Looking Back, Moving Forward: How Meaningful is Your Meaningful Use?

Healthcare providers have been engaged in heroic efforts to bring about meaningful use of electronic health records (EHRs) since the 2010 passage of the Centers for Medicare and Medicaid Services’ (CMS) Incentive Program introduced as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The intent to promote the transition of healthcare from a “fee-for-service” to a “fee-for-value” world was apparent from the beginning. This paper reflects on the foundation that has been laid in Stage 1 of the meaningful use (MU) program, along with the challenging work yet to be accomplished as healthcare providers continue their journey to meaningful use of their EHRs.

Encore contends that achieving meaningful use requires employing full lifecycle methodology, with the ultimate goal of realizing value-based performance improvement. MU can be seen as foundational to establishing a platform for defining, calculating and reporting the 2014 electronic clinical quality measures (eCQMs), and achieving the Stage 2 goals and beyond. Successfully meeting meaningful use requires more than just setting up another IT project, checking off boxes, and receiving incentive payments. Rather, a compelling case can be made for adopting a strategic and programmatic approach to enable ultimate success over successive stages. It requires implementing a program with consideration of standardization, improved workflows, documentation at the point of care, interoperability, eCQMs as defined by multiple quality programs, and an auditable defense portfolio that provides evidence of the provider’s compliance and intent. A full lifecycle looks beyond the initial incentive payments. It employs a comprehensive approach that closes the loop on every aspect of the program. It establishes the culture and business plans which support improved patient care outcomes and efficiencies necessary to survive in the new fee-for-value healthcare world.
Where are we with Meaningful Use?

The MU Program was designed to encourage adoption of Certified Electronic Health Record Technology (CEHRT), and in that respect, progress has been made. Cumulatively, through June 2013, CMS has paid over $15.5 billion to eligible professionals (EPs) and eligible hospitals (EHs) through the parallel Medicare and Medicaid programs since 2011. More than 305,500 EPs and over 4,000 EHs have received incentive payments from the Medicare and Medicaid EHR Incentive Programs. Nearly 3 out of every 5 Medicare and Medicaid EPs and about 8 out of 10 EHs have made a financial commitment to an EHR.

It was understood from the outset that simply converting from paper to electronic patient records would not guarantee better patient care nor enhance the experience of providing or receiving healthcare. For this to occur, the use of electronic records would have to be “meaningful.” To support achieving “meaningful,” as outlined in Figures 3 and 4, the EHR Incentive Programs are staged with increasing requirements for participation: Data capturing and sharing, advanced clinical processes, and improved outcomes.

The Stage 1 Final Rule focused on functionality related to capturing and reporting on structured data, implementing clinical decision support at the point of care and using the captured data for care coordination. This was all seen as foundational to the ultimate goal of providing evidence-based, patient-centered care. Now that the substantially more difficult Stage 2 requirements have been released, along with the 2014 edition EHR Certification Criteria, it is evident the foundation which was laid for the Stage 1 attestation will profoundly affect the ability of hospitals and providers to meet Stage 2 and the 2014 eCQM reporting requirements. It has become clear that adopting a strategic and programmatic approach is required to successfully implement advanced clinical processes in Stage 2 and achieve improved outcomes targeted for Stage 3.
To adopt a programmatic approach, eligible hospitals and providers must be willing to invest the time, money and resources into meeting the “spirit” of the measures, by setting up systems, processes and workflows that serve to enhance the patient and provider experience.

What has been accomplished for achieving MU can also be leveraged by other quality-based initiatives such as Accountable Care and Value-Based Purchasing (VBP). In addition, the newly available structured data can support population health management, clinical integration and new payment models.

Taking a programmatic approach to achieving meaningful use can provide untold benefits in the long run. It requires a commitment from the organization’s leadership for the creation and overall management of a value-based improvement program along with extensive change management.

With MU Stage 2, it is critical to understand how approaches taken in Stage 1 profoundly affect an organization’s ability to prepare and succeed in Stage 2, especially for some key differences.

