A GUIDE TO ACHIEVING MEANINGFUL USE

Leverage Your EHR to Redesign Workflows and Improve Outcomes

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Helga Rippen has been a leader in bridging technology and health care to maximize value to the patient, clinician, and health care sector for more than 20 years. She has worked with diverse groups such as physicians and consumers on a variety of topics, including electronic health record (EHR) roadmap development and adoption across physician offices, hospitals, and other health care entities. Rippen has worked on health care quality and reporting, disease management, ethics, a national health information infrastructure, usability, privacy, and consumer control. She led the conceptualization, prototype development, and implementation of many consumer tools. Rippen has presented to numerous wide-ranging audiences and has published in many trade and peer-reviewed journals.

Rippen has experience in roles that span all aspects of technology and health care, including treating patients, basic research, product development, implementation, clinical outcomes, and national policy development. She has been able to leverage her expertise, roles, and understanding as an effective change agent, strategist, visionary leader, problem solver, communicator, and implementer. Rippen is the Chief Health Information Officer and Vice President of Westat’s INSIGHT, Center for Health Information Technology, providing consulting services to government and private-sector clients. She was the Chief Health Information Officer and Vice President of Health Information Technology (Health IT) for HCA where she led the development of the clinical EHR Program. Rippen served as Senior Advisor for Health IT for the Secretary’s office at the US Department of Health and Human Services where she was involved with the creation of the Office of the National Coordinator for Health IT (ONC). Previously, she was Director of the Science and Technology Policy Institute for RAND, supporting the White House Office of Science and Technology Policy, Director of Health IT for Pfizer Health Solutions, and Founder of the Health IT Institute for Mitretek Systems (now Noblis).

Rippen received her medical degree, with honors, from the University of Florida and completed her medical residency training in General Preventive Medicine at Johns Hopkins University, where she also received her Masters in Public Health with a focus on health policy and management. Rippen obtained her PhD in biomedical engineering from Duke University. She is a Fellow of the American College of Preventive Medicine and Board Certified in Public Health and General Preventive Medicine with active medical licenses in Maryland and Virginia. She can be reached at HelgaRippen@westat.com.

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Denise Scott brings her nursing perspective from 28 years of acute and ambulatory patient care, more than 10 years of varied experiences in advancing the use of health information technology, and her current work with physicians to use their EHR data to improve the quality of care and transform their practices while cashing their checks for meeting Meaningful Use in the EHR Incentive Program. She is currently the Director of Quality & Informatics at Cooley-Dickinson Practice Associates (CDPA), a multispecialty independent-practice
association in western Massachusetts whose community physicians have adopted one common EHR, successfully attested, and are on the transformative road to becoming medical homes. Before joining CDPA, Scott was the Director of Clinical Integration & Quality at a 160+ IPA in central Massachusetts, leading their EHR adoption, quality, and Meaningful Use efforts. To facilitate the IPA physicians’ achievement of Meaningful Use, Scott created a ten-webinar series on operationalizing MU measures in a sustainable manner for small practices.

Scott was the Manager, Health Information Technology Services at Masspro and had the great fortune of working on a variety of contracts, including an ONC/CMS secure-messaging project, a New York PCMH transformation and recognition project of more than 200 physicians, and the CMS DOQ-IT project, all precursors to the EHR Incentive Program. Through her work in the use of HIT in physician practices, she has collaborated with physician groups who are some of the nation’s early adopters and current leaders in innovative, transformative use of HIT.

During her many years in health care, Scott has significant experience in adopting and leveraging technology in physician offices, workflow analysis and redesign, process improvement, EHR optimization, and pay-for-performance systems and strategies. She continues to guide physician practices through the NCQA PCMH application process to Level 3 recognition.

