Demonstrating EHR “Meaningful Use”

Final rule requirements of the EHR Incentive Program

White paper

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Executive summary

In July 2010, the US Department of Health and Human Services (HHS) issued the final rule detailing requirements for meaningful use of electronic health records (EHR) technology in Stage 1 of the EHR incentive program established by the American Recovery and Reinvestment Act of 2009 (ARRA). The incentive program is being implemented in three stages over five years.

The final rule for Stage 1 establishes objectives to help healthcare providers electronically record and exchange information, improve quality of care, and measure and report results. HHS took into account more than 2,000 comments from the healthcare community when designing these objectives, resulting in a more flexible and phased process for implementing the new EHR systems than originally proposed.

This white paper offers a comprehensive look at EHR incentive program Stage 1 meaningful use requirements and objectives, and addresses areas of interest to providers such as eligibility, registration, certification, staffing and costs. Understanding these details will help your practice implement EHR technology more smoothly, take advantage of the financial incentives and ultimately avoid penalties for noncompliance with EHR-related payment requirements.

Introduction

"Meaningful use" and the race to capture federal EHR dollars

When the US government announced in September 2009 that it would offer healthcare providers financial incentives to invest in electronic health record (EHR) systems, many medical practices that had been putting off EHR implementation moved that prospect to the front burner. However, it has been difficult for many practices to go very far beyond preliminary planning, since the Department of Health and Human Services (HHS) did not fully define certain requirements for "meaningful use" of the technology until July 2010. Now that HHS has issued the final rule spelling out these criteria (which the regulation refers to as "objectives"), practices can participate in the program without lingering questions about how to meet the criteria for payment.

What's at stake?

Under the Health Information Technology (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), healthcare providers who receive Medicare and Medicaid payments may be eligible to benefit from more than $36 billion in financial incentives for investing in EHR technology. The following tables show the incentive payments that physicians can receive under ARRA.

Figure 1: Eligible Provider Incentive Payment Plan Schedule Under ARRA

HITECH ACT: MEDICARE REIMBURSEMENT PLAN

	ADOPTION 2011	ADOPTION 2012	ADOPTION 2013	ADOPTION 2014	ADOPTION 2015+
2011	$18,000	$0	$0	$0	$0
2012	$12,000	$18,000	$0	$0	$0
2013	$8,000	$12,000	$15,000	$0	$0
2014	$4,000	$8,000	$12,000	$12,000	$0
2015	$2,000	$4,000	$8,000	$8,000	$0
2016	$0	$2,000	$4,000	$4,000	$0
TOTAL	$44,000	$44,000	$39,000	$24,000	$0
Health Prof. Shortage Area	$48,400	$48,400	$42,900	$26,400	$0

U.S. Congress. House. American Recovery and Reinvestment Act Of 2009. H.R. 1. 111th Cong., 1st sess. (February 10, 2009). http://edocket.access.gpo.gov/2010/E9-31217.htm (Tables 22 and 23, accessed June 2010).

HITECH ACT: MEDICAID REIMBURSEMENT PLAN

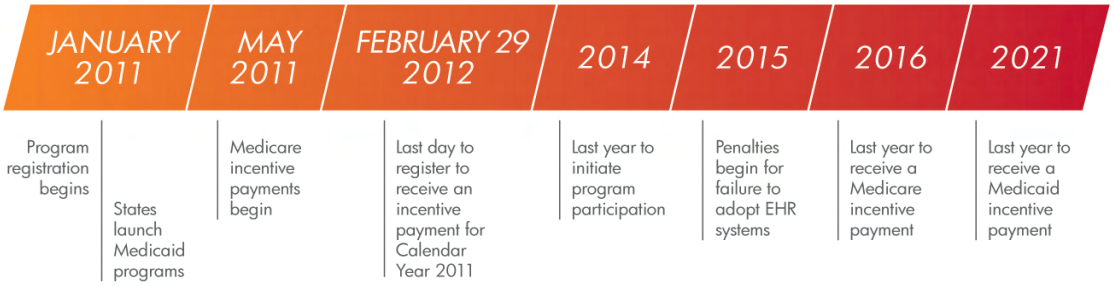
	ADOPTION 2011	ADOPTION 2012	ADOPTION 2013	ADOPTION 2014	ADOPTION 2015	ADOPTION 2016	ADOPTION 2017+
2011	$21,250	$0	$0	$0	$0	$0	$0
2012	$8,500	$21,250	$0	$0	$0	$0	$0
2013	$8,500	$8,500	$21,250	$0	$0	$0	$0
2014	$8,500	$8,500	$8,500	$21,250	$0	$0	$0
2015	$8,500	$8,500	$8,500	$8,500	$21,250	$0	$0
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250	$0
2017	$0	$8,500	$8,500	$8,500	$8,500	$8,500	$0
2014	$0	$0	$8,500	$8,500	$8,500	$8,500	$0
2019	$0	$0	$0	$8,500	$8,500	$8,500	$0
2020	$0	$0	$0	$0	$8,500	$8,500	$0
2021	$0	$0	$0	$0	$0	$8,500	$0
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750	$0