**Key Differences**

- Increase of thresholds for utilization measures; physician engagement is critical
- Change of eight menu set measures to core
- Focus on portals and patient engagement
- Removal of Clinical Quality Measures as separate objective
- Increase of focus and expansion of eCQMs

Among the more challenging thresholds are CPOE, Problem List and Medication Reconciliation.

Clients who took the “value-based” approach at the outset are now in the lead with regard to successfully preparing for the Stage 2 requirements.
The Journey to Meaningful Use Stage 2

How Have Organizations Approached Meaningful Use?

Choosing a Path

As organizations began to prepare for their meaningful use journey, approaches varied widely. Gaining a solid understanding of the regulations was a common baseline; however, the path to achieving MU took different turns. All too often MU was seen as an IT project, and achievement was seen as a means to secure additional funding, which resulted in “checking off the boxes” with little input from end users. With this approach, implementations were fraught with workarounds, frustrated end users, challenges with meeting MU thresholds, and failure to achieve the foundational gains intended by CMS; not to mention, a higher potential for penalties as a result of random auditing.

Organizations who took the short route are now facing Stage 2 with increased thresholds, a focus on sharing data and engaging patients, increased focus on eCQMs, and realizing they have significant work ahead. The MU experience has proven to be a difficult task, even for organizations who have been pioneers in the use of HIT, such as Vanderbilt University, who rolled out its homegrown EHR back in 2001. Margaret Head, COO and CNO for the Vanderbilt Medical Group told attendees at the AMA Group Association's annual conference held in March 2013, “Just because Vanderbilt has an EHR doesn’t mean that everyone uses it,” adding that “being completely electronic doesn’t necessarily equate with meaningful use.”6 She also noted that the homegrown nature of their EHR led to department customization and wide variation in workflows and use. So, along with timing and technological challenges, there were also cultural challenges to achieving meaningful use.

Meeting the Challenges of Stage 2: Key Considerations

For those organizations that chose the “easy way out” as a path to financial gain, certain areas will present a greater challenge in Stage 2. The use of the Problem List and Medication Reconciliation are key measures that were meant to lay the foundation for population health management, patient safety, shared risk and patient engagement. The challenges identified for adequate capture of CQMs in MU Stage 1 have been well documented and will be compounded in Stage 2. Additional complications will face those who have continued to rely on disparate, non-integrated systems and those who did not do a “deep dive” on their data analysis. Then too there is the vendor reliance issue. Most all organizations are subject to reliance on the functionality and MU reports provided by their chosen vendor. Yet home-grown systems are not an easy alternative, as has been discovered by those who have struggled to self-certify and write their own MU reports. Finally, not all organizations created detailed documentation regarding the work they did to meet the measures, such as the decisions they made to support the requirements or the validation they might have applied to their MU reports. Now that both pre and post payment audits are being conducted, some will face never getting the incentive monies in the first place and others may be asked to return what they have already received.

- Problem List
- Medication Reconciliation
- eCQMs
- Vendor MU Reports
- Data Elements and Workflow Analysis
- Disparate Systems
**Problem List**

Thresholds for the Problem List measure were set high at 80 percent in Stage 1 and many organizations struggled to meet this requirement. CMS left a “loop hole” in the measure specifications and allowed the use of a post discharge coded diagnosis to suffice. Many vendors automatically suggested building an interface to meet the measure, and IT departments latched on to this as a quick route to compliance. In so doing, they missed a rich opportunity to link order sets to problems, and create clinical decision support (CDS) that advised clinicians of best practices and suggested patient-specific education. In addition, a problem list with post discharge coding as its foundation is of no use when profiling patient populations, or creating an opportunity for “in the moment” care management for specific populations. The intent of the measure was to actively identify and manage patient problems; inability to do so creates a huge gap for organizations that chose the easy way out. Additionally, in order to correctly identify and manage problems, an “up-to-date” problem list must be maintained. This requires the clinicians to not only identify problems, but also to manage (close out, or make inactive) problems as the patient condition changes. Gaining consensus on who should “own” this responsibility is not an easy decision. Organizations who routinely tackled these critical decisions with their clinicians are well positioned in building a solid foundation for improved outcomes, shared risk and decreased cost. Those that didn’t are now faced with greater challenges as they look to Stage 2 and the demands to manage cost and improve outcomes.