Since 2010, Scott has been a subcontractor to Booz Allen Hamilton, providing subject-matter expertise on EHR implementation and workflow redesign education. She is one of four lead content designers for ONC’s EHR Implementation Boot Camp and cocreator of a virtual class on workflow redesign, educating Regional Extension Center staff across the United States. She is a skilled communicator and motivator with recognized success in leading and facilitating clients to successful outcomes. She has spoken nationally on EHR implementation, workflow redesign, and secure messaging. Her audiences appreciate her ability to interpret the language of policy, explain the objectives and intent of programs to a better level of understanding, and share the reality of everyday challenges and successes in working with physician practices adopting HIT while providing actionable, practical approaches and tools to use in their own efforts.

Scott earned a Masters in Management with a health care–management concentration at Cambridge College, a Bachelor of Arts at Framingham State University, and a nursing diploma from Framingham Union Hospital School of Nursing. She holds a certificate in Health Care Informatics and is ANCC board-certified in Nursing Informatics. Scott is a registered nurse in the Commonwealth of Massachusetts. She can be reached at dmscott44@tds.net.

Carolyn P. Hartley, MLA

Carolyn Hartley, coauthor and the author team’s project manager, brings deep knowledge of EHR systems and their implementation and reporting processes to this book on Meaningful Use. She is President, CEO of Physicians EHR, Inc, a Cary, NC–based company that educates and serves as selection, implementation, workflow evaluation, and process redesign project manager, overseeing the front- to back-office operations and all clinical aspects of the data migration in 23 states. She and her health IT team also serve as contracted EHR technical facilitators to national and state medical societies, including the American Society of Clinical Oncology, American College of Cardiology, American Medical Association, American Dental Association, and Texas Association of Community Health Centers (TACHC).
Since 2010, Hartley has been a subcontractor to Westat to coach and provide subject matter expertise to ONC’s Vendor Selection and Management Communities of Practice (CoP) and is one of four lead content designers for ONC’s EHR Implementation Boot Camp. She is lead or coauthor of 17 textbooks on health information, privacy and security risk management, and health information exchange that have been published by the American Medical Association, American Society of Clinical Oncology, American Dental Association, and American Gastroenterological Association. She is a nationally recognized keynote and breakout-session speaker addressing privacy, security, EHR implementation project management, and workflow analysis and redesign.

Hartley holds a Master of Liberal Arts degree from Baker University with an emphasis in philosophy and medical anthropology and can be reached at Carolyn@physiciansehr.com.
INTRODUCTION

In their article for the New England Journal of Medicine, David Blumenthal, MD, MPP, and Marilyn Tavenner, RN, MHA, provided a perspective about the Meaningful Use rule that is cited frequently because of the clarity behind the rule’s incentive and purpose.

The widespread use of electronic health records (EHRs) in the United States is inevitable. EHRs will improve caregivers’ decisions and patients’ outcomes. Once patients experience the benefits of this technology, they will demand nothing less from their providers. Hundreds of thousands of physicians have already seen these benefits in their clinical practice.

But, inevitability does not mean easy transition. We have years of professional agreement and bipartisan consensus regarding the potential value of EHRs. Yet, we have not moved significantly to extend the availability of EHRs from a few large institutions to the smaller clinics and practices where most Americans receive their health care.

The Meaningful Use rule is part of a coordinated set of regulations to help create a private and secure 21st-century electronic health information system. On June 18, 2010, the Department of Health and Human Services (DHHS) issued a rule that laid out a process for the certification of EHRs so providers can be assured their EHR systems are capable of helping them achieve Meaningful Use. The department has also issued another regulation, which lays out the standards and certification criteria that EHRs must meet in order to be certified. Finally, realizing that the privacy and security of EHRs are vital, the DHHS has been working hard to safeguard privacy and security by implementing new protections contained in the HITECH legislation.

The Meaningful Use rule strikes a balance between acknowledging the urgency of adopting EHRs to improve our health care system and recognizing the challenges that adoption will pose to health care providers. The regulation must be both ambitious and achievable. Like an escalator, HITECH attempts to move the health system upward toward improved quality and effectiveness in health care. But the speed of ascent must be calibrated to reflect both the capacities of providers who face a multitude of real-world challenges and the maturity of the technology itself.¹

In creating this book, the authors leveraged lessons learned from years of implementation project management, consensus building, data-build and management, policy making, and weekend calls from physicians trying to make sense of their newly installed EHR. We learned not only from the EHR vendors, rule makers, and incentive payers, but also from you, our physician clients, readers who are also our best resources.