U.S. Congress8 House. American Recovery and Reinvestment Act Of 2009. H.R. 1. 111th Cong., 1st sess. (February 10, 2009). https://edocket.access.gpo.gov/2010/E9-31217.htm (Table 28, accessed November 2010.)

To qualify for payments, physicians must demonstrate meaningful use of the technology by meeting a number of specific objectives. This paper reviews the objectives in detail on pp. 6-8.

What's the rush?
There is some urgency associated with the EHR incentive program. The sooner medical practices begin participating, the higher the total amount of reimbursement for which they are eligible. To realize the maximum financial benefit, a practice must register for the program's Medicare track by February 2012, at the latest, and must implement an EHR system by 2013. (For a more detailed discussion of eligibility and registration requirements, see p. 11.) Start dates and deadlines for the Medicaid track will vary from state to state, since it will be administered by individual state Medicaid agencies. Some states will start offering the Medicaid program in 2011, at the same time as the Medicare start date. Regardless of the state start date, however, all Medicaid participants must register no later than 2016 in order to participate.

Figure 2: Physician Incentive Program Milestones



But what if you do nothing? Note that when it comes to acting in a timely manner, incentives are only part of the picture. As indicated in Figure 2, beginning in 2015, Medicare participants that do not adopt EHR systems at all risk being penalized by having their Medicare payments reduced. This begins with a 1% reduction in 2015 and increases each year thereafter to a 5% maximum. These non-participation penalties do not apply to Medicaid participants, however.

The remainder of this paper focuses on familiarizing readers with the final rule for meaningful use and examines the criteria and timing associated with the rule. In addition, the paper addresses related areas of ongoing concern, such as program eligibility and registration, systems certification, and staffing issues.

What is Meaningful Use?

The evolution of a meaningful and useful definition

Under the Health IT provisions of ARRA, the Centers for Medicare and Medicaid Services (CMS) within HHS held the main responsibility for defining what constitutes "meaningful use" of EHR technology falls. The Department of HHS proposed a set of meaningful use requirements in January 2010 and solicited comments from the healthcare community. After taking more than 2,000 responses into account, HHS revised the requirements and issued its final rule on meaningful use in July 2010.

Compared to the January 2010 proposed rule, the final rule imposes somewhat less stringent demands on program participants and offers them a more flexible route to reimbursement. The following summarizes the major areas in which the requirements for meaningful use have been relaxed in the final rule.

More flexible criteria and reporting methods
The original proposed criteria for demonstrating meaningful use required program participants to demonstrate that they were meeting 25 specific objectives. However, in a July 2010 *New England Journal of Medicine* article, HHS reported receiving many comments that the proposed approach was too demanding and inflexible - an all-or-nothing test that too few providers would be likely to pass.[1] Therefore, HHS changed the requirement with objectives divided into one set of 15 core objectives that all participants must achieve, and another set of 10 objectives from which participants can choose five additional objectives. Furthermore, HHS relaxed the proposed objective requiring that all orders be entered using computerized physician order entry (CPOE). The final rule requires providers to use CPOE only for medication orders. Finally, HHS lowered performance levels that providers must report as from 75% or higher in many cases to 50% or lower For example, in the proposed rule, participants had to submit 75% of prescriptions electronically, while the final rule reduced it to 40% – taking into account, among other things, that not all pharmacies have capacity to process electronic prescriptions yet.

