



# WHITE PAPER

---

## *Meaningful Use Strategies for Hospitals with Non-Automated EDs*

EDIS & Paper Clinical Documentation Solutions  
Emergency Departments | Urgent Care | Primary Care | Government

[www.tsystem.com](http://www.tsystem.com) | 800.667.2482 | 4020 McEwen Drive | Dallas, TX 75244



# *Meaningful Use Strategies for Hospitals with Non-Automated EDs*

The financial rewards gained from meeting Meaningful Use and the future penalties for failure to comply have most facilities investigating potentially viable compliance strategies. In many cases, attaining Meaningful Use while maintaining optimal provider efficiency and maximizing revenue are competing priorities. The emergency department (ED) sees the vast majority of patient visits for most facilities, and it does so in a compressed timeframe. With these demands, the need to maximize efficiency and revenue potential while providing high-quality healthcare are great concerns.

Many facilities are looking to their core electronic health record (EHR) as a platform for meeting Meaningful Use. Extending that solution to the ED often comes with significant disruptions to business operations. Moreover, implementing systems not specially designed for ED operations can have a long-lasting impact on ED physician productivity and satisfaction. When implementing a system that is not designed specifically for ED workflow need, it is not uncommon for physician productivity to drop 30 percent or more initially, with sustained reductions of 20 percent or more. However, any reduction in productivity directly affects operations, resulting in longer lengths of stay and waiting times as well as reduced revenues and increased expenses. For these reasons, many facilities are implementing automated nursing solutions in the ED, but significant concerns about physician workflow and documentation automation remain.

Meaningful Use attainment does not have to negatively impact operations, revenue or provider and patient satisfaction. Structured template paper provides the most efficient mechanism for physicians to document the clinical encounter in the ED. With minimal automation of physician workflow, limited to clinical orders (CPOE) and discharge instructions, Meaningful Use can be obtained by the facility.

The Centers for Medicare & Medicaid Services (CMS) allows facilities to choose one of two methods for determining which ED patient populations to include in Meaningful Use denominator calculations: the “Obs method” and the “All ED Patients method.” In the former, ED patients who are ultimately admitted or placed in observation are to be included. Because many of the Meaningful Use measures use the concept of a unique patient when determining compliance, the act of meeting a measure on an individual patient, in any venue of care, at any time during the reporting period, ensures compliance for that patient for the entire reporting period. For example, a CPOE medication order can be placed on a patient once admitted, and that patient is 100 percent compliant for the reporting period, even if there is no CPOE medication order in the ED. The same would be true if the order was placed in the ED and no further orders were placed during

# Meaningful Use Strategies for Hospitals with Non-Automated EDs

the inpatient stay or on future visits during the reporting period. This method allows facilities to drive Meaningful Use compliance primarily with an “inpatient” system, selectively deploying functionality where it is of most value.

Using the “All ED Patients” method, all ED patients, regardless of disposition, are to be included in the calculations. No matter which method is chosen, the facility can obtain Meaningful Use while still allowing physicians to document clinical care efficiently and maintain optimal business operations.

Following is an outline of a potential strategy for facility attainment of Meaningful Use incentives, while maintaining optimal workflow, productivity and revenue through physician paper template documentation. As demonstrated below, the majority of data elements required for Meaningful Use measure calculation are gathered by nurses in the normal course of care in the ED; therefore, additional burdens need not be placed on nurses for Meaningful Use attainment for most measures. This strategy assumes the following:

- Nursing documentation is performed in a solution certified for Meaningful Use (e.g., the core HIS)
- CPOE is implemented for use in the facility by physicians through the core HIS vendor. Given the low threshold (30 percent) for Stage 1 Meaningful Use, the ED physicians may not have to use an automated CPOE system. However, CPOE inherently has great value and ED implementation can provide MU attainment or at least reduce the risk of failure to meet thresholds in the inpatient environment.
- An electronic discharge instruction solution certified for Meaningful Use is deployed in the ED.

## Use CPOE for medication orders for 30 percent of patients

Implementing CPOE in the ED would be helpful to comply with this requirement, though most hospitals do not need to use CPOE in the ED to meet the 30-percent threshold if using the CMS “observation method” to calculate patient inclusion. If using the “All ED Patients method,” it is generally possible to meet these thresholds in the ED alone. Because of CMS clarifications, orders must be entered by a licensed provider, and the order in CPOE must be the first instance of the order. Therefore, physician-entered orders and nursing protocol orders qualify. The best practice in this scenario is to have the ED physicians enter orders into CPOE (and nurses enter protocol orders).

## Implement drug-drug and drug-allergy interaction checks

This can be accomplished by enabling this functionality within the CPOE module.

# Meaningful Use Strategies for Hospitals with Non-Automated EDs

## Implement drug-formulary checks

This can be accomplished by enabling this functionality within the CPOE module.

## Maintain an active medication list for 80 percent of patients

Nursing generally captures this information in the EHR as a course of normal practice. This could occur in the inpatient environment, ED or both.