**Medication Reconciliation**

The same principles hold true for Medication Reconciliation. The data shows that one of the largest factors for readmissions, especially in the frail elderly, is the mismanagement of discharge medications and home meds. Often patients are confused about generic brands and in the absence of tightly managed home and hospital medication reconciliation, patients will take double doses of the same medication and end up suffering dire consequences. The ability to identify patient home meds at admission and reconcile these medications at transitions of care was meant to provide a safety net to avoid costly readmissions and untoward patient events. Clinicians everywhere recognized this as a critical feature, yet several things happened in implementation of the MU program that ultimately resulted in many organizations not choosing this measure from the menu set. Many vendors did not understand the importance of creating functionality that was seamless to clinicians and a part of their natural workflow. As Medication Reconciliation was a menu set measure, many organizations simply put this measure on the “back burner” to work on and improve in the optimization phase. Now organizations will have no choice but to address this complicated process since the Medication Reconciliation measure has been moved to the core set measures for Stage 2. Special attention will need to be taken as part of Stage 2 preparation to address workflow, functionality and adoption issues. For EH organizations with disparate ED systems this becomes more complex, compounding issues of patient safety.

**Electronic Clinical Quality Measures (eCQMs)**

The evolutionary path from manually abstracting quality measures to electronically reporting from certified EHR technology is getting clearer, but the road is complex. As referenced in the recent study commissioned by AHA, “A Study of the Impact of Meaningful Use Clinical Quality Measures,” the current approach to automated quality reporting has not delivered on the promise of feasibility, validity and reliability of measures and has placed an increased reporting burden on hospitals and providers.

Policy recommendations outlined in the AHA study include slowing the transition to electronic reporting for CQM’s with fewer but better tested measures in Stage 2. In the meantime, these challenges are very real and will need to be remediated as hospitals and providers prepare for MU Stage 2.
Three key areas of eCQM challenges have emerged in Stage 1 and will only be accentuated in Stage 2. These are:

1. **Technology Challenges**: Vendor reports did not function as expected. There were issues with not adequately defining the measure specifications, which drove changes in workflow to capture data.
2. **Clinical Challenges**: Negative impact to clinical workload and no perceived benefit to care. Staff did not trust the data.
3. **Strategic Challenges**: Little to no return on investment was seen.

Additionally, starting in 2014 all specifications for CQMs have changed. Vendors must update their 2014 certified software. The National Quality Forum (NQF) Quality Data Model (QDM) specifications continue to be refined, and vendors must devise a way to update their already certified 2014 software with these new specifications. The latest updates were released in April 2013 for EHs and in June 2013 for EPs. However, vendors are NOT required to re-certify their 2014 software every time new specifications are released. The impact of this is that different vendors and EH’s will be on different versions of the CQM specifications, which is yet another reason why electronic measures are not yet reliable for comparison of performance between hospitals. It is also important to note that CQMs are independent of stage beginning in 2014. While core and menu set measures vary from Stage 1 to Stage 2, the same clinical quality measures will apply to attesters in any stage of the program beginning in October 2014.
The evolution to electronic quality reporting has left hospitals and providers facing the challenges outlined above and added to confusion as a result of introducing dual processes for quality reporting. Hospitals are finding themselves with a “foot in each world” as they wait for harmonization of these measures. The end result is an undue burden on organizations for reporting, and concern about the validity of the data being reported.

Figure 7 shows the timeline for moving from abstraction to electronic reporting. It will soon be apparent which organizations have been ignoring the significance and ultimate electronic reporting of MU measures, as these, along with all other quality measures will be publicly reported.

It is important to understand that performance will be measured, and reimbursement will be linked to quality measure results. Therefore, organizations must be able to electronically capture and report on the data that make up these quality measures.
**Vendor Meaningful Use Reports**

Most organizations chose to rely on the standard MU reports provided by their vendors for all the measures, although CMS allowed use of a non-certified reporting solution for the core set and menu set measures. The vendor reports provide limited functionality. They generally consist of individual hospital or provider level reports aggregated by measure to a single reporting timeframe with limited drilldown capability. Customization of the vendor reports was mostly non-existent as the vendors were required to code the reports to a structured set of content with an expectation that users would be populating information into specific forms or code within a modeled and standard workflow.

