Understanding the "Meaningful Use" Regulations

July 2010 Update based on CMS' Final Rule

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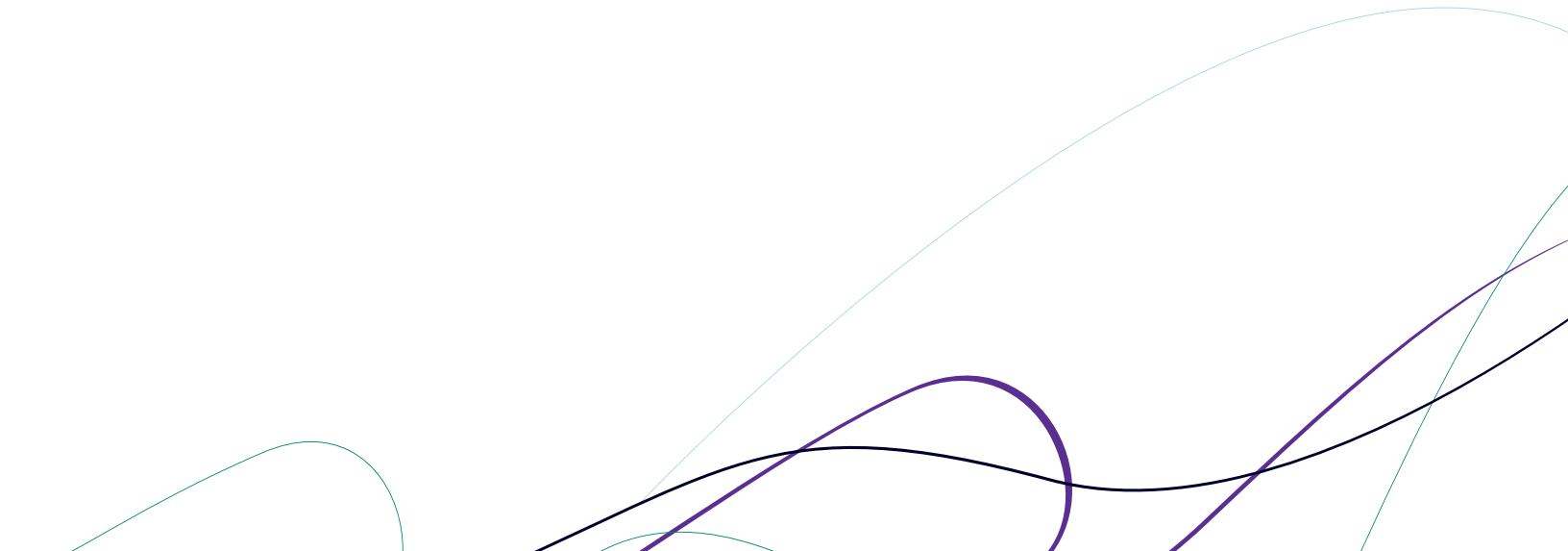

Understanding the "Meaningful Use" Regulations

By Elizabeth W. Woodcock, MBA, FACMPE, CPC

This white paper informs the reader about the federal government's final proposed criteria for "meaningful use" of electronic health records (EHR) systems in order to qualify for Medicare and Medicaid reimbursement bonuses starting in 2011. Focusing exclusively on how the proposed criteria apply to eligible professionals, including physicians, this paper also provides physicians and practice executives with a framework for understanding the goals of the EHR incentive program and preparing to meet its objectives.

In February 2009, Congress passed, and President Obama signed into law, landmark legislation to encourage the adoption of electronic health records (EHRs). Part of the multi-billion dollar package known as the American Recovery and Reinvestment Act (ARRA), the Health Information Technology for Economic and Clinical Health (HITECH Act) allocates $19 billion to encourage the health care industry to adopt information technology. The funds — aimed at improving the quality, efficiency and safety of the nation's health — are available in the form of bonus payments to qualifying physicians and hospitals.

