungs:** Clear to auscultation bilaterally.  
**Abdomen:** Soft, nondistended, no hepatosplenomegaly.  
**Extremities:** No edema, clubbing, or cyanosis.  
**Neurological:** Intact.

**ASSESSMENT :**

**Major Problem:** OTITIS MEDIA : 382.9


**PLAN :**

Patient was encouraged to complete the prescribed course of antibiotic treatment. Advised the patient to watch for and immediately report pain and fever - which could be signs of infection. Instructed patient not to use Q-tips for cleaning the ear canal. Suggested it might help to wear earplugs or use something such as lamb's wool to keep the ears dry when swimming or taking a shower. Dry the ears carefully if you get water in them. You can use a hair dryer (on the "warm" setting) at least 6 inches from your ear to help dry the water in the ear canal. Avoid any substance that may cause an allergic reaction of the ear canal skin. Read product labels carefully and ask your health care provider before you use chemicals or medications in the area around your ear.

Influenza vaccination injection given in the:  
Dose: 0.5ml Lot#: 12345 Manufacturer: Merck  
Vaccination information sheet given to patient.  
Procedure: INFLUENZA VACCINE: 90663

**Combining Voice Recognition with Discreet Data Capture**

# Manual vs. Interface

Template: **LIPID PANEL**  \* indicates a comment exists.

	09/29/11	04/21/11	03/15/10	04/13/04	10/10/02	12/05/9
CHOLESTEROL	247	245	230	240	230	198
LDL-CHOL	146	142	140	148	33	
VLDL CHOL	38	39	40	40	50	
HDL-CHOL	73	74	65	65	90	
CHOL/HDL RATIO						
TRIGLYCERIDES	235	215	210	255	205	
ALPHA LIPOPROTEIN						
APOLIPOPROTEIN A-1						
APOLIPOPROTEIN B						
BETA LIPOPROTEIN						
CARDIO RISK FACTOR						
CAROTENE						
LDL, DIRECT						
PHOSPHOLIPIDS						
PRE-BETA LIPOPROT						

# Building a Meaningful Use Implementation Plan

- Meaningful Use Consultation
- Gap Analysis
- Readiness Assessment
- MU Configuration
- MU Training
- Conversions and Interfaces
- MU Auditing & Reporting



# Meaningful Use Consultation

## Core Set Objectives

### Core Set

*(These objectives are to be achieved by all eligible professionals, hospitals, and critical access hospitals in order to qualify for incentive payments.)*

<b>Core Set Meaningful Use Objective #1</b>	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.
<b>Measure</b>	More than 30% of unique patients with at least one medication in their medication list seen by the eligible provider have at least one medication order entered using CPOE.
<b>Exclusion</b>	This objective and associated measure do not apply to any EP who writes fewer than one hundred prescriptions during the EHR reporting period.
<b>Product Requirements</b>	Patient Records, E-prescribing and optionally the Order Entry module (Order Entry is only needed for this objective if you enter medication orders through that module)
<b>Reporting Capabilities Provided with Certified Release</b>	<ul style="list-style-type: none"> <li>– Numerator: The total number of patients in the denominator that have at least one medication order entered using the Order Entry module or e-prescribing module. Patients “on no meds” will not be counted.</li> <li>– Denominator: The total number of unique patients with at least one medication in their medication list seen by the eligible professional (EP) during the electronic health record (EHR) reporting period.</li> </ul>
<b>Assumptions:</b>	You must be live on the e-prescribing module and optionally Order Entry
<b>Cross Product Implications</b>	N/A
<b>Workflow Considerations</b>	<ul style="list-style-type: none"> <li>– The majority, if not all, of your medication orders will be entered using electronic prescribing.</li> <li>– However, medication orders can also be placed using the Order Entry module. The most common use case for using order entry for a medication order instead of electronic prescribing would be if you are administering the medication in your office. Both medication orders entered using electronic prescribing and order entry will count toward the calculation of this measure.</li> <li>– For this measure, orders do not have to be transmitted electronically to the recipient; they can be printed as a requisition, faxed or completed in-office. As long as the order is placed in Patient Records, it will count towards this numerator.</li> </ul>
<b>What to Do Now</b>	Refine practice workflow to make full use of the e-prescribing module and/or Order Entry.

# Gap Analysis

Meaningful Use Menu Objectives: Choose 5 from the list of 10 - at least one must be from the Population & Public Health Outcome objectives set	Measure	Related EHR Feature	MU Reference	Exclusion	Pre Upgrade Score	Post Upgrade Score	Action Plan/Notes
1) Implement drug formulary checks	The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	SureScripts or Info Scans	Is the provider using SureScripts or InfoScans formularies? Does the site have enough room on their server to setup the SureScripts formularies?	Any EP who writes fewer than 100 prescriptions during the EHR reporting year			
2) Incorporate clinical lab test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	Order Entry and Lab Tables	Is the site using any lab interfaces? What is the majority way that lab information is entered? (ex. Manually into the Lab section, scanned, through an interface) Is the provider and staff using Order Entry for ordering structured lab orders?	Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period			
3) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition	Patient Inquiry and Problem Tab	Has the site used the Patient Inquiry feature before? Repeat question: Does the provider enter problems in the major problem list with ICD-9 codes?	None			
4) Send reminders to patients per patient preference for preventive/ follow up care	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period	Patient Reminders	Does the practice have a recall system for upcoming procedures or appointments? If so, what is the procedure?	Any EP who has not patients 65 years old or older or 5 years old or younger			

# MU Auditing & Reporting

## Clinical Quality Measures Report

Reporting Period: 1/1/2010 to 12/31/2010

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**Provider: COMBINED - All Providers**

### **CORE Measure: NQF 0013: Hypertension: Blood Pressure Measurement**

Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.

Numerator/Denomintor #: 1	numerator:	0
	denominator:	4
	exclusions:	0
	measure score:	0.00

### **CORE Measure: NQF 0028a: Tobacco Use Assessment**

Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.

Numerator/Denomintor #: 1	numerator:	6
	denominator:	6
	exclusions:	0
	measure score:	100.00

### **CORE Measure: NQF 0028b: Tobacco Cessation Intervention**

Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months who received cessation intervention.

Numerator/Denomintor #: 1	numerator:	0
	denominator:	6

# Questions