The most important lesson you have taught us is one we are proud to pass along to others: Meaningful Use is a process to achieve incentive funds, but it is not the end goal. Rather, the goal of Meaningful Use is to incentivize physicians and health care professionals nationwide to use their EHR and to ensure that EHR vendors provide functionality so that the EHR becomes a tool rather than an obstacle.
This book is not necessarily a book to be read from cover to cover but rather in segments, with sections you can pull out and use with your clinical and administrative teams. We leaned far out on a ledge not only to recap what you could have found if you explored the Centers for Medicare & Medicaid Services EHR Incentive Program pages, but also to provide practical field guidance that you won’t find searching the Internet.

_A Guide to Achieving Meaningful Use_ is divided into three parts. Part I focuses on the nuts and bolts of achieving Meaningful Use (Chapter 1) and the value of data (Chapter 2). If you are new to the Meaningful Use process, these chapters will get you well on your way with an abundance of Web site links should you need a deep dive into unique situations. Part II is intended for Meaningful Use project managers who also seek to improve workflow processes and begin using data for business and clinical-reporting purposes. Readers who faced data-collection challenges in Stage 1 reporting will immediately connect with the process redesign chapter. Also included in Part II is a chapter on standards now and those to come, including strategies to secure the infrastructure. Part III is a physician’s clinical guide to Meaningful Use written by a physician. Whereas Parts I and II address how to operationalize Meaningful Use, Part III addresses Meaningful Use from a physician’s view. What follows is a brief overview of each part.

**PART I: NUTS AND BOLTS**

In Chapter 1 you will find the nuts and bolts of Meaningful Use. If you are a first-timer, this is a “what to do and how to do it” instruction guide. Included in this chapter is a Meaningful Use gap analysis developed for physician practices, a tool you can use to avoid roadblocks in the middle of attestation. Chapter 1 provides guidance for specialty and multispecialty practices selecting clinical quality measures for reporting purposes.

In Chapter 2 we look at the value that EHRs are bringing to health care and the challenges of adoption. We also challenge you to find innovative ways to use the data you are building in your system. Accurate and dependable clinical data are a necessity for a physician. This chapter also provides guidance on what to expect from your EHR and from the EHR vendor and how to anticipate and plan how your EHR will be used in the future.

**PART II: OPERATIONALIZE MEANINGFUL USE**

In Chapter 3 you will learn how to build a Meaningful Use infrastructure that supports a secure environment for networking, data capture and management, and patient-portal decisions. There is also a small section on standards that you should know about. This chapter also guides you through the discussions you should have with your EHR vendor. No one wants to learn about “known issues” after diving deeply into the first reporting period.

Chapter 4 focuses on how to redesign your workflows not just for Meaningful Use, but also to ensure that you are capturing critical data that will help in decision making. This chapter compares Meaningful Use workflows by measure and by role and incorporates the process into a patient visit. These workflows are an incredibly difficult process to capture on your own and represent hundreds of hours of trial and error, studies, and successful attestations.

Chapter 5 is your survival chapter and provides strategies for surviving attestation. This includes knowing how to come up with the numbers and documenting the decisions you made along the way so that, in the event of an audit, you can explain how you came up with the numbers that you did. In this chapter, we also provide guidance on how to minimize surprises and how to track when you will receive your incentive funds.
PART III: CLINICAL ASPECTS OF MEANINGFUL USE

Chapter 6 provides advice on a doctor-to-doctor level on building a meaningful patient relationship. Physicians nearly always pride themselves on the relationships they have with their patients and may feel threatened by the initial imposition that a computer brings into the relationship. This chapter provides guidance on how patient portals and clinical summaries help to empower patients.

