Meaningful Use for Surgeons—It's Not as Complicated as You Think

Cheryl Toth, MBA

It's spring. Have you started your Meaningful Use reporting yet? More important, have you begun reporting at all?

"Say the words *Meaningful Use* to most orthopedists, and they usually roll their eyes or shake their heads," says Cheyenne Brinson, MBA, CPA, a KarenZupko & Associates consultant who has been advising surgical practices on Meaningful Use since the program's inception. Although many orthopedists are successfully using certified electronic health records (EHRs) to e-prescribe and enter radiology and laboratory orders, Brinson says many other requirements are misunderstood and perceived as overly complex. In many cases, practices are doing more work than they need to in order to attest.

"It's actually not that complicated to meet Meaningful Use requirements," she says. "The trick is to zero in on what's relevant only for *surgeons*. This isn't crystal clear in the CMS [Centers for Medicare & Medicaid Services] documents, and it's not the forte of most EHR vendors or trainers either." In fact, in Brinson's experience, most EHR trainers present Meaningful Use to every practice as if it were primary care. Yet, the requirements for surgeons are different for primary care and are, frankly, less involved.

That's good news. Because if you didn't attest for Meaningful Use in 2014, the first year that reporting was required, you're automatically getting dinged 2% on your Medicare payments in 2015. So, it's time to get organized and get moving to avoid further penalties.

Avoid These Four Common *Faux Pas*

Brinson says the Clinical Quality Measures (CQMs) are hands down the most misunderstood component of Meaningful Use. "When I explain Meaningful Use to surgeons, I can't jump up and down and wave my hands in the air enough to call attention to this," she quips.

At issue: There are 64 CQMs, but very few are applicable to surgeons. Yet, many surgeons think they *have to* perform them for Meaningful Use. Not so, says Brinson. "Surgeons have to report a CQM *only if it's clinically relevant*. If none of the CQMs are clinically relevant in your practice, it's okay to report a zero value if you have not actually performed it."

Here's how this plays out. In Stage 2, physicians must report 9 CQMs across 3 domains; Population/Public Health, Patient Safety, and Efficient Use of Healthcare Resources are examples of domains that are most applicable to orthopedists. "If you choose *Low Back Pain: Use of Imaging Studies* as one of these, it's possible an orthopedist would have a numeric value to report," Brinson says. "But if you also choose *Use of High-Risk Medications in the Elderly*, an orthopedist will probably report a zero value. And that's totally acceptable. You will not be penalized for reporting zero."

Another common misconception is around the Vital Signs and Smoking Status measures. "We have worked with surgical practices that think Meaningful Use is *requiring* them to collect vital signs and smoking status at every visit, even though they may not be clinically relevant," says Brinson. Again, not true.

"Height and/or weight and blood pressure, as well as smoking status measures, need to be reported only once per patient during the reporting period," Brinson clarifies. "So from a practical standpoint, most orthopedic practices can collect this data from new patients and then again as clinically necessary," adding there are even exclusions for physicians who attest that either height and weight and/or blood pressure has no relevance to their scope of practice at all.

Brinson also sees practices do more work than they need to when it comes to *Patient Care Reminders*. She recently worked with a surgery practice that sent reminders for colonoscopies. "Not exactly clinically relevant," she says, "and an unnecessary step for staff." That's because physicians aren't required to send reminders that aren't relevant to their specialty.

The *Federal Register* states, "An eligible provider (EP) should use clinically relevant information stored within the [EHR] to identify patients who should receive reminders.... The EP is best positioned to decide which information is *clinically relevant* for this purpose."

Cheryl Toth is a health care business and technology writer with KarenZupko & Associates. Ms. Toth is a former practice management advisor and technology executive. She can be reached at ctoth@karenzupko.com. Cheyenne Brinson can be reached at cbrinson@karenzupko.com.

KarenZupko & Associates offers a 30-minute webinar, *Crash Course in Stage 2 Meaningful Use for Surgeons*, in which Brinson leads listeners through the details and provides resources and tools ($49 at karenzupko.com).

Address correspondence to: Cheryl L. Toth, MBA, KarenZupko & Associates, 625 N Michigan Ave, Suite 2225, Chicago, IL 60611 (tel, 312-642-5616; fax, 312-642-5571; e-mail, ctoth@karenzupko.com).