Elimination of 90-day reporting requirement in Year 1 for Medicaid track
One concern about the original proposed rule was that it didn't allow program participants to collect incentives in Year 1 of the program unless they could demonstrate meaningful use through 90 continuous days of reporting on their efforts to adopt, implement or upgrade EHR technology. This has been modified for Medicaid participants, for whom the 90-day reporting time requirement has been moved to the second year. Providers will still have to demonstrate that they have adopted, implemented or upgraded EHR technology, but there is no EHR reporting period associated with this in the first payment year. This should make it easier for Medicaid participants to collect incentives in 2011.

Objectives

Specific requirements in the final rule for meaningful use

As explained in the previous section, the government's final rule on meaningful use established 25 objectives for EHR incentive program participants to use to demonstrate meaningful use of EHR technology – 15 required core objectives, and 10 additional objectives from which they can choose five, all of which are listed here. The remaining five additional objectives must be met as part of Stage 2, in 2013.

(15) REQUIRED "CORE GROUP" OBJECTIVES	(10) ADDITIONAL "MENU SET" OBJECTIVES:
	(Must meet five menu options with at least one public health objective selected*)
• CPOE • Drug interaction checks • Maintain list of current and active diagnoses • E-prescribing • Active medication list • Active medication allergy list • Patient demographics • Vital signs • Patient smoking status • Clinical quality measures • Clinical decision support rules • Patient's electronic copies of health information • Patient's clinical summaries of office visits • Capability to exchange clinical information electronically • Protection of electronic health information in the EHR system	• Drug formulary checks • Clinical lab-test results • Patient lists by conditions for use in quality improvement, reduction of disparities and outreach • Patient reminders for preventive or follow-up care • Timely electronic access to health information • Patient-specific education resources • Medication reconciliation • Summary of care records for transitions and referrals • Submit electronic data to immunization registries • Submit reportable lab results electronically (as required by law) *The remaining give objectives must be met for Stage 2 Meaningful use in 2013.

Core Objectives

Medical practices must meet all 15 of these objectives to qualify for EHR incentives. The chart on the following page describes each objective, states the measure for determining whether a practice has met the objective, and notes any exceptions.