Chapter 7 presents recommendations on how to improve patient outcomes, from the patient to population levels that best align with the physician practice. As the health care community transitions its perspective to a population view, this chapter makes the case for Meaningful Use measures in public health and disease surveillance and how EHRs can help improve quality of care.

We thought about you as we researched, collected data, and pulled together lessons learned so that this would be the most useful Meaningful Use book in your library.

We hope you’ll let us know how you are doing.

REFERENCE

PART I

Nuts and Bolts
Chapters 1 and 2 in Part I of *A Guide to Achieving Meaningful Use* are written for the physician practice that has yet to achieve Meaningful Use (MU) Stage 1 or completed MU attestation, but new workforce members have come on board and need to know more about how the practice reached the numbers it did.

Chapter 1 provides the nuts and bolts of MU, gap analysis tools, and guidance for selecting clinical quality measures for reporting purposes.

Chapter 2 focuses on the value of data in managing a practice, patient health information and demographics, as well as addresses how best to take advantage of data that are stored inside the electronic health record (EHR) software. Practical advice is available as well, if you are contemplating switching to another EHR.
Nuts and Bolts of Meaningful Use Stages 1 and 2

**WHAT YOU WILL LEARN IN THIS CHAPTER:**

- What the electronic health record incentive program (Meaningful Use) entails
- Step-by-step instructions for meeting Meaningful Use (MU) Stages 1 and 2
- Who is eligible for MU incentives, and what Centers for Medicare & Medicaid Services (CMS) program is right for you
- Nuts and bolts of MU core measures, menu set measures, and clinical quality measures for Stages 1 and 2
- What you should document for MU attestation
- How to file for MU
- What payment adjustments are and to whom they apply
- What's in store for Stage 3
- What MU means for
  - Physicians
  - Staff
  - Patients
  - Stakeholders
- Steps to take

**Key Terms Introduced in This Chapter**

- Attest
- Certified Electronic Health Record Technology
- Clinical Quality Measures
- Core Measures
- Covered Entity
- Eligible Professional
- Eligible Hospital
- Meaningful Use
- Meaningful User
- Meaningful Use Objective
- Measure
- Menu Set Measures
The Medicare and Medicaid EHR Incentive Programs provide a financial incentive to eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) when they achieve “Meaningful Use.” EPs can receive up to $44,000 through the Medicare program and up to $63,750 through the Medicaid EHR Incentive Program.

In this chapter, we define Meaningful Use (MU) and what it means to be a “meaningful user.” We also will describe the value of using certified electronic health record (EHR) technology (CEHRT) to achieve health and efficiency goals. The EHR Incentive Program is not a reimbursement program for purchasing or replacing an EHR, as the recipients of MU funds must demonstrate they can extract specific details from the EHR.¹

As our primary reference to this and all subsequent chapters, we continually reference three Web sites with continuously updated guidance:

1. www.CMS.gov/EHRIncentivePrograms
   a. This is Centers for Medicare & Medicaid Services’ (CMS’) official Web site for Meaningful Use.
   b. The MU incentive program is a combination of several pieces of legislation, all of which can be accessed at the Health and Human Services (HHS) health IT portal, www.healthit.gov. Throughout the book, we will reference how they govern the MU incentive program. Rules include:
      - Standards and Certification Criteria, Stage 1, and another rule for Stage 2
      - Temporary Certification Program (TCP)
      - Permanent Certification
      - Meaningful Use of Electronic Health Records
      - CLIA [Clinical Laboratory Improvement Amendments] Program and Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: Patients’ Access to Test Reports. Stage 2 leverages HIPAA Security Rule and holds EHR vendors accountable for embedding HIPAA technical safeguards in their systems.

   Note the Web sites posted to help keep you current. Throughout this book you will find links to various pages of this Web site.

2. www.HealthIT.gov
   a. This Web site, maintained by the HHS, provides guidance to patients and consumers, health care professionals, and policymakers and researchers.
   b. Use this Web site to find detailed guidance on MU core and menu set measures.

   a. This is a portal providing legislative links to regulations and guidance, Office of the National Coordinator for Health Information Technology (ONC) initiatives, news, events and resources, and Health Information Technology for Economic and Clinical Health Act (HITECH Act) program initiatives.
   b. Use this Web site to learn more about policymaking, funding announcements, and links to legislation.