Although the government has attempted to encourage the use of EHRs for nearly two decades, implementation has been limited at best. Research studies vary greatly on the percent of physicians who use EHRs. As many studies have been based on small samples, a large, representative national sample of U.S. physicians in 2008 may provide the most reliable finding: just four percent of private practice-based physicians reported having a fully functional EHR system and 13 percent reported having a "basic system."[1]

The HITECH Act intends to put an end to the industry's resistance to embrace information technology. It authorizes incentive payments of up to $63,750 to physicians who implement an EHR system.

Like any government program where the "prize" is a payment, there's a catch. The government requires physicians to actually adopt technology; that is, they must move beyond purchasing and even implementing an EHR. Physicians must prove that they have put the system to "meaningful use" in their practices. Of course, such "meaningful use" is indeed defined by the government. Those who fail to comply within the projected timeframe face penalties in the form of reduced Medicare payments.

The Final Rule for the Medicare and Medicaid Programs; Electronic Health Record Incentive Program, released July 13, 2010 by the Centers for Medicare and Medicaid Services (CMS), outlines the final set of standards, specifications for implementation and criteria for EHR "meaningful use".[2]

A closely related Final Rule issued on the same day by the Office of the National Coordinator for Healthcare Information Technology (ONC) describes the standards, implementation specifications, and certification criteria and process for EHR systems.[3] The ONC's certification standards are designed to support CMS's meaningful use criteria.

Examining the CMS rule in detail reveals the essential objectives and criteria for the regulation's goal of "meaningful use" and how physicians must demonstrate that use in order to participate in the EHR incentive program. The CMS rule also describes the processes by which physicians are expected to demonstrate meaningful use, the timing of the implementation and phase-out of the incentive bonus programs, and other requirements that were broadly outlined in the HITECH Act.

The final set of standards published by CMS can serve as a map for those who wish obtain the "prize" promised for successful participation in the EHR incentive program — and avoid the payment penalties imposed on those who choose not to.

An Overview of the HITECH Act

Objectives

The HITECH Act lists three broad objectives:

- Physicians use certified EHR technology in a meaningful manner, including electronic prescribing;
- Systems they use must have the capability to provide electronic exchange of health information to improve the quality of care; and
- Providers must submit information clinical quality and other measures as defined by the Secretary of HHS.

The HITECH Act assigned responsibility for developing details of these objectives to CMS. The task of creating criteria to certify the EHR systems on which physicians and hospitals would carry out the objectives was assigned to the ONC.

The Act outlines the federal government's financial support for health care industry efforts to improve the use of information technology. Of particular interest to physicians are the bonuses for "using certified EHR technology in a meaningful manner…."[4]

Eligible Professionals

Available through Medicare and Medicaid, the HITECH Act established two incentive payment programs for the healthcare industry. Eligible professionals, the focus of

Exhibit One: Medicare EHR Bonus Schedule

Year	2011	2012	2013	2014	2015	2016	Total
2011	$18,000	$12,000	$8,000	$4,000	$2,000	$ -	$44,000
2012	$ -	$18,000	$12,000	$8,000	$4,000	$2,000	$44,000
2013	$ -	$ -	$15,000	$12,000	$8,000	$4,000	$39,000
2014	$ -	$ -	$ -	$12,000	$8,000	$4,000	$24,000
2015	$ -	$ -	$ -	$ -	$ -	$ -	$ -

this white paper, and eligible hospitals can participate in either program, although under different rules and requirements.

For the Medicare program, "eligible professionals" — or "EPs" — are defined as doctors of medicine or osteopathy; doctors of dental surgery or dental medicine; doctors of podiatric medicine; doctors of optometry; and doctors of chiropractic medicine.

Eligible professionals for the Medicaid program include physicians, dentists, certified nurse midwives, nurse practitioners and physician assistants who are practicing in federally qualified health centers (FQHCs) or rural health clinics (RHCs) led by a physician assistant.

For either program, eligible professionals may not be hospital-based, which is discussed in more detail below. Eligible professionals who do not participate with the Medicaid or Medicare programs are not eligible for the bonus program's funds.

In this white paper, the term "physician" is used interchangeably with eligible professional unless a specific exception or requirement of one type of professional is to be described.

