

COMMENTARY

Meaningful Use Criteria: What's Missing?

BY CHRISTOPHER NOTTE, M.D., AND NEIL SKOLNIK, M.D.

Since the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act in February 2009, there has been a tremendous amount of discussion about the idea of “meaningful use.” Associated with the meaningful use criteria are financial incentives for those who adopt an electronic health record and care for Medicare and Medicaid patients. Such incentives might total more than \$40,000-\$60,000 per provider. Those who fail to meet the criteria will find their reimbursements reduced beginning in 2016.

Despite the abundance of commentary and speculation over meaningful use, until recently the term had not actually been defined. And now that the full set of rules for meaningful use is available, it might surprise some to know what has actually been excluded from the criteria.

In explaining the meaningful use concept at the beginning of this year, the U.S. Department of Health and Human Services laid out several objectives and priorities centered on improving the quality, safety, efficiency, and accessibility of care. Any aspects of electronic health record (EHR) implementation that do not meet those goals have been specifically left out of the criteria. In doing so, the intent is to challenge health

care providers to move forward toward the goal of EHR implementation, while acknowledging the limitations of the technology currently available.

The first and most fascinating exclusion is any requirement for encounter note generation. While most EHR products emphasize electronic note generation, the authors do not think this provides a significant benefit over handwritten charting in meeting the goals of HITECH (Federal Register 2010;75:1843-2010). Still, it might be difficult to implement an EHR without this piece, as once an office becomes dependent on the technology, workflow can be significantly hindered by searching for documentation that is not in the electronic record.

To address this, some practices have chosen to scan in handwritten notes. Unfortunately, this might preclude critical data points from being captured by the system, and make it impossible to meet some of the quality reporting goals laid out elsewhere in HITECH.

A second intentional omission in the criteria is the requirement that providers make educational resources available to patients. Although the authors admit that proper information and education are critical, they are reluctant to make this a necessity, saying “there is currently a paucity of knowledge resources that are integrated within EHRs, that are widely available, and that meet [our] cri-

teria, particularly in multiple languages.”

As it turns out, many EHR products do include integrated patient education resources, but these often are limited in quality and come at an additional fee. As an alternative, online resources available through Web sites such as familydoctor.org and emedicine.com provide numerous educational tools that are free and peer reviewed.

Another anticipated requirement that's been excluded from the criteria is the necessity for orders to be transmitted electronically from care provider to testing, diagnostic imaging, or treatment facilities. It should be noted that Computerized Physician Order Entry (CPOE) is greatly emphasized under HITECH, with the objective that 80% of orders be entered through the EHR.

CPOE is defined as “the provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.” But in the criteria released so far, the requirements “will not include the electronic transmittal of [those orders] to the pharmacy, laboratory, or diagnostic imaging center.” Seemingly contrary to this, the guidelines do require e-prescribing to meet criteria, so further clarification is needed to determine which orders must be sent electronically and which do not.

A review of these exclusions makes it apparent that no one is completely sure how the meaningful use criteria will affect the day-to-day practice of medicine. But with the lofty goals of improving the quality and accessibility of care, the authors of the legislation have attempted to challenge the status quo and yet maintain a practical perspective on what is possible with the resources at hand. Many physicians will remain skeptical of any government intervention in health care but can at least now be assured that the financial incentives are attached to a fairly practical set of requirements. ■



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COMMENTARY

The Other Face of ADHD: Inattentive Type

The children most likely to be diagnosed with attention-deficit/hyperactivity disorder are the obvious ones: stir crazy after a bit of time in the waiting room, in trouble at school, and bouncing off the walls at home.

It is children with the other face of ADHD—technically diagnosed as ADHD, predominantly inattentive type—who might be silently impaired and flying below the radar in your office and at school.

They are often diagnosed at older ages than children with ADHD predominantly characterized by hyperactivity and impulsivity, largely because their symptoms make them easy to overlook at school.

They don't get sent to the office, but might bring home report cards that seemingly fail to reflect their intelligence. Their work remains unfinished, and they seldom know the answer when called on in class. Yet if neuropsychological testing were performed, they would be likely to test in the normal range.

Research suggests that inattentive children might have an entirely separate diagnosis from those who better fit the official ADHD title, which incorporates “hyperactivity”—a feature they might not exhibit at all.

The likelihood of comorbid learning disorders is much higher in children with inattentive-type ADHD than with classically hyperactive children with ADHD—as high as 70% in some studies.

Among the third of children who “outgrow” ADHD, few are of the inattentive type, suggesting that the un-

derlying neuroprocessing deficits in these children are more fixed.

The differential diagnosis for inattentive-type ADHD is broad and complex, akin to headache. Within it are physical problems, social stresses, and a variety of closely linked disorders that might be present as well, or masquerading as ADHD. The physician must consider each of these, then refer a child with suspected inattentive-type ADHD for neuropsychological testing to sort out subtleties within the processing and cognitive realms.

I begin with targeted hearing and vision screening because a child who cannot see the blackboard or hear the teacher is absolutely going to tune out. Next is the possibility—although unlikely—of absence (petit mal) seizures, which can look like inattention and have been known to persist

for months without being diagnosed. Social preoccupation is the next major consideration on my list. Maybe the child isn't paying attention in school because she is thinking about her alcoholic father, depressed mother, sexual abuse, or consequences of misbehavior.

Language issues might complicate the diagnosis and may coexist with inattentive-type ADHD. If these are suspected, a referral to a speech and language specialist is critical. Cognitive ability might need to be formally tested as well. Perhaps the child is not inattentive, but simply does not have the intelligence to keep up in school as the material grows ever more complex.

Far and away, the most common missed diagnosis and frequent bedfellow of inattentive-type ADHD is anxiety. Although it feels like our practices are filled with children with ADHD, anxiety is a more common pediatric disorder. It is present in 12%-13% of the patients we see, compared with 4%-12% with ADHD. Anxiety is heritable and highly treatable, but may be interwoven with other disorders and difficult to tease out.

When I see combined anxiety/ADHD, inattentive type, I might treat the ADHD first, simply because response to stimulants is quicker and might enable a more comprehensive approach to the child's anxiety.

Keep in mind that medication management of ADHD children with predominantly inattentive type is somewhat different from the standard regimens for children with hyperactivity and impulsivity. The stimulant family is still often used first, but the most efficacious dose might be lower and trickier to spot, and initial choices should be the least anxiety-provoking medications. Some clinicians prefer with this population to try extended-release atomoxetine (Strattera).

With these children, I start low and go slow, getting frequent, objective feedback from parents and teachers to try to stop within a narrow window of maximum efficacy for inattention. ■

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