The purposes of this chapter are to both pull together the nuts and bolts from these Web sites and many other credible sources and present leading practices that we have learned from supporting hundreds of physicians through MU attestation. To achieve attestation, you must make a claim or series of claims that, by using your system and information in your medical charts, you were able to meet the requirements in each measure.

To begin, let’s take a look at how we got to MU.

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**A NATION’S BRIEF PATH TO MEANINGFUL USE**

On April 27, 2004, President George W. Bush called for the widespread use of EHRs by creating executive order 13335, an initiative to make EHRs available to most Americans
within 10 years. That was the start of a series of government initiatives known as the Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care.²

The Secretarial Summit on Health Information Technology launching the National Health Information Infrastructure 2004: Cornerstones for Electronic Healthcare was well attended by over 1,500 people representing the private and public healthcare industry. In challenging both sectors of the healthcare industry, Secretary Tommy G. Thompson stated, “Health information technology can improve quality of care and reduce medical errors, even as it lowers administrative costs. It has the potential to produce savings of 10 percent of our total annual spending on health care, even as it improves care for patients and provides new support for health care professionals.” A report, titled The Decade of Health Information Technology: Delivering Consumer-Centric and Information-Rich Health Care, ordered by President George W. Bush in April, was presented on July 21, 2004, by David Brailer, the National Coordinator for Health Information Technology, whom the president appointed to the new position in May. For more information about health IT policy and research, Strategic Action can be accessed at www.healthit.gov/policy-researchers-implementers.³

The impetus for this transition to EHRs was largely based on rising health care costs and the need for both clinical and outcomes data to help improve the quality of care.

- Baby boomers are becoming eligible for Medicare at the rate of 10,000 per day, driving up entitlement benefits.¹
- People are living longer. Medicare outlays have grown twice as fast as the economy for the last 5 years.⁴
- Healthcare premiums have risen 9% for families per year when inflation was running at 2%.⁵
- New procedures improve the quality of care but also increase costs to consumers.
- Unlike the communications, banking, manufacturing, and transportation industries, the health care industry is just starting to agree on standards that facilitate exchange of information.

Between 2004 and 2008, policy advisors and collaborators, medical organizations, privacy and security collaboratives, standards-setting organizations, patient-advocacy groups, and other health care stakeholders set out to study the pros and cons of how the nation could consolidate hundreds of different sets of standards into a narrow few so that physicians could electronically access a current longitudinal patient record and securely exchange health information with other health care providers and their patients. Federally and privately funded programs sponsored prototypes, and the Certification Commission for Health Information Technology (CCHIT) developed the first EHR certification program, providing physicians with some guidance on what EHR system to purchase. Even so, adoption was slow going. By the time EHRs were getting more user-friendly, the nation’s economy had begun to collapse, causing more financial strain on physicians and their practices.

Financial barriers created the most significant hurdle because the physician investment would likely yield monetary benefits to other entities, such as third-party payers. Additional barriers included disruption to the office workflow, lack of training and knowledge, some discomfort with the use of computers, and a perceived shift in the doctor-patient relationship. Evidence also suggested that, at the time, a large number of EHR products were too costly for small physician practices, some products were not yet ready for the market, and the amount of technical support needed for ongoing business needs would further burden the practice.⁶
To respond to these barriers, health information technology (health IT or HIT) initiatives were expanded when President Obama and the 111th Congress passed the American Recovery and Reinvestment Act (ARRA) of 2009. Embedded in ARRA was the HITECH Act, authorizing more than $20 billion to roll out an HIT adoption plan that incentivized EPs and EHs if they could demonstrate that they are meaningful users of HIT.

The intent of the HITECH Act was to lay the groundwork for: (1) improved health care quality, safety, and efficiency through the use of HIT, including EHRs; (2) the infrastructure to support the adoption of EHRs; and (3) private and secure electronic health information exchange (HIE).