Incentive Bonuses

Physicians receiving payment for treating Medicare patients can receive up to $44,000 payable over a five-year period (See Exhibit One: Medicare EHR Bonus Schedule.) The payments to those eligible are linked to 75 percent of the physician's annual allowed charges from Medicare, up to the maximum annual bonus. A physician seeking to qualify for the maximum $18,000 bonus in 2011, for example, must bill $24,000 in allowed charges for services to Medicare beneficiaries during that year. Eligible professionals treating Medicaid patients would receive up to $63,750, capped at 85 percent of the government's evaluation of current market cost for the implemented (and meaningfully used) EHR system, and payable over a six-year period. Physicians and other eligible professionals may select to participate in only one of the bonus programs.

Physicians who choose not to participate or who cannot meet the objectives will receive a one percent reduction in their Medicare allowed charges, beginning in 2015. This reduction will increase by one percent each subsequent year, up to a maximum of five percent, after which the penalty will become permanent subject to the discretion of the Secretary of Health and Human Services. (See Exhibit Two: Medicare Reimbursement Penalties for Non-Participation). Physicians who are excluded from participation — hospital-based physicians, for example — are not subject to the reimbursement reductions that commence in 2015. Notably, there are no such penalties associated with the Medicaid program.

Exhibit Two: Medicare Reimbursement Penalties for Non-Participation

Year	Penalty
2015	1%
2016	2%
2017	3%
Beyond	<5%

The Stages of Meaningful Use

CMS will implement its meaningful use criteria in a three-stage process. (See Exhibit Three: Stages of Meaningful Use Criteria by Payment Year.) The Final Rule describes the initial stage, which covers the first two years of the program (2011 and 2012). Important to those wishing to ensure they meet the goals of this first set of regulations are the objectives of **Stage One**, which CMS clarifies as:

- Electronically capturing health information in a coded format;
- Using that information to track key clinical conditions and communicating that information for care coordination purposes;
- Implementing clinical decision support tools to facilitate disease and medication management; and
- Reporting clinical quality measures and public health information.

Stage One: The Criteria

Understanding the government's policy priorities will help physicians in selecting and adopting EHRs into their practices. To that end, the proposed regulations outline five priorities for health outcomes policy:

1. Improve quality, safety, efficiency, and reducing health disparities;
2. Engage patients and families in their health care;
3. Improve care coordination;
4. Improve population and public health; and
5. Ensure adequate privacy and security protections for personal health information.

Each priority comes with several specific care goals and, in turn, objectives and measures are aligned with each of those goals.

CMS presents 15 objectives, representing actions that meaningful users must take in order to demonstrate meaningful use. In addition to these "core" objectives, physicians must also choose five objectives from a menu of 10 offered by CMS. For the menu-based measures, one of the two public health criteria must be chosen.

Exhibit Three: Stages of Meaningful Use Criteria by Payment Year

	Payment Year				
First Payment Year	**2011**	**2012**	**2013**	**2014**	**2015****
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015*					Stage 3

*Avoids payment adjustments only for EPs in the Medicare EHR Incentive program.
**Stage Three criteria of MU or a subsequent update to the criteria if one is established through rulemaking.

CMS is allowing states to propose additional core meaningful use criteria that would be required of physicians to successfully participate in their Medicaid incentive program. For physicians and other eligible professionals participating in the Medicaid program, meaningful use is not required in the initial year of the program; Medicaid physicians can qualify simply by proving that they are in the stage of adopting, implementing or upgrading certified EHR technology.