One of the most significant aspects of using vendor reports has been that organizations believed the certified software they had purchased would necessarily and accurately fulfill reporting the MU measure percentage results. Given this thinking, little attention was given to “validating” the reports. In reality, all the standard reports provided by the EHR vendors require configuration for each individual environment, based on specific client workflows and EHR build. Therefore the standard MU reports do need to be validated as standard does not mean “off the shelf.” The added complexity of new measure specifications being released by NQF in April for the 2014 software makes validating this data all the more important.

Last year Congress requested that the Office of Inspector General (OIG) review the CMS oversight of the EHR Incentive Program. One of the focus areas for this evaluation was a review of the MU report requirements. The OIG submitted its first review of CMS oversight of the EHR incentive Program in November of 2012. There were two recommendations to ONC with regard to MU reports:

1) Require that certified EHR technology be capable of producing reports for Yes/No MU measures where possible, and
2) Improve the certification process for EHR technology to ensure accurate EHR reports.

ONC concurred with both recommendations.

**Data Element and Workflow Analysis**

Not all standard EHR implementations addressed the complete data requirements needed to demonstrate quality, improve performance and achieve regulatory compliance. Failure points included gaps in identifying the data required for quality reporting, not incorporating those requirements into workflow/process redesign, and not engaging physicians and clinicians in the process. While some organizations relied on shortcuts and workarounds to report on Stage 1 measures, others had a larger vision of what is obviously going to be the future of quality measure reporting. The organizations who embraced a programmatic approach to MU from the outset paid close attention to the initial measure requirements, analyzing each of the CQMs down to the data element level detail. The clients who took this comprehensive approach went on to identify the same level of detail for the Stage 1 core set and menu set measures as well.

Organizations intent on leveraging the work done for MU for other eMeasure initiatives undertook the onerous task of data mapping to ensure accurate measure calculation. The data mapping involved identifying the required data elements for a given measure, assessing the availability of the data elements in the correct format, and confirming the existence of each element by mapping it to its location in the EHR.
Data mapping along with detailed workflow review, modification and documentation were not popular or prevalent practices for many MU Stage 1 attesters due to the immense effort and complexity involved. For example, an analysis of the 47 Stage 1 MU measures (core set, menu set, and CQMs) reveal nearly 150 distinct data elements, and over 2,300 individual codes contained in nearly 100 value sets. And this was just the starting point. Now Stage 2 has introduced hundreds more data elements and nearly 500 additional value sets. Nonetheless, organizations which conducted detailed analysis have established a valuable foundation for reporting on not only MU Measures, but other programs’ measures as well.

**Disparate Systems**

Organizations with vendors who do not have true “enterprise” systems were also faced with multiple challenges as they embarked on their meaningful use journey. Often the Emergency Department (ED) and Obstetrics/Gynecology (OB/GYN) systems for the EH population had disparate vendors. MU Stage 1 presented issues with reporting from non-integrated systems and highlighted the gaps in information flow. Dealing with certification, reporting and workflow opened the window for discussions around moving to enterprise systems. Those who did not tackle these tough decisions, including disparate ambulatory systems, are considering the economic and cultural challenges of developing alternative solutions. Organizations must keep their focus on the larger goals of CMS and the increased challenges ahead to make informed decisions related to systems that will ultimately allow them to share information across multiple patient venues.

**So Are You Thinking About Self-certification?**

In order to meet the requirements of MU, organizations were required to utilize CEHRT. Most chose to purchase these systems from the established vendors who were capable of delivering the advanced functionality required for MU objectives. Few organizations elected to self-certify home grown or multi-vendor EHR technology due to the rigorous certification process, cost, maintenance associated with supporting an application, and ongoing certification requirements.

Reporting is one area where self-certification was pursued. The larger organizations with existing analytics environments and an Enterprise Data Warehouse (EDW) were better prepared to engage in self-certification for reporting eMeasures.