Figure 1-1 provides an overview of the health information adoption timeline.

**Figure 1-1**

Health Information Technology Adoption Timeline

Abbreviations: ARRA/HITECH indicates American Recovery and Reinvestment Act/ Health Information Technology for Economic and Clinical Health Act; ATCB, Accredited Testing and Certification Body; EHR, electronic health record; EP, eligible professional; HIE, health information exchanges; HIT, health information technology; IOM, Institute of Medicine; MU, Meaningful Use; ONC, Office of the National Coordinator for Health Information Technology; and RECs, regional extension centers.

Physicians typically find they must manage a number of challenges when adopting EHRs in their practices.

- Power outages caused by natural or unnatural events are a given. In anticipation of such events, the practice must determine how it will capture information when electronic access is unavailable.

- As physicians experience greater mobility using portable tablets and handheld devices, security breaches have skyrocketed. The Ponemon Institute’s third annual Benchmark Study on Patient Privacy and Data Security documented that 94% of hospitals reported a breach between 2009 and 2011, with 45% of those hospitals reporting five or more breaches during the two-year period.

- Process analysis and redesign is a leading practice with hospitals. In the process, hospitals receive a visual map on paper of how workflows are completed so that those workflows can be analyzed for efficiencies and inefficiencies and then be redesigned for the EHR. Without a budget to complete a process analysis, smaller physician
practices tend to import paper-based workflows into the EHR and then become frustrated when the EHR does not meet their expectations.

- HIEs often are initiated by hospitals promising physicians access to the HIE if the physician will upload patient information, but the promise may or may not be accompanied by detailed benefits to the physician.

- Emerging EHRs designed for specialists may be less expensive or focus on that specialty’s needs, but they may not survive entry into the EHR market because of generalist and large EHR companies’ domination.

The pathway to an EHR is not easy, nor should any EHR software company tell you a conversion from paper to EHR or from one system to another can be done in a few hours or over a weekend. The reality is that adopting an EHR is a layered, multifaceted task that is best done with help from a peer who has completed the implementation or works with a team who knows EHRs and clinical workflows.

To that end, the MU incentive funds are designed to reward users who have learned to use CEHRT.

### GETTING STARTED WITH MEANINGFUL USE

If you haven’t purchased an EHR system yet, consider reading the American Medical Association’s (AMA) *EHR Implementation: A Step by Step Guide for the Medical Practice*, 2nd edition, by Carolyn P. Hartley and Edward D. Jones. If you haven’t yet entered the MU program, this chapter will get you well on your way to understanding what to do and how to do it. But, if you have already registered and attested for MU funds and received first- or second-year funds, this chapter will provide you with the nuts and bolts of Stage 2 and initial direction for Stage 3.

This chapter is for those who:

- Are just getting started with the Medicare or Medicaid MU incentive programs.
- Are looking to adopt an EHR and want to know if their vendor will support them on the road to MU.
- Are in need of a refresher course on the MU process.
- Want to understand the basics of Stage 2 MU requirements.

### Overview of Meaningful Use

As briefly discussed earlier, the HITECH Act embedded in the ARRA of 2009 escalated the adoption of EHRs and ensured that patients and their healthcare professionals could communicate securely in an electronic environment.

The HITECH Act included a number of requirements, including financial incentives under Medicare and Medicaid to hospitals and EPs who demonstrate they are *meaningful users* of CEHRT. A meaningful user must capture health information in a standardized format using a certified EHR and use that information to track key clinical conditions. Stage 1 MU measures focus on five core objectives:

- Improve quality, safety, and efficiency and reduce health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information
Critical Point

Objective is another word for “what to do.” For example, core objective #1 [of the EP MU Core Measures (measure 1 of 15) before 2013] has to do with using computerized provider order entry (CPOE) for medication orders.

Measure refers to the information (data) you must capture to meet the objective. For core objective #1, the measure is to report that at least 30% of unique patients with at least one medication have had at least one order entered using CPOE.