For each objective, a Stage One measure is outlined to indicate how the physician should plan to report on the use of those capabilities. Each objective and measure is also accompanied by an exemption to which physicians can attest if their scope of practice does not allow them to participate. For example, consider the following selected core objectives, measures and exemptions:

Objective: *Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.*

Measure: *More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.*

Exclusion: *Any EP who writes fewer than 100 prescriptions during the EHR reporting period.*

Objective: *Record and chart changes in vital signs: height, weight, blood pressure; calculate and display BMI; plot and display growth charts for children 2-20 years including BMI.*

Measure: *For more than 50% of all unique patients age 2 or over seen by the EP, height, weight and blood pressure are recorded as structured data.*

Exclusion: *Any EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.*

Exhibit Four: Stage One Criteria for Meaningful Use

core set

Objectives	Measures	Exclusions
Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE	Any EP who writes fewer than 100 prescriptions during the EHR reporting period
Implement drug-drug and drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period	None
Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	Any EP who writes fewer than 100 prescriptions during the EHR reporting period
Record demographics: preferred language, gender, race, ethnicity, date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data	None
Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data	None
Maintain active medication list	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	None
Maintain active medication allergy list	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	None
Record and chart changes in vital signs: height, weight, blood pressure, calculate and display BMI, plot and display growth charts for children 2-20 years including BMI	For more than 50% of all unique patients age 2 or over seen by the EP, height, weight and blood pressure are recorded as structured data	Any EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice
Record smoking status for patients 13 years or older	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded	Any EP who sees no patients 13 years or older
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule	None
Report ambulatory clinical quality measures to CMS or the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of the Final Rule	None
	For 2012, electronically submit the clinical quality measures discussed in section II(A)(3) of the Final Rule	None
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request	More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period
Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	Any EP who has no office visits during the EHR reporting period
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	None
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) of the Final Rule and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	None

Objectives	Measures	Exclusions
Implement drug-formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period	None
Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab-test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	Any EP who orders no lab tests whose results are either in positive/negative or numeric format during the EHR reporting period
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the EP with a specific condition	None
Send reminders to patients per patient preference for preventive/follow-up care	More than 20% of all unique patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period	Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP	More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information	Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) in the July 13, 2010 Final Rule during the EHR reporting period
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients seen by the EP are provided patient-specific education resources	None
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP	Any EP who was not the recipient of any transitions of care during the EHR reporting period
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals	Any EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period
Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)	Any EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically
Capability to submit electronic sydromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology capacity to submit electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits information have the capacity to receive the information electronically)	Any EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically

Objective: *Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.*

Measure: *More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days.*

Exclusion: *Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.*

(See Exhibit Four: Stage One Criteria for Meaningful Use.)

While the HITECH Act outlined a general requirement for meaningful users to report clinical quality measures, detailed descriptions of the measures are contained in CMS Final Rule. Many of the measures CMS proposes are the same as found in its Physician Quality Reporting Initiative but CMS adds flexibility to the requirements in the Final Rule. Eligible professionals must report on six total measures: three required core measures (but may substitute alternate core measures where necessary, such as the measure does not apply to their specialty). They also must report three additional measures that they may select from a list CMS provides. The core measures include:

- Blood pressure management;
- Tobacco use assessment and cessation intervention; and
- Adult weight screening and follow-up.
- Preventative care and screening for tobacco use and intervention; and
- Adult weight screening and follow-up.

CMS decided to drop its proposed specialty measure focus, instead allowing physicians to choose which optional criteria apply to the scope of their practice — and, if applicable, exempt themselves from the core criteria if the measurements do not pertain to them.

What's important to recognize is that while physicians have some choices and flexibility for the meaningful use criteria they will pursue during Stage One, the criteria they defer during this initial stage are likely to be required at a later Stage to remain eligible for payments. It's also important to understand that about 70 percent of the payments available to eligible physicians in the Medicare incentive program are earned during Stage One. Physicians may choose to opt out for part or all of the incentive program's duration, but while participating they must meet all of the criteria in order to receive the incentive payment; that is, there is no graduated scale for meeting less than the minimum criteria required at any stage of the program.

Subsequent Stages

Stage Two is intended to migrate users from Stage One's less rigorous actions of capturing and sharing data to executing advanced care processes with decision support. The requirements to meet this higher level of use will be proposed by the end of 2011 and commence in time for the 2013 payment year. CMS anticipates that its Stage Three definitions will be proposed by the end of 2013 in time for the 2015 payment year. These timeframes are expected to allow physicians to anticipate the additional actions they must take to continue receiving incentive payments.