Key advantages to organizations self-certifying their reporting solution was the ability to analyze and aggregate across multi-site and multi-system environments. Developing dashboards created the ability to drill down within measures to track and monitor performance across the reporting timeframe. Additionally, these organizations envisioned that by collecting the required information for MU in a structured reporting environment, they could expand their analytical capabilities to correlate system usage with treatment patterns and overall outcomes.
Audit Documentation – Closing the Loop

Another area that Stage 1 attesters approached in differing ways was the level of effort applied to creating an electronic record of the work that went into becoming a meaningful user.

This included:

- Documenting ownership of certified systems;
- Keeping records of decisions made to support the attestation results, such as the ED counting method employed;
- Providing evidence of EHR design decisions and workflows as well as related policies such as the organization’s CPOE Policy;
- Detailing report configuration, logic and validation; and
- Documenting results of required activities such as tests related to submitting public health information and conducting a security risk assessment.

This has become an especially important topic in light of the MU audits currently being conducted. While early attesters were initially only subject to post payment desk audits, 2013 has seen the introduction of both pre-payment audits and on-site audits. Clearly, the level of detail applied to creating an electronic MU auditable defense portfolio has become an important consideration.

How Have Vendors Approached Meaningful Use?

Often the EHR vendors built with a focus on certifying the systems quickly to increase market share. Customers of vendors who chose this approach have often found their EHR functionality to be deficient with regard to workflow and associated data capture, and the standard MU reports difficult to install and validate.

As Stage 2 deadlines approach, vendors are lagging behind.

Recent articles such as “Stage 2 changes may be rude awakening” published in Healthcare IT News, July 30, 2012; “AHA, AMA: Meaningful Use Requirements Should Be Eased” published in iHealthBeat, July 26, 2013; and “MU Stage 2 Requirements 'Overly Burdensome,' Say AHA, AMA” published in HealthLeaders, July 25, 2013 all highlight these issues.

Certification for Stage 2 has become increasingly challenging due primarily to the change in electronic specifications for CQMs, inclusion of portal functionality and the interoperability requirement to use the Direct standards-based exchange method for transmission of Protected Health Information (PHI), including the Continuity of Care Document (CCD).

Customers are demanding vendor release notes and upgrade schedules in order to develop project plans and line up resources. Vendors are not always quick to provide such documentation, and this adds to the pressure and challenges of meeting Stage 2 in a meaningful and timely way. The vendors who chose to understand the full picture of MU, collaborating with CMS to create the rules and invest in building systems that support workflow and discrete data capture, are coming out as the “winners” in this critical next step for improving healthcare.
Major Requirements and Considerations for Meaningful Use Stage 2

**Problem List**
Structured problem lists will be key to enabling EHR interoperability moving forward with each stage of meaningful use. As noted by Michelle Consolazio, Meaningful Use Policy Analyst in the Office of the National Coordinator for Health IT’s Office of the Chief Medical Officer, problem lists are an integral part of the MU program, especially as it progresses beyond Stage 1. A number of tools the ONC has developed for providers start with problem lists. ONCs Health IT Policy Committee’s recommendations for Stage 3, expected by October 2013, will rely more heavily on the use and accuracy of problem lists.14

**Transitions of Care and Summary of Care**
An increased focus on transitions of care will be essential for achieving Stage 2 and beyond. The ability to coordinate patient care across the continuum, enhancing transitions, is supported by several key attributes. Among these are systems that provide a seamless view of the patient and allow the collection of discrete and disparate data to manage both the individual patient and population health. Meaningful use was meant to build this foundation. “Digital documentation does not go very far without the ability to exchange patient data, and indeed, data silos are one of the prime obstacles to care coordination, as ONC admitted to Congress.”15 The major challenges center on seamless use of an active problem list and active medication list (medication reconciliation), as well as the components CMS outlines in the Summary of Care measure for MU Stage 2.

Many organizations are looking to the HIE vendors to solve these data synchronization issues, not understanding the foundational requirements of data governance, clean workflow and data capture that are keys to success. Stage 2 begins to address the sharing of data by providing the Summary of Care documents electronically among providers, but information is limited to its content and transmission is from a Direct transmission protocol process that limits delivery options. HIEs, along with the Direct “push” sharing transmission will play a part in sharing patient information across multiple providers and care settings, but full continuum of care and data sharing will continue to evolve.