(15) REQUIRED "CORE GROUP" OBJECTIVES

Use CPOE	
Description: Instead of entering medication orders into medical records manually, clinicians enter them electronically using CPOE.	**Measure:** More than 30% of patients have at least one medication order entered using CPOE. Does not apply to clinicians who order less than 100 medications during an EHR reporting period.
Implement drug interaction checks	
Description: Clinicians use their EHR system's drug-drug interaction and drug-allergy interaction features to automatically check for potential problems when a drug is prescribed.	**Measure:** The practice has enabled this functionality.
Maintain a problem list of current and active diagnoses	
Description: Clinicians use the EHR system to enter patient diagnoses electronically for each patient (or to note that the patient doesn't currently have any known problems, if that's the case).	**Measure:** More than 80% of patients have at least one entry (or an indication that no problems are known for the patient) recorded as structured data.
Transmit prescriptions electronically	
Description: Instead of writing prescriptions manually, clinicians generate them on the EHR system and send them electronically to the pharmacy.	**Measure:** More than 40% of prescriptions are transmitted electronically. Does not apply to clinicians who order less than 100 medications during an EHR reporting period.
Maintain active medication list	
Description: Clinicians use the EHR system to enter a list of medications for each patient (or to note that the patient is not on any medications, if that's the case).	**Measure:** More than 80% of patients have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Maintain active medication allergy list	
Description: Clinicians use the EHR system to enter a list of medication allergies for each patient (or to note that the patient doesn't have any medication allergies, if that's the case).	**Measure:** More than 80% of patients have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
Record patient demographics	
Description: Clinicians use the EHR system to enter a patient's preferred language, gender, race, ethnicity and date of birth.	**Measure:** More than 50% of patients have their demographics recorded as structured data.
Record and chart changes in vital signs	
Description: Clinicians use the EHR system to enter a patient's height, weight, blood pressure and body mass index (BMI). For patients 2-20 years old, clinicians also use the EHR system to create and maintain growth charts.	**Measure:** More than 50% of patients age two and up have their height, weight and blood pressure recorded as structured data. Does not apply if patients are under age two, or if the clinician believes the vital signs have no relevance on the scope of practice.
Record patient smoking status	
Description: Clinicians check the smoking status of every patient who is 13 or older and record it using the EHR system.	**Measure:** More than 50% of patients who are 13 or older have their smoking status recorded as structured data.
Report clinical quality measures	
Description: The medical practice reports ambulatory clinical quality measures to CMS or the state.	**Measure:** 2011: Submit clinical quality measures through attestation that the data has been collected using certified EHR technology. 2012: Submit clinical quality measures electronically.
Implement clinical decision support rules	
Description: The medical practice must implement at least one clinical decision support rule that's relevant to its specialty or that's a high clinical priority. The practice also has to show the ability to track compliance with the rule.	**Measure:** Implement one clinical decision support rule.
Provide patients with electronic copies of health information	
Description: If a patient wants an electronic copy of health information – such as test results, problem list, medication list or medication allergies list – the medical practice must provide it.	**Measure:** More than 50% of patients who request an electronic copy of their health information get it within three business days. Does not apply to practices that receive no patient requests during the EHR reporting period.
Provide patients with clinical summaries of office visits	
Description: The medical practice must provide patients with clinical summaries of each office visit.	**Measure:** More than 50% of patients receive clinical summaries of their office visits within three days. Does not apply to practices that have no office visits during the EHR reporting period.
Have the capability to exchange clinical information electronically	
Description: The medical practice must be able to exchange key clinical information – problem lists, medication lists, medication allergies lists and diagnostic test results – with other care providers electronically.	**Measure:** Perform at least one test of the certified EHR technology's capability to electronically exchange clinical information.
Protect electronic health information in the EHR system	
Description: The medical practice must implement the technical capabilities to protect electronic health information.	**Measure:** Conduct or review a security risk analysis per HIPAA security rule guideline 45 CFR 164.308 (a) (1), implement security updates as needed and correct any security deficiencies that may be identified in its EHR system.

Additional Objectives: Participants' choice of five out of ten

Medical practices must also meet five of the following ten objectives to qualify for EHR incentives, and they can choose which five they meet. The remaining five objectives must be met for Stage 2 Meaningful Use in 2013.

10 ADDITIONAL "MENU SET" OBJECTIVES	
Medical practices may choose five of the following objectives during Stage 1, and adopt the remaining five during Stage 2.	
Implement drug formulary checks	
Description: Clinicians use the EHR system to automatically check drug formularies.	**Measure:** The practice has enabled this functionality and has access to at least one drug formulary.
Incorporate clinical lab-test results into EHR	
Description: Clinicians bring clinical lab-test results into the EHR system as structured data.	**Measure:** More than 40% of clinical lab tests results are incorporated into certified EHR technology as structured data. Does not apply to clinicians who order no applicable tests during the EHR reporting period.
Generate lists of patients by conditions to use for quality improvement, reduction of disparities and outreach	
Description: Clinicians create lists of patients organized by specific conditions. These lists are to be used for quality improvement, reduction of disparities, research of outreach.	**Measure:** Generate at least one report listing patients with a specific condition.
Send reminders to patients for preventive or follow-up care	
Description: The medical practice sends reminder to patients, per their preferences, for preventive or follow-up care.	**Measure:** More than 20% of patients over 65 or under 5 are sent an appropriate reminder during the EHR reporting period. Does not apply to clinicians who have no patients in the designated age categories with electronic records.
Provide patients with timely electronic access to health information	
Description: The medical practice provides patients with electronic access to their health information – including lab results, problem list, medication list, medication allergies list – within four days of it becoming available.	**Measure:** More than 10% of patients have electronic access to their health information within four business days of the information being updated in the EHR system. This requirement is subject to the clinician's discretion to withhold certain information.
Identify patient-specific education resources	
Description: The medical practice uses certified EHR technology to identify patient-specific education resources and provide them to patients.	**Measure:** More than 10% of all patients during the EHR reporting period are provided with patient-specific education sources.
Perform medication reconciliation	
Description: On receiving a patient from another provider, the medical practice performs medication reconciliation.	**Measure:** Medication reconciliation is performed in more than 50% of transitions of care. Does not apply to practices that do not receive any transitions of care.
Provide summary of care records for care transitions and referrals	
Description: On transitioning a patient to another care setting or provider, the medical practice provides a summary of care record.	**Measure:** Summary of care record is provided in more than 40% of transitions of care and referrals.
Be able to submit electronic data to immunization registries	
Description: In situations where a medical practice is required by law to provide data to immunization registries, the practice must be able to use the EHR system to submit the data – assuming the registries are capable of getting the information electronically.	**Measure:** Perform at least one test of the certified EHR system's capability to submit electronic data to immunization registries that are capable of receiving information electronically; follow up submission if the test is successful. Does not apply to practices that administer no immunizations during the EHR reporting period.
Be able to submit reportable lab results (as required by law) electronically	
Description: In situations where a medical practice is required by law to provide reportable lab results to public health agencies, the practice must be able to use the EHR system to submit the data – assuming the public health agencies are capable of getting the information electronically.	**Measure:** Perform at least one test of the certified EHR system's capability to provide electronic submission of reportable lab results to public health agencies that are capable of receiving information electronically; follow up submission if the test is successful.

