Go! Knowledge Activity: Meaningful Use and the Hospital EHR

Discipline applications

This activity has been developed as an introduction to Meaningful Use and its application in the electronic health record. The focus is on the relevance of Meaningful Use to members of the healthcare team in the hospital setting. Using a chart in the EHR the student will compare the chart to the Core Objectives for Hospital Measures. This will expose students to not only the policy and attestation requirements of Meaningful Use but also the applicable features to everyday practice. The student will need to use additional resources to complete the activity. These resources may include chart resources, videos, textbooks and/or online websites.

Learning objectives

1. **Define** key terms and concepts related to meaningful use.
2. **Compare** a patient chart in the EHR to the Core Objectives for Hospital Measures.
3. **Explain** the importance of core objectives to the healthcare team.
4. **Apply** critical thinking skills to explain challenges with implementing meaningful use.
5. **Apply** current knowledge of electronic health records and appropriate, accurate documentation.

Pre-requisites

1. Complete the activities:
   a. Go! EHR Orientation
2. Go to the HealthIT.gov website to read about meaningful use.
   [http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives](http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives)

Student instructions

1. If you have questions about this activity, please contact your instructor for assistance.
2. You will review the chart of *Gwen Cummings* to complete this activity. Your instructor has provided you with a link to the *Meaningful Use & the Hospital*
**EHR** activity. Click on **Launch EHR** to review the patient chart and begin this activity.

3. Refer to the patient chart and any suggested resources to complete this activity.
4. Complete the pre-requisites.
5. Document your answers directly on this document as you complete the activity. When you are finished, you will save the document and upload it to your Learning Management System (LMS).

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**Glossary**

**Attestation:** In a health information technology (HIT) context, is a process that documents that an organization or individual has successfully demonstrated meaningful use and is successfully fulfilling the requirements for electronic health records (EHR) and related technology.

**Clinical Decision Support (CDS):** Is defined as a process for enhancing health-related decisions and actions with pertinent clinical knowledge and patient information to improve healthcare delivery. In the EHR clinical decision support includes alerts, reminders and documentation templates aimed to improve clinical processes and outcomes. For the purposes of Meaningful Use clinical decision support builds upon the foundation of an EHR to provide healthcare providers with information to enhance health and health care.

**Clinical quality measures (CQMs):** Are tools that help measure and track the quality of health care services provided by eligible professionals, eligible hospitals and critical access hospitals (CAHs) within our health care system.

**Computerized physician order entry (CPOE):** Is the process of a medical professional entering medication orders, or other physician instructions, electronically instead of on paper charts. A primary benefit of CPOE is that it can help reduce errors related to poor handwriting or transcription of medication orders.

**Immunization registry:** A confidential, population-based, computerized information system that attempts to collect vaccination data about all persons within a geographic area.

**Meaningful Use:** Meaningful use describes the use of health information technology (HIT) that leads to improvements in healthcare and furthers the goals of information exchange among health care professionals.
**Medication Reconciliation:** The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.

**National Quality Strategy (NQS):** NQS guides and assesses local, state, and national efforts to improve health and the quality of health care. NQSs focus more on the patient’s needs. NQS’s address better and more affordable care and healthy people and communities.

1. Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
2. Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
3. Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

**Syndromic surveillance:** The surveillance (collection and analysis) of health data about a clinical syndrome that has a significant impact on public health, which is then used to drive decisions about health policy and health education.

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**The activity**

**Student name: _____________________________**

**Introduction to Meaningful Use**

At the core of the current healthcare reform initiatives, is the incentivized adoption of electronic health records (EHRs). The adoption of EHRs by hospitals and providers will improve the quality of the patient’s care and better manage care costs. EHRs will help hospitals and providers meet clinical and business needs by capturing, storing, and displaying clinical information when and where it is needed. This will improve individual patient care and provide aggregated, cross-patient data analysis. EHRs have the capability to manage the health care data entered by the EHR user. This improves information access and availability enabling both the provider, the health care team and the patient to better manage the patient’s health by applying the capabilities provided in the EHR.