The Stage 2 Final Rule makes it abundantly clear that CMS is serious about interoperability. “We continue to believe that making vendor-to-vendor standards-based exchange attainable for all meaningful EHR users is of paramount importance. In that regard, and as we look toward MU Stage 3, we will monitor the ease with which EPs, eligible hospitals, and CAHs engage in electronic exchange, especially across different vendors’ EHRs.”16

This is especially evident in exchange requirements for the Summary of Care and Patient Electronic Access Stage 2 measures. Vendors that have typically produced mostly proprietary solutions and do not provide easy access to the collected data are now being challenged to join the Internet age of communication.

**Transitions of Care versus Summary of Care**
Two different subjects with one objective; one must provide a Summary of Care for each Transition of Care.

Transition of Care is the action of moving from one setting to another and the Summary of Care is the document provided with the transition.
In a New England Journal of Medicine article, Drs. Kenneth Mandl and Issac Kohane comment on EHR vendors’ intentional lack of focus on interoperability, having adopted an attitude that has “thwarted medicine's decades-long quest for an electronic information infrastructure capable of providing a dynamic and longitudinal view of the health care of individuals and populations... Although EHR vendors have proliferated — more than 700 vendors now produce about 1750 distinct certified products — their systems' inability to work together has not helped doctors or patients.”17

The CMS EHR Incentive Program is now forcing vendors to reconsider their typical closed system design approach and the Stage 2 Final Rule clearly states that interoperability requirements will continue to increase and be enforced. “If we do not see sufficient progress or that continued impediments exist such that our policy goals for standards-based exchange are not being met, we will revisit these more specific measurement limitations and consider other policies to strengthen the interoperability requirements included in meaningful use as well as consider other policies and regulations through which the Department could affect the outcome we seek.”16

**Patient Portals**

Stage 2 of the government’s meaningful use program requires that at least 5 percent of patients view, download, and transmit their health information and send a secure electronic message to their provider. The CMS lowered this objective from 10 percent to 5 percent when it published its Stage 2 final rule.

Organizations that view this measure as implementation of software and checking off the box will find themselves caught short as they work to meet even these modest thresholds. Not to be underestimated is the amount of planning, consensus-based decision making, and focused market campaigning to engage patients in using the portal. Budgeting resources and allowing adequate time for the activities necessary to truly engage patients in the use of the portal can impact timelines for 2014 attestations. All too often this is overlooked and organizations must go back to the budget and planning process, thus delaying attestation dates.

Key decisions must be made at an organizational leadership level around what functionality to install, what information will be shared (i.e., sensitive lab results), who can view the information (minors), and how to effectively market this information to patients. The impact of the marketing campaign should not be underestimated.

**Figure 9. Meaningful Use Supports Patient & Family Engagement**18
A recent journal article summarizes key considerations for patient-centered portal best practices. A patient-centered portal will not hinder patients’ pre-existing efforts to engage with their health, but will give them an easy-to-use platform that can simplify and hopefully enhance them. Four best practices were categorized as: 
*Branding, Usability, Functionality and Reliability.*

The key takeaway here is that installing a portal does not mean patients will automatically use it. Be sure to allow adequate time and budget for strategic decision making and a robust marketing campaign. Engaged patients who take accountability for their health are integral to sharing risk, reducing costs, and improving outcomes.

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### Evaluating Successes and Gaps

As an industry moving from Stage 1 to Stage 2 in the meaningful use journey, it is time to pause and take a critical look at the broader objectives CMS has laid out—improving outcomes, decreasing cost, driving data capture and introducing advanced clinical processes. This section highlights key considerations for successful achievement of Stage 2 as well as future stages.