Impact

Using program objectives to meet the definition of meaningful use

It can be easy to get lost in the details of the objectives described in the previous section, and overlook their relevance to ARRA's larger definition of meaningful use. As a reminder, the meaningful use definition includes three primary components:

- The use of a certified EHR in a meaningful manner (e.g., e-Prescribing);
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care;
- The use of certified EHR technology to submit clinical quality and other measures.

Viewed in the context of these components, the objectives can be seen clearly as a means to an end. For example, when a practice invests in an EHR system with the capability to securely exchange clinical data, and demonstrates this capability as required by the core objectives, that relates directly to the second component of the definition of meaningful use of EHR technology – i.e., to exchange health information to improve the quality of care.

Clinical Quality Measures

While e-Prescribing and electronic information exchange may be fairly self-explanatory, the definition's last component may require further explanation. It involves using EHR systems to report on clinical quality measures, which are tools for measuring or quantifying healthcare processes, outcomes, patient perceptions and organizational systems associated with the ability to provide quality care. Participants in the EHR incentive program have until 2012 to start submitting clinical quality measures electronically. Until then, they may submit measures with a declaration that EHR technology was used to collect the information.

The final rule for meaningful use requires medical practices to report on six specific clinical quality measures – three "core" measures, and three that select from a set of thirty-eight. The three core measures are:

- Hypertension: Blood pressure measurement
- Preventive care and screening measure pair: a) tobacco use assessment, b) tobacco cessation intervention
- Adult weight screening and follow-up

The thirty-eight measures from which participants may select three to submit can be found online at https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp.

A phased approach

Delaying the requirement to submit clinical quality measures electronically until 2012 is an example of HHS allowing participants in the EHR incentive program to gradually demonstrate meaningful use, rather than having to take on the financially and operationally stressful task of complying with all requirements at once. Such an approach addresses concerns in the healthcare community about having insufficient time to meet the requirements.

To address concerns about how quickly participants could reach the goal of meaningful use, CMS developed a three-stage, five-year process that builds up to a more robust definition of meaningful use based on anticipated technology and capabilities development.[4]

- **Stage 1** sets the baseline for electronic data capture and information sharing by requiring program participants to fulfill the specific objectives discussed at length in this paper. Also, to meet certain objectives and measures, 80% of patients must have records in certified EHR technology at the end of this stage.

- **Stage 2** will expand on Stage 1 criteria, with the menu set of objectives from Stage 1 becoming the basis of the core set for Stage 2. A larger number of core objectives will reflect expanded criteria in the areas of disease management, clinical decision support, medication management, support for patient access to health information, transitions in case, quality measurement and research, and bi-directional communication with public health agencies. Measures will be reevaluated and possibly reformulated to have higher thresholds.
- **Stage 3** will focus on improvements in quality, safety and efficiency; decision support for national high priority conditions; patient access to self-management tools; access to comprehensive patient data; and improvements in population health outcomes.

