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"MEANINGFUL USE" FOR EHR'S DEFINED

Last week, the Department of Health and Human Services set out definitions for the "meaningful use" of electronic health records. Designed to qualify eligible providers for incentive payments, these rules will spark a revolution.

You could read the 864-page document published in the Federal Register which defines the government's ideas of "meaningful use" for electronic health records. But to save time, the National Coordinator for Health Information Technology published a summary in the New England Journal of Medicine.

The Health Information Technology for Economic and Clinical Health Act (HITECH) passed last year by Congress and the Obama administration made available $27 billion over 10 years to promote the adoption of electronic health records by health care providers. Non-hospital based clinicians are eligible to receive up to $44,000 over 5 years through Medicare incentive payments. Medicaid incentive payments total $63,750 over 6 years per clinician. Non-physician clinicians such as podiatrists and chiropractors are also eligible for funding.

In order to qualify, electronic health records must contain a "core set" of 15 objectives plus another 5 choices chosen from a "menu set" of 12 options. The core set of meaningful use objectives requires the following:

- record of patient demographics
- record of vital signs
- maintain up-to-date problem lists of current diagnosis
- maintain active allergy lists
- record smoking status
- provide patients clinical summaries of each office visit (discharge summaries for hospitals)
- provide patients electronic copies of their health information
- computer provider order entry for medications
- create and transmit prescriptions electronically
- drug-drug and drug-allergy checks
- electronic exchange of key information between providers

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Blumenthal, M and Tavenner, M. The Meaningful Use Regulation for Electronic Health Records. NEJM. Online July 13, 2010.

- at least one clinical decision support rule
- protecting privacy and security of patient data
- reporting quality measures to CMS or states

The menu set allows the clinician to choose 5 of the following 12 options to add to their core EHR functionalities:

- perform drug formulary checks
- incorporate clinical lab tests
- generate patient lists sorted by diagnosis
- provide patient-specific educational resources
- perform medical reconciliation
- provide summary of care for transitions/referrals
- submit immunization information to registries
- electronic syndromic surveillance
- record advance directives
- report certain lab results to public health agencies
- send patient reminders for follow up
- allow patients to electronically access their record

Highlights

- Electronic health records should perform 15 core functions and at least 5 of 12 additional optional functions to be considered “meaningful use”
- To be eligible for Medicaid bonus payments, clinicians must have a Medicaid volume of 30 percent
- Estimates of physician uptake of EHRs range from 10-30 percent

Commentary

The rules released by DHHS cover the first two years (2011 and 2012) of the electronic health record (EHR) bonus payment program. Clinicians must purchase and use an EHR that meets all 15 core functions and another 5 (of 12) optional functions.

Unfortunately, one of the most important functionalities - incorporation of clinical laboratory data into the health record - is considered optional. Other required functions, such as recording smoking status or providing patients with an electronic copy of their records are far less important than having access to real clinical data. Other important functions from the menu set include the recording of advanced directives and public health information (reportable laboratory results, syndromic surveillance, and immunizations).

Most of the core set of functions only serve to digitize the medical record. Only three actually act to transform health care from an isolated physician-run endeavor to a collaborative health system: (1) electronic exchange of clinical information among providers and “patient-authorized entities,” (2) clinical decision support, and (3) support for quality improvement metrics. Policy makers must remember, a patient’s medical record ought to be like VISA, “it’s everywhere you want to be.”