As required by the HITECH Act, four subsequent regulations have been released that define MU. Table 1-1 provides an overview of each of those four rules and what agency regulates them. In subsequent chapters we will present details about when the rules were developed and what agency regulates the adoption of each rule.

<table>
<thead>
<tr>
<th>Regulation</th>
<th>What It Does</th>
<th>Who Regulates It?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentive Program for Electronic Health Records</td>
<td>Defines the incentive payments allowed to eligible hospitals and EPs under the Medicare and Medicaid Incentive Programs and the minimum eligibility requirements providers must meet to qualify for payments in Stages 1 and 2.</td>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
</tr>
<tr>
<td>Standards and Certification Criteria for Electronic Health Records</td>
<td>Rules that identify the standards and certification criteria for certified EHR. This regulation also defines the temporary and permanent certification bodies that can certify that an EHR will meet the core and menu set objectives as well as clinical quality measures.</td>
<td>Office of the National Coordinator for Health Information Technology</td>
</tr>
<tr>
<td>Meaningful Use of Electronic Health Records</td>
<td>Provides definition of meaningful user in guidelines to health professionals and hospitals on how to adopt and use EHR technology to help improve the quality, safety, and efficiency of patient care.</td>
<td>CMS</td>
</tr>
<tr>
<td>Stage 1 and Stage 2 MU Requirements</td>
<td>These are two pieces of legislation, both submitted with a comment period and now posted as final in the Federal Register. 42 CFR Parts 412, 413, 422, et al.</td>
<td>CMS</td>
</tr>
</tbody>
</table>

For more information on regulations and guidance documents, consult the Web site http://healthit.hhs.gov.

Meaningful Use Stages 1, 2, and 3 are designed to incrementally increase the use of EHRs, and explained in the next section.

Overview of the Three Stages for Meaningful Use Participation

There are currently three stages for MU participation, though it is possible that more stages will be added after 2016. In order to successfully attest to MU, you will be required to pull
PART II

Operationalize Meaningful Use
Part II of this book drills down into operationalizing Meaningful Use (MU).

Chapter 3 provides you with details on how to build a Meaningful Use infrastructure that will support a secure environment for networking, data capture and management, and patient-portal decisions. A section on standards is enough to provide highlights on how electronic health records should be built with similar standards that support interoperability, or as it is rapidly becoming known as “data liquidity.”

In Chapter 4, we tackle the workflows that often make data entry and management unwieldy. In this chapter, the authors compare MU workflows by measure and by role, and then incorporate the process into a patient visit. Tackling workflows may offer the greatest advantage, as you move into MU Stage 2.

Chapter 5 is your attestation survival guide, providing you with guidance rarely offered until you are at the CMS’ attestation work-page, trying to figure out what to do and to come up with the numerators and denominators for a successful attestation. This chapter also identifies documentation strategy so that you can explain how you arrived at the numbers in the event of an audit.
PART III

Clinical Aspects of Meaningful Use
What Physicians Need to Consider:
Patient Engagement and Leveraging Tools to Manage Outcomes
Physicians and their practices will undergo significant changes in both workflow and processes as they implement electronic health records (EHRs) and successfully attest to the Meaningful Use (MU) measures. With change comes opportunity. Physicians often do not have the luxury of stepping back to reflect how best to optimize their practice; MU provides them this opportunity.

In a health care environment that includes medical homes, accountable care organizations, pay for performance, and increasing reporting requirements, how can physicians leverage the EHR to help their practice succeed? Chapters 6 and 7 provide physicians a way to address these broader themes while meeting the MU requirements. They focus on a broader view of the MU themes around patient engagement, outcomes, and population health. These three themes encompass:

- The heart of a practice—the physician-patient relationship
- The nature of the practice—the population seen by the practice
- The practice’s effectiveness—clinical outcomes

By combining the three, a physician can leverage the positive impact of the relationship (eg, better health outcomes, less litigation), the more effective management of a business (eg, population-level interventions that provide the largest return to the practice and the patient), and the quality of care delivered.
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