Key Issues

Related areas of ongoing concern

Since the announcement of the EHR incentive program, several areas of ongoing concern for medical practices have emerged. Although recent action on the part of CMS has resolved many of these issues, the following are still active discussion topics.

Eligibility. Qualified participants in the EHR incentive program are known as Eligible Professionals, or EPs. As part of its final rule for implementation of the program, CMS reiterated the requirements for eligibility:

1. A Medicare EP is defined as non-hospital-based doctor, dentist or chiropractor. (A doctor is defined as hospital-based if 90% or more of his or her services are performed in a hospital inpatient or emergency room setting.)
2. A Medicaid EP is defined as a physician, nurse practitioner, certified nurse-midwife, dentist or physician assistant furnishing services in a federally qualified health center or rural health center that is led by a physician assistant. A Medicaid EP must not be hospital-based and must meet one of the following criteria:
   - Have a minimum 30% Medicaid patient volume
   - Have a minimum 20% Medicaid patient volume for pediatricians
   - Practice in a federally qualified health center or rural health center and have a minimum 30% patient volume attributable to needy individuals

Anyone who is eligible for both the Medicare and Medicaid programs must choose to participate in one or the other. Figure 3 summarizes the differences between the programs.

Figure 3: Major Differences Between Medicare and Medicaid EHR Incentive Programs

MEDICARE PROGRAM	MEDICAID PROGRAM
• Participation opportunity available at time of official program launch	• Participation opportunity to coincide with state launch date (varies from state to state)
• Incentives up to $44,000 ($48,400 in Health Provider Shortage Area)	• Incentives up to $63,750
• Requirement to demonstrate meaningful use of EHR technology each year	• Requirement to demonstrate meaningful use of EHR technology each year after first year (first year requirement to adopt, implement, upgrade or demonstrate meaningful use of the technology)
• Registration required by 2012 to receive maximum incentive payment	• Participation required by 2016 to receive maximum incentive payment
• Penalties for non-participation. Medicare fee schedule payments will be reduced by 1% in 2015, by 2% in 2016 and by 3% in 2017.	• None

Registration. EPs will be able to register for the EHR incentive program sometime in early 2011; specific dates will be announced on www.cms.gov. Meanwhile, CMS has announced the criteria for valid registration. EPs will need to demonstrate their compliance with program registration requirements by:

- Having a National Provider Identifier (NPI)
- Being enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS), unless you are an EP who is participating only in the Medicaid program
- Having an active user account in the National Plan and Provider Enumeration system (NPPES)

If you do not have an NPI, are not enrolled in PECOS or do not have an NPPES account, please visit www.cms.gov for more information about how to meet these requirements. Making these arrangements now will ensure that you are prepared when CMS announces registration dates.

Certification. One of the requirements of the EHR incentive program is that participants in the program use EHR systems that have been certified by testing and certification organizations named by the Office of the National Coordinator (ONC). Certification provides assurance that the system a medical practice purchases offers the technological capability, functionality and security to help meet the criteria for meaningful use.

ONC issued its final rule on standards and certification criteria in July 2010, establishing the required capabilities, standards and implementation specifications that EHR technology must include to be certified. ONC has also begun naming authorized testing and certification bodies, which currently include:

- Certification Commission for Health Information Technology
- Drummond Group, Austin, Texas
- InfoGuard Laboratories, San Luis Obispo, California

A current list of certified systems is available from the Department of Health and Human Services at http://onc-chpl.force.com/ehrcert.

Staffing. One concern expressed by potential participants in the EHR incentive program is the need to add health IT staff to implement systems. HealthImaging.com recently reported on this issue, suggesting the potential for difficulty meeting this need, given what it calls "a growing shortage of health IT workers."[5] To help address this issue, ONC has announced the ARRA Health IT Workforce Development Program to help train technicians and professionals to work with hospitals and medical practices to help meet meaningful-use criteria. Practices may also consider contracting with technology vendors for IT services assistance in implementing EHR systems. A services approach provides the flexibility to meet IT needs without hiring permanent employees.