Many months will pass before Stage Two criteria are officially released for public comment. For a smoother and more informed route to EHR purchase, and implementation adoption, it is worth considering the hints CMS has already given about Stage Two requirements — those requirements which must eventually be adopted to remain a meaningful user and receive subsequent incentive payments.

Stage Two would expand upon the Stage One criteria in the areas of disease management, 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 Three would focus on achieving improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data, and improving population health outcomes.

Proving Meaningful Use

In the NPRM preceding the Final Rule, CMS revealed its inability to electronically accept data from EHRs in time for the 2011 payment year. Therefore, it plans to allow "attestation" through a web-based portal rather than electronic submission of data to prove compliance with the program during in its inaugural year. The agency explained in the Final Rule that it was developing an audit strategy to "ameliorate and address" the risk of fraud and abuse in attestation. Electronic attestation is expected to begin in 2012.

The Final Rule leaves the door open for states to require different eligibility reporting for the Medicaid incentive program if they choose to establish the same or more

stringent requirements. Understanding the criteria for the state in which a physician practices (or, in the event that physicians treat patients from more than one state, then the state with which they choose to align), in the case of participating in the Medicaid incentive program, will be essential.

Getting Paid

In the announced Final Rule, CMS asserts that during the initial year of the program, it will release the incentive funds — $18,000 for Medicare, for example — after a physician has proven to have met the meaningful use criteria over a consecutive 90-day period during that calendar year. For example, physicians who begin using a certified EHR by January 1, 2011, could file their attestation of their meaningful use of a certified system in April 2011 and CMS payments would begin. The physician will still have to wait until allowed charges of $24,000 have been billed to Medicare to obtain the maximum of $18,000 ($24,000, multiplied by the required 75 percent threshold). But the good news is that some physicians may qualify to receive their first incentive checks soon after the conclusion of the first quarter of 2011, and the even better news for many is that physicians can wait until October 1, 2011 to report and still qualify for that year's bonus payment.

The incentives will be paid in single, consolidated annual payments. They will be made to physicians on a rolling basis as soon as they demonstrate meaningful use for the reporting period (after 90 consecutive days in the first year, and after the calendar year in subsequent years). Depending on the incentive program in which the physician participates, the incentive payments will come via a Medicare carrier or state Medicaid program.

It is important to note that physicians can only obtain incentives from one of the programs, even if they qualify for both. Fortunately, CMS confirmed that physicians can transfer — once, and only once — from the Medicaid to the Medicare incentive program — or vice versa.

For physicians seeking incentives through Medicaid, eligibility requires a minimum of 30 percent of patient encounters attributable to Medicaid over any representative, continuous 90-day period in the most recent calendar year prior to reporting. Medicaid physicians can qualify for the initial year's bonus payment by adopting, implementing or upgrading certified EHR technology, but not necessarily becoming a meaningful user. In following years they, too, will need to demonstrate meaningful use in order to qualify.

With more than a quarter of Medicare physicians now receiving bonus payments through the program's Physician Quality Reporting Initiative (PQRI), it is logical to ask if one could continue to participate in that program while also gaining an EHR incentive bonus. Fortunately, the answer from CMS is "yes." In fact, it is likely that participation with PQRI has better prepared those physicians for the coming regime of EHR use and reporting. As for another Medicare incentive program, ePrescribing, physicians who are eligible for the Medicare program will not be able to access the bonuses from ePrescribing in addition to EHR incentive bonuses, however, CMS will allow participants in the Medicaid program to remain eligible.

Hospital-Based Physicians

The HITECH Act provides a separate program of EHR incentive bonuses to hospitals. Because the technology deployed by hospitals is made available to physicians who perform most of their work there, argues CMS, the incentive program for eligible professionals excludes these "hospital-based" physicians as a way to prevent potential "double-dipping" of the incentives.

For the purposes of these regulations, CMS defines hospital-based physicians as those who furnish "substantially all" — defined in the proposed regulations, and confirmed in the Final Rule, as at least 90 percent of their services (not charges) in a hospital setting. Specifically, CMS will use the place-of-service codes on physician claims — 21 (inpatient hospital) and 23 (emergency room; hospital) — to determine whether physicians furnish substantially all of their professional services in a hospital setting and are, therefore, hospital-based. Based on this definition, CMS estimates that approximately 14 of percent of physicians will be excluded from the EHR incentive program.

