

EDITORIAL

No Outcome, No Income CMS's "Meaningful Use" Initiative

Those of you who follow events involving health policy in this country have no doubt encountered the term "meaningful use." The term relates to criteria that hospitals and eligible providers must meet through their use of certified electronic health record (EHR) technology to qualify for incentive payments from the Centers for Medicare and Medicaid Services (CMS). Providers who fail to achieve meaningful use will receive decreased payments from CMS for clinical services beginning in 2015 and beyond.¹

The incentive payments, and the program which supports them, are part of a master plan to encourage the use of health information technology (HIT) in the US to improve the quality, safety, and efficiency of health care. The meaningful use initiative is part of the American Recovery and Reinvestment Act of 2009 (ARRA), specifically the Health Information Technology for Economic and Clinical Health (HITECH) Act, which appropriates an estimated \$27 billion to support the adoption and use of EHRs.² The Act defines criteria that must be met, such as electronic prescribing, electronic exchange of health information, and submission of clinical quality measures, in order to qualify for the financial incentives associated with achieving meaningful use.³ Because the implications of this program are so significant, we thought it important to devote this month's editorial to a discussion of meaningful use.

For all involved, the embrace of meaningful use represents no less than a turning point in thinking about what we pay for in health care. Phrased in the language of quality, it can be summarized as "no outcome, no income." In other words, this program is not simply about purchasing hardware and computerizing medical records. Instead,

policy makers view EHRs as the core of an emerging HIT infrastructure, which has the potential to improve the nation's health care system and the health of Americans.² It is well known that fragmentation of the US healthcare system has led to numerous problems and inefficiencies. By increasing access to information, computerization has the potential to significantly improve this situation much as it has done for other major industries.⁴ Indeed, not only does healthcare IT adoption in the US lag behind other industries, but the US also lags behind other countries in the adoption of EHRs and HIT.⁵ In the US, only 4% of physicians in ambulatory practice and 1.5% of hospitals reported using a fully functional EHR.^{6,7}

There are numerous criteria to be met by providers and hospitals to qualify for the incentive payments (up to \$44,000 for Medicare providers, \$63,750 for Medicaid providers, and millions for individual hospitals) for achieving meaningful use. To best understand the program itself and its goals and potential implications, it's useful to examine the program's three stages.

Stage 1 (years 2011-2013) criteria for meaningful use focus on the relatively basic elements of HIT and quality, such as electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information.

Stage 2 (years 2013-2015) expands upon the Stage 1 criteria in the areas of disease management, clinical decision support, medication management, support for patient access to their health information, transitions in care, quality measurement and

research, and bi-directional communication with public health agencies.

Stage 3 (years 2015 and beyond) criteria have not been officially published, but will focus on improvement in all areas of quality and safety that can be facilitated by HIT, with the goal of improving population health outcomes.

In summary, the federal government and CMS have put forward a comprehensive program to bring providers and hospitals into the 21st century with regard to the use of information technology. However, due to the voluntary nature of this program, there is great uncertainty as to the extent that the vision of improved population health through the meaningful use of EHRs will be realized.

The Jefferson School of Population Health (JSPH) is actively involved in the meaningful use program in two specific ways, one internal to Jefferson and one external.

Internally, we provide input to the Jefferson University Physicians EHR implementation team on how to choose and meet the clinical quality measure criteria for meaningful use. This involves interaction with both the information technology (IT) team, who support the EHR software, and physician champions, who facilitate the implementation at the provider level. Specific recommendations to the IT team include discussions about data field layouts to optimize utilization by physicians and staff. Suggestions to the physician champions include process and culture changes necessary to ensure the fulfillment of the meaningful use criteria.

Externally, we help providers in the community achieve meaningful use by

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participating in the Regional Extension Center Program (REC) for Eastern Pennsylvania.⁸ The REC program, another initiative funded under the HITECH Act, is designed to support primary care physicians in the adoption and implementation of EHRs on their quest towards meaningful use. As a participant in the REC initiative, JSPH faculty and staff collaborate with physician practices in the community as advisors and consultants on meaningful use. ■

Richard Jacoby, MD

Associate Professor

Bettina Berman, RN

Project Director for Quality Improvement

David B. Nash MD, MBA

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As always, we welcome your feedback. Please feel free to contact Dr. Nash with your questions or comments at david.nash@jefferson.edu.

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