Upfront costs. Some medical practices will find it a hardship to pay for EHR technology up front and then wait for incentive payments. Fortunately, there are several alternatives available to them. These options are covered in greater detail in the HP white paper "**Financing Your EHR Implementation.**"

- Traditional bank-based business loans
- Software-vendor financing
- Hardware-vendor financing
- OEM and/or reseller programs
- State-based incentives

In addition, the U.S. government has allocated more than $1 billion in grant funding to set up health information technology centers to help physicians and hospitals adopt electronic records.[6]

Conclusion

Just as the objectives for meaningful use can be seen as a means to fulfilling the larger definition of the term, so too can that larger definition be seen as a means to an even greater set of goals. As CMS explains in a fact sheet about the final rule for meaningful use, programs like the EHR incentive program "seek to improve the health of Americans and the performance of their health care system through 'meaningful use' of EHRs to achieve five health care goals."[7] These five goals are:

1. To improve the quality, safety and efficiency of care while reducing disparities

This ties into using EHR technology to maintain and improve access to comprehensive health data, by using CPOE, providing clinical decision support (through drug interaction and allergy checks, problem/diagnosis lists and e-prescriptions), and reporting information to patient registries and public health agencies.

2. To engage patients and families in their care

A number of objectives that medical practices must meet to demonstrate meaningful use of EHR technology relate to providing patients and families with timely access to their health information, creating clinical summaries of patient encounters and offering patient education resources.

3. To promote public and population health

The ten objectives from which incentive program participants may choose five to satisfy program requirements include having the ability to submit electronic data to immunization registries and to submit reportable lab results (as required by law) electronically.

4. To improve care coordination

One of the three defining components of meaningful use is the use of EHR technology for electronic exchange of health information to improve the quality of health care; it is this prospect of electronic exchange that holds the promise of better care coordination. When a medical practice shares electronic records of things like problem lists, medication and allergies, and test results with other care providers, the patient benefits from improved care coordination.

5. To promote the privacy and security of EHRs

One of the core objectives for meaningful use is complying with HIPAA privacy and security guidelines, including the directive to conduct a security risk assessment and implement changes if necessary to protect information in the EHR system.

As far as the EHR incentive program is concerned, EHR technology was never intended to be an end in itself; it was always meant to serve as a way of meeting the healthcare goals listed here. Now that the government has issued its final rule on the criteria for meaningful use of EHR systems, medical practices can move ahead to reap the financial rewards of playing their part in achieving these goals.

About HP for healthcare

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Specifically to support EHR adoption, HP has developed the HP EHReady program, which provides an end-to-end solution of hardware, software and IT services to help guide hospital-affiliated physicians through EHR implementation. The program covers everything including assessments, network and device installation, training and financing. It's designed to deliver EHR solutions that may help healthcare professionals meet the meaningful use objectives established by CMS and HHS for the federal EHR incentive program.

For more information

To read more about HP technology for small and medium-sized medical practices, please visit:

http://www.hp.com/sbso/solutions/healthcare.

Notes

1 “The Meaningful Use Regulation for Electronic Health Records,” *New England Journal of Medicine,* July 13, 2010.

2 “Final Rule in ‘Meaningful Use’ Includes Host of Changes for Providers,” *iHealthBeat,* August 12, 2010.

3 “Ready or not: On the road to the meaningful use of EHRs and health IT,” PricewaterhouseCoopers’ Health Research Institute report, June 29, 2010.

4 Electronic Health Record Incentive Program Final Rule, Federal Register, Vol. 75, No. 144, July 20, 2010.

5 “Report: Meaningful use criteria = health IT staff gaps,” HealthImaging.com, August 24, 2010

6 http://www.hhs.gov/recovery/programs/hitech/index.html

7 “CMS and ONC Final Regulations Define Meaningful Use and Set Standards for Electronic Health Record Incentive Program,” Fact Sheet, Centers for Medicare & Medicaid Services, July 13, 2010

4AA3-2147ENA, December 2010