## Perform medication reconciliation

This measure refers to the reconciliation of home medications at the beginning of the visit—not the transition of care within the facility, which this term is generally accepted to mean. As described above, nursing will generally capture this information and reconcile it against a known list (or no list) of current medications, thus meeting this measure.

## Maintain an active medication allergy list for 80 percent of patients

Nursing generally captures this information in the EHR as a course of normal practice. This could occur in the inpatient environment, ED or both.

## Record patient demographics (language, gender, race, ethnicity, date of birth, date and cause of death) for 50 percent of patients

The elements of preferred language, race, ethnicity and gender are generally captured by registration in the enterprise system. While the time and cause of death is generally determined by the physician, anyone can document this information in the inpatient EHR, including nurses, coders, etc. A viable approach is to have the death information entered by nursing or through coding/billing individuals.

## Record smoking for patients 13 years of age or older in 50 percent of patients

Nursing generally captures this information in the EHR as a course of normal practice. This could occur in the inpatient environment, ED or both.

## Record and chart changes in vital signs for 50 percent of patients

Nursing generally captures this information in the EHR as a course of normal practice. This could occur in the inpatient environment, ED or both.

# Meaningful Use Strategies for Hospitals with Non-Automated EDs

## Maintain an up-to-date problem list of current and active diagnoses

Nursing generally captures this information in the EHR as a course of normal practice. This could occur in the inpatient environment, ED or both.

## Provide 50 percent of patients with an electronic copy of their discharge instructions (if the patient requests their discharge instructions electronically)

While the ED will need to adhere to this requirement to meet the threshold, an electronic discharge instruction solution is inexpensive, easy to implement and provides value beyond Meaningful Use compliance. Examples of certified vendors include ExitCare and Exit-Writer. In this scenario, staff would provide electronic discharge instructions through this vendor.

## Provide patient specific educational material

Both the electronic discharge instructions as well as other materials provided to the patient during the normal course of care would qualify for this measure.

## Document advance directive status

This measure applies only to the inpatient environment, but it can be facilitated by nursing documentation of the advance directive in the ED on admitted patients. Nursing personnel are generally the care providers that document this information during the normal course of care.

## Provide 50 percent of patients with an electronic copy of their discharge instructions at time of discharge, upon request (eHI)

The facility can follow the same procedures as it does for providing patients with hard copies of their medical records. In general, the Health Information Management (HIM) department would manage this task from records in the enterprise EHR. The delivery of eHI requires that a CCD is provided containing demographic information, medications, allergies, problem list and lab results. These data elements will be available in the core HIS as described in this document. Providing a human-readable view of the CCD (e.g., "style sheet" XSLT) satisfies this portion of the requirement. Most core HIS vendors include this functionality.

# Meaningful Use Strategies for Hospitals with Non-Automated EDs

## Report hospital clinical quality measures

The facility will need to record timestamps for: disposition decision time, disposition time and departure time in the ED as well as other inpatient measures. The values can be entered into the certified EHR by anyone, and it need not happen at the point of care. This could occur at the point of care through data and tracking in the ED (e.g., nursing or clerical staff) or retrospectively through data extraction.

## Implement one clinical decision support rule related to a high-priority hospital condition with the ability to track compliance with that rule

This can be accomplished by enabling this functionality within the inpatient EHR.

## Report data externally (public health surveillance, immunization reporting and/or submission of reportable labs)

At least one of these external data submissions must be attempted by the facility. The successful completion of this task is not required for Stage 1 Meaningful Use compliance; therefore, the inpatient EHR need only be certified for this measure and an attempt undertaken by the facility to complete this task.

## Capability to exchange key clinical information among providers of care and patient-authorized entities electronically

The facility must only try to send a CCD or CCR document to another electronic system. The successful completion of this task is not required for Stage 1 Meaningful Use compliance; therefore, the inpatient EHR need only be certified for this measure and an attempt undertaken by the facility to complete this task.

## Protect electronic health information

This measure is met by a security audit of certified systems and would not be affected by physician paper documentation.

As demonstrated above, Stage 1 Meaningful Use can be attained through ED nurse documentation automation in the ED, while maintaining efficiency with physician paper documentation. Additionally, very little additional burden on nursing, if any at all, must be imposed to comply with Meaningful Use and receive incentive funds. The facility can receive robust returns simply by making slight modifications to existing

## *Meaningful Use Strategies for Hospitals with Non-Automated EDs*

processes within the ED. Several facilities have demonstrated success with this approach. They have received Stage 1 Meaningful Use incentives, while experiencing optimization of their EDs through physician documentation on structured paper templates.

It appears that Stage 2 requirements will be delayed until at least federal fiscal year 2014, beginning October 1, 2013. It is likely that Stage 2 requirements will provide incentives to automate physician documentation and workflow, although final requirements will not be available until summer 2012. The delay of Stage 2 provides facilities much needed time to focus on Stage 1 attainment and evaluate solutions for Stage 2.