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What steps might a large hospital follow to achieve meaningful use of the problem list in one year?

A first step for hospitals in achieving meaningful use is to understand its implications. Stage 1 has a timeline defined for 2011 – 2012. (Blumenthal, Tavenner , 2010) Stage 1 there are two different directives that apply differently to providers than they do to hospitals. Hospitals will be responsible to demonstrate compliance on a total of 23 objectives. Among these, they are required on some and allowed to pick on others. The objectives are broken down into two different categories.

1) There a set of 15 objectives considered core and listed to be achieved by all eligible professionals, hospitals, and critical access hospitals in order to qualify for incentive payments. These core objectives "comprise basic functions that enable EHRs to support improved health care. As a start, these include the tasks essential to creating any medical record, including the entry of basic data: patients' vital signs and demographics, active medications and allergies, up-to-date problem lists of current and active diagnoses, and smoking status." (Blumenthal et al)
2) There are an addition set of 10 objectives from which hospitals can choose on their own to pick from to implement. The pick list aims to "gives providers latitude to pick their own path toward full EHR implementation and meaningful use. (Blumenthal et al)

As part of the core set of Stage 1 Meaningful Use Objectives within the functional measure, the following objectives relate to the problem list and apply to hospitals. Of them are four that are in the list of 15 core objectives that are required. The other two are from the optional list.

	Core Set	Measure
1	Maintain up-to-date problem list of current and active diagnosis	More than 80% of patients have at least one entry recorded as structured data
2	Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR
3	On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures)	More than 50% of requesting patients receive electronic copy within 3 business days
4	Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

5	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one listing of patients with a specific condition
6	For Hospitals, provide an electronic copy of hospital discharge instructions on request	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days; more than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided with it.

(Blumenthal, 2010)

The six identified objectives are interrelated in the following ways. From the final ruling, it states "electronic copies of health information given to patient will be useless if it does not contain basic information such as a problem list, medication list or allergy list. Exchange of information to other members of the health care team across settings will depend on having structured data of these elements." (DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2010)

- Objective 1 - Updated problem lists are needed direction and specified directly in the final ruling of "Meaningful Use" for objectives 2, 3 and 4. This objective is among the core 15 that is required.
- Objective 2 – Among the optional list of 10 from which eligible professionals can pick from.
- Objective 3 - Among the core 15 that is required.
- Objective 4 - Among the core 15 that is required.
- Objective 5 – In order to generate a report on specific conditions, an obvious input could a patient's problem list from their electronic health record. Objectives 1 would help to ensure that the patient list would be up to date and accurate. This objective is among the optional list of 10 from which eligible professionals can pick from.
- Objective 6 – Prior to the final ruling, the language of "Meaningful Use" specifically called out for the problem list to be included as part of the discharge instructions. In the final ruling, this appears to be less restrictive. This objective is an optional core set that can be chosen, but not required. This objective is among the core 15 that is required.

Focusing in on the above objectives would offer immediate benefits to a hospital seeking to achieve meaningful use within stage 1. Some other objectives that would no doubt complement the effort would be the updated electronic record of patient's demographics and vital signs.

While implementing, it is important to note that large hospital would most likely be eligible for the Eligible Hospital vs. the Eligible Professional Medicare classification as it relates to incentive payments and penalties (in the form or reduced reimbursement). The Eligible Hospital classification would make

the organization eligible for incentive funds based on a moderately complex formula that considers factors such as Medicare mix, adjusted gross discharges, etc. Incentive payments will be awarded for achieving Stage 1 Meaningful Use by 2015.

In the first year, to achieve meaningful use of the problem list, the aforementioned hospital would need to select and implement a certified EHR system. Further, it would be critical that as patients are seen, at least a single diagnosis for each patient is entered formally onto a structured problem list. Most of the large EHRs will allow the problem list to be based on a discrete identifier such as the International Classification of Disease (ICD) code and/or Current Procedural Terminology (CPT). By affiliating each diagnosis on the problem list to an ICD or CPT code, you will be storing each problem by a discrete identifier. Storing the problem discretely will allow for queries to be run and reports on population disease management to be generated. Further, by using a standard discrete identifier such as ICD, the data becomes portable and interoperable with health information exchanges (HIE), personal health records (PHR), and continuity of care documents (CCD); positioning the EHR system well for successful fulfillment of a couple other Meaningful Use objectives.

Two of the potential challenges to achieving the meaningful use 80% threshold for a hospital will be the change in workflow and the affiliation of the physicians with the hospital. In a hospital setting, the problem list will be very dynamic over the course of an admission versus the span of a clinic visit. Because patients are often admitted with a combination of problems, some of which will be resolved and some of which will change through the course of a visit, there will be a significant amount of documentation that must occur on the problem list in the EHR to keep it up to date for discharge. The second potential challenge relates to the type of medical staff that operates within the hospital. It is not uncommon for large hospitals to have relatively few employed physicians, and have a large amount of contract, privileged physicians. Ownership for the hospitals success and achievement of meaningful use incentive will vary by medical staff.

References

Blumenthal, D., M.D., M.P.P., & Tavenner, M., R.N., M.H.A. . (2010). The "Meaningful Use" Regulation for Electronic Health Records. [Editorial]. *The New England Journal of Medicine, 10.1056/NEJMp1006114*, 1-4. Retrieved July 23, 2010 from the World Wide Web: http://healthcarereform.nejm.org/?p=3732.

DEPARTMENT OF HEALTH AND HUMAN SERVICES. (2010). *Medicare and Medicaid Programs; Electronic Health Record Incentive Program*. [Electronic version]. Baltimore, MD: Centers for Medicare & Medicaid Services: http://www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf

Levine, David L., MD, FACEP (2010). *Meaningful Use: Impact on the Practioner.* Northwestern University Medical Informatics 402 Summer 2010 Term Lecture.