**If your approach was not robust enough, what can you do?**

The following questions cover key areas that Encore has seen successful organizations embrace on a journey to MU readiness:

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<th>Questions</th>
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<tr>
<td>1</td>
<td>Does your organization have true executive sponsorship for meaningful use?</td>
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<td>2</td>
<td>Have you been proactive in making meaningful use a platform for the broader initiatives laid out by CMS, or have you approached MU as a “check off the box” route for payment? If so, what are your plans to move forward in a proactive way for Stage 2?</td>
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<td>3</td>
<td>Do you truly understand the scope and the challenge for meeting Stage 2, and have you aligned resources and budgeting to support increased attention to clinician engagement and workflows?</td>
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<td>4</td>
<td>Have you committed the resources, time and money required to sustain complex quality measure reporting in the long term, especially if your organization is required to report across multiple facilities and/or hundreds of EPs?</td>
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<td>5</td>
<td>Have you involved a multidisciplinary team including clinicians, quality, risk management and other key disciplines? Have you engaged Change Management to facilitate adoption?</td>
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<tr>
<td>6</td>
<td>Do you truly understand your vendor’s approach and timeline for meeting Stage 2, including certification for Stage 2, upgrades, release notes, and full transparency in terms of needed functionality and reporting capabilities?</td>
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The increased focus on “engaging patients and their families” is not to be taken lightly. The development of a patient portal is a project that goes beyond installing hardware. Considerations for privacy and security, engaging patients in their use, and communication call for involvement of a multidisciplinary team including leadership, Health Information Management (HIM), medical staff, nursing and risk management.

These decisions take time, and require development of associated policies, procedures, training and communication plans. This must be considered in your timeline and work plan.

**Tactical Steps and Recommendations**

- Identify and act upon lessons learned.
- Embrace a big vision; leverage the MU effort.
- Understand the scope and level of effort required; don’t underestimate Stage 2 challenges – thresholds, interoperability, and patient portal and engagement.
- Include all stakeholders; align with quality and performance improvement.
- Develop program management and governance.
- Focus on adoption and change management.
- Understand vendor approach; challenge and check.
- Create an auditable defense portfolio and an audit plan.
- Budget for upgrades, software and services; understand how this will affect the timeline.
- Establish a comprehensive Portal Plan to include security, access, outreach, content, policies and procedures.
- Pay special attention to the Summary of Care – the complexities, the content to include physician documentation for care planning.
Summary

As we look back at the journey taken and ahead to MU Stage 2 and beyond, it is clear the organizational approach to MU directly impacts future success. Organizations that chose to employ a comprehensive approach will be the frontrunners in this new world of value-based payment and performance improvement.

As outlined in this paper, there are lessons learned from the past and principles for success to be leveraged going forward. Meaningful use is truly a journey that must be embraced beyond the IT department. CMS has laid out a vision and a plan, and invested millions of dollars. In return they expect providers and hospitals to build a platform for the future to demonstrate meeting the program’s goals.

This is emphasized in the draft recommendations for MU Stage 3 as presented in the August 7, 2013 HIT Policy Committee (HITPC) by the Meaningful Use Work Group (Figure 10). The draft recommendations state the desire to leverage lessons learned from Stages 1 and 2, which is an indication a recommendation from HITPC to CMS could be several months away. Also of high interest is the recommended option for providers who can demonstrate improved or sustained improvement in specific quality measures as having satisfied a subset of the MU measures and perhaps also to allow success in one year of the MU program to be “deemed” as meeting the requirements of other programs such as ACOs. Although this is highly preliminary, it does speak to the continued desire to simplify and/or align requirements between the various programs.

To be successful, organizations must take a programmatic approach and adopt the principles laid out in this paper. Take note of key success factors such as employing proactive executive sponsorship that supports the long-term, value-based, performance improvement vision. Realization of the vision depends on developing and delivering a well-structured program consisting of a collaborative and multidisciplinary team to include organizational leadership and departmental resources, the vendor, and in some cases, subject matter expert consultants.

Organizations and vendors who adopt this approach will be aligned for success. Those that don’t may find they are arriving too late in the game to compete. Encore’s hope is that this paper provides the context for reflection and initiating tactical steps to move forward.

Align the organization around a vision of the future, and build a solid foundation for value-based performance improvement.

“He who has not first laid his foundations may be able with great ability to lay them afterwards, but they will be laid with trouble to the architect and danger to the building.” Niccolo Machiavelli (1469-1527); The Prince (1532)
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