Take Action

With less than six months before the initial year of the EHR incentive program, physicians have little time to begin a thoughtful and thorough process of reviewing their options. The time to begin the process is now.

Those who have not yet purchased an EHR should develop a plan to complete the following actions:

- Assemble a team of staff and physicians to develop purchase goals;
- Define useful qualities;
- Select a list of vendors to approach;
- Write and disseminate a request for proposal (RFP); and
- Commit to reviewing prospective EHR systems by assessing RFP responses, product demonstrations and references from practices similar to theirs.

(See Exhibit Five: Timeline to Implement an EHR.)

Those who already own an EHR should look carefully at the objectives and measures CMS will require for qualifying as a meaningful user. *(See Exhibit Six: Eight Steps to Become a Meaningful User.)*

Although the government has defined meaningful use for the industry, it's up to each of you to make it meaningful for you — and your patients.

Exhibit Five: Timeline to Implement an EHR

Day 0 to 30:

Gather a Team and Develop Criteria for Selection

Day 30 to 60:

Develop and Send a RFP to Vendors

Day 60 to 90:

Await Responses; Hold Discussions about Impact on Billing, Workflow and other aspects of the Practice

Day 90 to 120:

Receive RFPs, Compile Results

Day 120 to 150:

Choose Top 3 to 5 Vendors; Develop Specific Selection Criteria

Day 150:

Contact Vendors to Schedule Demonstration

Day 150 to 210:

Watch Demonstration; Grade each Vendor based on Selection Criteria; Check References; Hold Internal Discussions

Day 210 to 240:

Decide; Gather Information about Financing Options

Day 240 to 270:

Purchase; Discuss Conversion Logistics; Decide on Implementation Date

Day 270 to 330:

Implement; Comply with MU Criteria

Exhibit Six: Eight Steps to Become a Meaningful User

1. Form EHR payment program committee.
2. Assemble resources and educational material about the HITECH Act for committee members' background reading and review.
3. Carefully read and evaluate published tables, focusing on the 25 "core" and "menu" objectives and measures, 15 of which are required, and five additional ones to choose from, as presented in Exhibit Four.
4. Divide criteria into (a) implemented; (b) system capable, but not implemented and (c) system not capable.
5. Based on current capabilities and employed processes, establish a timeframe and goals for meaningful use compliance.
6. One-by-one, with involvement of key stakeholders, begin steps to implement "system capable, but not implemented."
7. Assign responsibility to commence internal and external discussions, with vendors and stakeholders, regarding the expansion of system capability(ies).
8. Establish, in writing, specific timeframes, action steps and responsible party(ies); meet, review and update monthly to identify progress based on goal of compliance.

1 DesRoches CM, Campbell EG, Rao SR. “Electronic Health Records in Ambulatory Care — A National Survey of Physicians” NEJM Vol. 359:50-60. July 3, 2008. Accessed January 13, 2009, at http://content.nejm.org/cgi/content/full/NEJMsa0802005

2 Centers for Medicare and Medicaid Services; Medicare and Medicaid Programs, Electronic Health Record Incentive Program. Final Rule. Released July 13, 2010. Accessed July 20, 2010, at http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf

3 Health Information Technology: Initial Set of Standards, Implementation, Specifications, and Certification Criteria for Electronic Health Record Technology. Final Rule. Released July 13, 2010. Accessed July 20, 2010, at http://edocket.access.gpo.gov/2010/pdf/2010-17210.pdf

4 H.R. 1., 111th Cong., 1st sess., Title IV—Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions. Section 4101, “Incentives for Eligible Professionals”, p. 356, Paragraph (i) “Meaningful Use of Certified EHR Technology.” Accessed January 13, 2010, at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf

5 Pediatricians may qualify with 20 percent Medicaid volume; Rural Health Clinics and Federally Qualified Health Centers may qualify with 30 percent “needy individuals”.

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