**Suggested Exercises and Discussion Questions**

1. What is the purpose of the meaningful use regulations?

The meaningful use regulations are intended to ensure that when electronic health records are implemented that they are used in meaningful ways. The regulations will support the five underlying goals of the healthcare system:

Improving quality, safety and efficiency

Engaging patients in their care

Increasing coordination of care

Improving the health status of the population

Ensuring privacy and security

1. Review the stage 1 criteria for certification in the PowerPoint lecture for this unit. Compare this to the current certification requirements established by CCHIT. Will CCHIT’s current certification program meet the requirements for meaningful use or will CCHIT need to update their certification program?

There are seven stage 1 data collection metrics required for meaningful use and to meet certification criteria:

* At least 80% of all unique patients seen by the EP or admitted to the EH have at least one entry or an indication of none recorded as structured data. Essentially, an up-to-date problem list of current and active diagnoses based on ICD-9 CM or SNOMED CT must be maintained.
* At least 80% of all unique patients seen by the EP or admitted to the EH have at least one entry (or an indication of none if the patient is not currently prescribed) recorded as structured data. It is suggested that RxNorm is used as the nomenclature system. RxNorm is a standardized nomenclature for clinical drugs and drug delivery devices produced by the National Library of Medicine. In RxNorm, the name of a clinical drug combines its ingredients, strengths, and/or form.
* At least 80% of all unique patients seen by the EP or admitted to the EH have at least one entry (or an indication of none if the patient has no medication allergies) recorded as structured data. (Unique ingredient identifiers (UNIIs) are used to identify and code for substances in drugs, biologics, foods, and devices. )
* At least 80% of all unique patients seen by the EP or admitted to the EH have demographics recorded as structured data. The minimum demographics required for Stage 1 are language, insurance, gender, race, ethnicity, and date of birth; plus date and cause of death in the event of mortality for EHs.
* At least 80% of all unique patients age 2 and over seen by the EP or admitted to the EH, record blood pressure and BMI (calculated from height and weight); additionally plot growth chart for children age 2 – 20.
* At least 80% of all unique patients age 13 and over seen by the EP or admitted to the EH, have “smoking status” recorded.

At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

The CCHIT certification requirements and test scripts are located at <http://www.cchit.org/get_certified>.

1. Part of meaningful use is to participate in health information exchange efforts that are either established or beginning in nearly every state. Investigate an HIE effort in progress. What efforts are being made to implement a statewide HIE? Who is leading the initiative? Who are the parties involved? Are the content exchange and vocabulary standards that are required by the Interim Final Rule for the HIT Standards, implementation Specifications, and Certification Criteria being considered in the HIE planning process?

The discussion will vary based on the HIE being evaluated.

1. Use a search engine to locate the specific requirements for a PQRI indicator that will be reported using a certified EHR for meaningful use by an eligible provider. Verify that this PQRI indicator is included as a meaningful use quality measure for an eligible provider. How will the EHR determine the summary data to provide for this quality measure?

The current PQRI information is located at <http://www.cms.gov/PQRI/20_AlternativereportingMechanisms.asp>. The downloads area has a file that lists the current PQRI indicators and the CPT Codes and ICD-9-CM codes that comprise that information. On October 1, 2013 the ICD-9-CM codes will change to ICD-10-CM/PCS. As the certified EHR’s mature data may be extracted with SNOMED-CT as well. Presently the 2010 PQRI indicators are listed but these are included in the proposed rule for the EHR incentive program under meaningful use.