Meaningful use is using certified electronic health record (EHR) technology to:
1. Improve quality, safety, efficiency, and reduce health disparities
2. Engage patients and family
3. Improve care coordination, and population and public health
4. Maintain privacy and security of patient health information

Ultimately, it is hoped that the meaningful use compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

Hospitals and providers have to attest to meaningful use for the following:

- Core objectives and menu objectives – are related to using the EHR to document, track, share, and data mine patient’s health information to improve care delivery, reduce costs, and improve patient outcomes.
- Clinical quality measures – focus on high-priority health conditions and best-practices for delivering care, improving public health and efficient use of healthcare resources.
- National quality standards – focus on improving health and the quality of health.

To better understand the importance of meaningful use as it relates to you, the EHR user and member of the healthcare team, you will perform an audit of a patient chart in Neehr Perfect.

Using the 16 Core Objectives for Hospital Measures (each question below) go through each of the 16 questions below. Using the EHR chart for Gwen Cummings, determine if the electronic health record for Gwen Cummings meets the 16 core objectives. Keep in mind that you are using an educational electronic health record. Some of the objectives will not be applicable, those will be identified below.

### Apply your knowledge

<table>
<thead>
<tr>
<th>Core Objective</th>
<th>Question</th>
<th>Your answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional.</td>
<td>Is CPOE part of the Neehr Perfect EHR? Explain your answer.</td>
<td>Yes, because it lets you type orders in through the computer system to avoid errors from poor handwriting.</td>
</tr>
<tr>
<td></td>
<td><strong>Record demographic information (preferred language, sex, race, ethnicity, date of birth, date and preliminary cause of death).</strong></td>
<td>Does Neehr Perfect have a place to record demographic information? Explain your answer.</td>
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<tr>
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</tr>
<tr>
<td>2</td>
<td><strong>Record and chart changes in vital signs (VS, Ht, Wt, BMI, growth charts).</strong></td>
<td>Does Neehr Perfect have a place for the user to document vital signs? Explain your answer.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Record smoking status for patients 13 years old or older.</strong></td>
<td>Does Neehr Perfect have a place specific for documenting smoking status? Explain your answer.</td>
</tr>
</tbody>
</table>
| 4 | **Use clinical decision support to improve performance on high-priority health conditions.**  
*An example of clinical decision support is smoking cessation:* “All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. The guidelines recommend that physicians advise all tobacco users identified during screening to seriously consider making an attempt to quit and that advice should be "clear," "strong," and "personalized". Physicians should assess the patient’s willingness to quit through a discussion of the health benefits of quitting, self-help materials, and referral to community groups. Patients who do not wish to quit should receive motivational interventions (e.g., the 5 R's: relevance, risks, rewards, roadblocks, and repetition).” | Using smoking cessation as an example, does Neehr Perfect have built in clinical decision support tools for smoking cessation? Explain your answer. | Yes you can develop a care plan to map out goals for the patient to quit smoking. Which could also help with getting the patient to quit other drugs she is taking as well. |
| 5 | **Provide patients the ability to view online, download and transmit their health information within 36 hours** | Explain the importance of having this ability in practice. | So patients can keep track of their care and to feel like they have control over what goes on. |
| 6 | | | |