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"In orthopedics, clinically relevant reminders could be for an outside referral, a follow-up on an MRI or other test, or a reminder to schedule a postoperative appointment," Brinson explains. "Work with your EHR vendor to create the reminders that are most appropriate for your patient base."

The final *faux pas* that Brinson finds: "Meaningful Use requires you to report data for *all patients*, not just Medicare patients. That seems to be a point of confusion for many."

Three Cheers for the Patient Portal Requirement

Stage 2 saw the addition of the *Patient Portal Requirement*, and Brinson suggests that the benefits of this tool go far beyond Meaningful Use. "Patient portals are essential to a modern practice," she says. "Patients use them to complete a health history prior to their appointment, pay their bill, schedule follow-up appointments, and more." Further, the patient portal facilitates another Meaningful Use Stage 2 requirement: secure electronic messaging with patients. For both Meaningful Use and risk management, moving away from e-mail and texting and toward secure/encrypted messaging is a must. The patient portal has this feature already built in, and all messages are stored securely and archived—which meets the HIPAA (Health Insurance Portability and Accountability Act) Omnibus requirements, too.

So if you've implemented a patient portal, that's good for your practice and your patients on many levels. But there is a caveat about meeting the Meaningful Use requirement. "For this requirement, 5% of the unique patients seen during the reporting period must 'view, download, or transmit to a third party their health information,'" Brinson explains. "So the onus is on your practice to 'sell' the benefits of the patient portal and get patients to use it so you can achieve the 5% threshold."

Clinical Decision Support and Summaries

The requirements of *Clinical Decision Support Interventions* and *Clinical Summaries* may seem daunting, but, if you think beyond Meaningful Use for a moment, both facilitate better care.

Take Clinical Decision Support Interventions. What would be helpful for you to know about a patient before surgery? What information would enable you to deliver better care?

"One surgeon told me that a family history of malignant hyperthermia would mean the difference between performing the case in the operating room versus the ambulatory surgery center," Brinson says. "This is a good example of an intervention that a surgeon would work with their EHR vendor to set up."

The objective states that each intervention is to be an evidence-based decision-support intervention based on each one and at least one combination of the following data: problem list, medication list, medication allergy list, demographics, laboratory tests and values/results, and vital signs. "Stage 1 requires physicians to implement 1 Clinical Decision Support Intervention, and Stage 2 requires 5," reminds Brinson.

And here's all you need to know about Clinical Summaries. Although there are 20 specific required elements of a clinical summary, physicians themselves need to provide details only for clinical instructions and the care plan, including goals and instructions. Ancillary staff can populate the other elements.

Brinson points out that surgeons are *not* expected to provide a copy of the patient's note, or to complete the note, before the patient checks out. The requirement under Stage 2 is that the clinical summary is provided to the patient within 1 business day. "From a practical standpoint, practices can print the clinical summary for patients at checkout. A well-done clinical summary is a practice efficiency tool as much as a clinical document. It can reduce phone calls from patients asking, 'Now what did the doctor tell me to do?'"

Often Overlooked

There are requirements that, Brinson says, surgeons often gloss over: *Protect Electronic Health Information* and *Text-Searchable Progress Notes*.

"Stage 2 requires physicians to conduct a privacy risk analysis to protect electronic health information," she explains. "Most EHR vendors don't offer this as part of their product, so it's frequently overlooked." Such an analysis typically requires an outside vendor, but there are free, do-it-yourself tools available, such as the Privacy and Security Toolkit for Small Provider Organizations,* from the Healthcare Information and Management Systems Society (HIMSS).

The analysis should follow HIPAA guidelines, and the most intensive part of this requirement is to conduct or review a privacy risk analysis of the clinical technology. "You've also got to address data encryption and security in the EHR, and ensure HIPAA policies and procedures are in place," Brinson states.

Text-Searchable Progress Notes are also a new requirement in Stage 2. All progress notes must be text searchable—practices can no longer include progress notes as scanned attachments. "That means no more PDFs," Brinson says. "Surgeons can still dictate, but the dictation must be entered into the EHR in such a way that it's searchable. In Stage 2, 30% of unique patients must have a minimum of 1 text-searchable electronic progress note created, edited, and signed in the EHR."

Conclusion

Meaningful Use does not have to be cumbersome. Focus on what surgical practices need to know, and attestation won't be as complicated as you think.

*http://www.himss.org/library/healthcare-privacy-security/small-provider-toolkit?navItemNumber=16493.