What 'Meaningful Use' Means

Criteria *from page 1*

► Will the process for certifying EHR technology help ACP members identify the appropriate solution for their practice needs as well as help practices maximize the benefit of the EHR incentive program for patient care?

► Are the measures selected for reporting clinically relevant, evidence-based, and truly associated with meaningful use of health information technology?

► Do the processes required for collecting data to document and report on meaningful use minimize administrative and financial burdens for practices?

Under the Health Information Technology for Economic and Clinical Health Act (HITECH), a part of 2009's federal stimulus law, physicians who treat Medicare patients can get up to $44,000 over 5 years for the meaningful use of a certified health information system. Physicians whose patient populations are made up of at least 30% Medicaid patients can earn up to $64,000 in incentive payments for their use of the technology. The regulations include a definition of meaningful use and outline other criteria for obtaining the full incentive payments.

The HHS issued a rule that outlines proposed provisions governing the incentive programs, as well as an interim final regulation that sets initial standards, implementation specifications, and certification criteria for EHR technology.

"We hope we've provided a pathway toward more uniform standards over time, while at the same time making it possible in 2011 for well-intended providers and health professionals who want to become meaningful users to become so, and for the industry to create technology that will support that," Dr. Blumenthal said.

The meaningful use criteria start with minimum requirements in 2011 and build gradually, with more requirements added each year. For stage 1, which begins in 2011, the requirements include:

► Use of computerized entry for 80% of all patient orders.

► Use of electronic prescribing for 75% of all permissible prescriptions.

► Maintenance of active medication and medication-allergy lists as part of the EHR for at least 80% of patients.

► Inclusion of demographic data (language, gender, ethnicity, insurance type, and date of birth) in the EHR of at least 80% of patients.

► Inclusion in the EHR of at least 50% of the lab results that can be recorded as either positive or negative or can be recorded with numerical data.

Other requirements deal with reporting quality data, filing claims electronically, encouraging patients to be active in their care, improving care coordination, and protecting the privacy of health records.

In 2012, the rules tighten for submitting quality data. Although providers are allowed to report quality data to the Centers for Medicare and Medicaid Services (CMS) through attestation in stage 1, data must be reported directly through certified EHR technology in stage 2.

"For clinical quality reporting to become routine, the administrative burden of reporting must be reduced," CMS said. That goal can be achieved "by using certified EHR technology to report information on clinical quality measures electronically to a health information network, a state, CMS, or a registry."

The American Medical Association responded cautiously to the proposed regulations. "We want physicians in all practice sizes and specialties to be able to take advantage of the stimulus incentives and adopt new technologies that can improve patient care and physician workflow," Dr. Steven Stack, a member of the association's board of directors, said in a statement. "We have provided ongoing input this year on standards for the use of EHRs and have stressed the importance of realistic timeframes for adoption, the removal of extraneous requirements that would delay successful adoption, and reasonable reporting requirements."

The Medical Group Management Association (MGMA), however, maintained that the proposed criteria "are overly complex and … medical groups will confront significant challenges trying to meet the program requirements." In a statement, the group cited among its objections "unreasonable thresholds" for some criteria, including CPOE and electronic claims submission, "potentially difficult meaningful use attestation after the first year," and a requirement that physician offices provide patients and others with electronic copies of medical records.

"We were pleased to see that the CMS and ONC rules include some flexibility, especially in the areas of escalating stages of meaningful use requirements, straightforward first-year attestation, and reasonable 90-day reporting windows," said MGMA president and CEO Dr. William Jessee. "However, we firmly believe that the government should make additional changes to achieve widespread adoption by professionals in all types of clinical settings." ■

For more information on the proposed regulations, go to www.cms.hhs.gov/Recovery/11_HealthIT.asp.

HITECH Rules Pose a Challenge

MY TAKE

The passage of the HITECH legislation created a monumental task for Dr. Blumenthal and the Office of the National Coordinator, who have done an excellent job in responding to the challenge of defining "meaningful use" of electronic health information systems.

The rules spell out a phased set of requirements that build upon the work of the preceding advisory process. And the financial incentives that Congress put in place are especially notable for all internists who care for patients in a fee-for-service setting.

However—and this is a big however—lawmakers and many within the bureaucracy still may not fully realize what an enormous hurdle practitioners must overcome in trying to go from paper to electronic records. Also, the voices of those concerned with privacy issues have yet to be fully heard. Even the multiyear approach laid out in the rules may be unreasonably ambitious.

ALAN R. NELSON, M.D., *is a member of the* INTERNAL MEDICINE NEWS *Editorial Advisory Board. He reports no conflicts of interest.*

Negative Pressure Wound Therapy Tied to Complications

BY ROBERT FINN

The Food and Drug Administration has warned clinicians and patients to be vigilant for potentially life-threatening complications with the use of negative-pressure wound-therapy devices.

The agency issued the notification after receiving reports of 6 deaths and 77 injuries associated with NPWT devices. "Most of the deaths reported to FDA occurred at home or in a long-term care facility," the FDA said.

Bleeding was the most serious complication; it was involved in 6 deaths and 17 injuries. Infections, which played a role in 27 reports, arose from the original open wound or dressing pieces retained in the wound. Overall, 32 injuries involved retention of foam dressing pieces; most of those patients required surgical procedures, wound debridement, and treatment of wound dehiscence, as well as additional hospitalization and antibiotic therapy.

The FDA notice listed wound types and conditions for which NPWT is contraindicated, as well as risk factors that should be considered before NPWT is used. (See boxes.)

NPWT is still useful "in the appropriate wounds and in the appropriate areas," said Dr. Paul Y. Takahashi, an internist and expert in wound care at the Mayo Clinic, Rochester, Minn.

The device is FDA approved and "can help, particularly with preventing amputations. It can help in some situations in which a flap or a skin graft is not appropriate. And it certainly can still be beneficial for wounds that are not healing," he said in an interview. But "you really have to be well trained in using the negative pressure device, and when you remove it … make sure it's well observed, make sure things are healing in nicely and that you're not having excess bleeding."

Unlike standard wound dressings, which are changed at least daily, NPWT dressings may not be changed for 3 or 4 days, so complications can go unnoticed in NPWT-treated wounds, he noted.

Staff and patients should be alert for certain problem signs, Dr. Takahashi said. The edges of the wound should remain pink. It's time to become concerned when the edges start turning red or the area becomes painful. Other concerning symptoms include fevers, chills, and changes in blood pressure. ■

A patient handout and a link to the notification is at www.fda.gov/ForConsumers/ConsumerUpdates/ucm193277.htm.

Risk Factors Relevant to NPWT Use

► Patients at high risk for bleeding and hemorrhage

► Patients on anticoagulants or platelet-aggregation inhibitors

► Patients with:
- Friable vessels and infected blood vessels
- Vascular anastomosis
- Infected wounds
- Osteomyelitis
- Exposed organs, vessels, nerves, tendon, and ligaments
- Sharp edges in the wound (e.g., bone fragments)
- Spinal cord injury (stimulation of sympathetic nervous system)
- Enteric fistulas

► Patients requiring:
- MRI
- Hyperbaric chamber
- Defibrillation

► Patient size and weight

► Use near vagus nerve (bradycardia)

► Application of circumferential dressing

► Mode of therapy—intermittent versus continuous negative pressure

Source: Food and Drug Administration

Contraindications For NPWT

Necrotic tissue with eschar present

Untreated osteomyelitis

Nonenteric and unexplored fistulas

Malignancy in the wound

Exposed vasculature

Exposed nerves

Exposed anastomotic site

Exposed organs

Source: Food and Drug Administration