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<thead>
<tr>
<th><strong>after discharge. This is not applicable to the Neehr Perfect educational EHR.</strong></th>
<th>Explain the importance of having security measures for data entered into Neehr Perfect?</th>
<th>The importance of security measures are so people who don’t have direct access to the patient can’t go into their chart and see what they are here for and so they also don’t get any personal information.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Protect electronic health information created or maintained by the Certified EHR Technology. Neehr Perfect is not a Certified EHR because it has been designed for education purposes. However, it is designed to protect the health information in the patient’s chart and what the student documents in their portfolio or in any chart.</strong></td>
<td>Does Neehr Perfect have a specific place to document and display lab results? Explain your answer.</td>
<td>Yes you can enter lab results in the labs tab in the chart.</td>
</tr>
<tr>
<td><strong>Incorporate clinical lab-test results into EHR.</strong></td>
<td>Explain how this would be beneficial to a hospital in practice.</td>
<td>They could see how other patients are coping with said illness and see different treatment measures being used to help other that end up diagnosed with the same thing down the road. Also to keep track of hospital generated illness such as UTIs.</td>
</tr>
<tr>
<td><strong>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. This is a function not applicable to the Neehr Perfect educational EHR at this time.</strong></td>
<td>Explain how this would be beneficial to a hospital in practice.</td>
<td>It is beneficial because it gives you only educational information that pertains to the patient and their illness.</td>
</tr>
<tr>
<td><strong>Use EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate. This is a function not applicable to the Neehr Perfect educational EHR at this time.</strong></td>
<td>Does Neehr Perfect support medication reconciliation either electronically or by manually checking the patient’s medications? Explain your answer.</td>
<td>It allows you to manually enter medication orders for each patient.</td>
</tr>
<tr>
<td><strong>Perform medication reconciliation. The hospital who receives a patient from another setting of care or provider of care should perform medication reconciliation.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Core Objective</td>
<td>Question</td>
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<tr>
<td>12</td>
<td>Provide summary of care record for each transition of care or referral. This is not applicable to the Neehr Perfect educational EHR.</td>
<td>What is the goal of being able to transmit the patient’s current medical information to another provider?</td>
</tr>
<tr>
<td>13</td>
<td>Submit electronic data to immunization registries. This is not applicable to the Neehr Perfect educational EHR.</td>
<td>What is the purpose of an immunization registry?</td>
</tr>
<tr>
<td>14</td>
<td>Submit electronic data on reportable lab results to public health agencies. This is not applicable to the Neehr Perfect educational EHR.</td>
<td>What is the purpose of reporting specific lab results to public health agencies?</td>
</tr>
<tr>
<td>15</td>
<td>Submit electronic syndromic surveillance data to public health agencies. This is not applicable to the Neehr Perfect educational EHR.</td>
<td>What is the purpose of reporting syndromic data?</td>
</tr>
<tr>
<td>16</td>
<td>Automatically track medications with an electronic medication administration record (eMAR).</td>
<td>In Gwen’s chart, there are medications administered and documented on the Meds tab. Explain the importance of this as it relates to the healthcare team.</td>
</tr>
</tbody>
</table>

**Critical Thinking Questions**

1. Think of meaningful use from the perspective of a member of the healthcare team directly caring for the patient in the hospital (e.g. nurse, case manager, respiratory therapist). Choose one of the 16 core objectives from above. In your own words, describe the importance of the core objective to the healthcare team. Provide an example.

**#16 is a very important value because it allows communication between other staff members. It allows nurses coming on for a shift to see what meds their patient has received and when incase they have an adverse reaction to the medicine, or so they don’t double the dose and to also keep**
track of pain medication administration incase in patients as for it. It also allows for access if the patient in the hospital is moved to another floor they can know what medicines can and should be given in case of an emergency.

2. Again, think as a member of the healthcare team working in the hospital setting. In your opinion are there any core objectives on the above list that you think will be more difficult to follow or implement? Provide an example to support your opinion.

The use of the EHR or education purposes because if there are in a busy setting they might not have the time to access other outside sources to give to the patient.

Submit your work

Document your answers directly on this document as you complete the activity. When you are finished reviewing the patient chart in Go!, click on the Close Session button at the top right of the screen. When you are finished documenting your answers, save this Word document. Then upload it to your Learning Management System (LMS). If you have any questions about submitting your work to your LMS, please contact your instructor.

References