The federal Health Information Technology for Economic and Clinical Health Act (HITECH) is the component of health care reform that provides federal incentive payments to doctors and hospitals when they adopt electronic health records (EHRs) and demonstrate their use in ways that can improve quality, safety, and effectiveness of care.

Incentive payments began in 2011 and will continue at diminishing levels for up to six years, ending once the incentive pool is depleted. After that, penalties will be assessed for non-qualification, resulting in reduced provider payments for services.

## Defining ‘meaningful use'

The term “meaningful use” implies that clinicians not simply use the EHR, but that it must play a meaningful role in care delivery. The Centers for Medicare and Medicaid Services developed metrics that were designed to signify that the EHR is used to improve patient care.

For year 1 (2011), qualifying clinicians had to use e-prescribing to: 1) directly deliver at least 40% of prescriptions from the EHR to the patient's chosen pharmacy, 2) print an after visit summary (AVS) documenting the diagnosis and care plan for more than 80% of patients, and 3) maintain an active problem list that must be reviewed or updated in 80% of ambulatory visits.

Despite external pressure, clinicians may delay adoption of EHRs if they perceive the meaningful use processes as contributing to decreased efficiency for most encounters.

However, the Glickman Urological and Kidney Institute adopted the EHR almost a decade ago both for documentation and e-billing as part of an enterprise effort. As a result of this early adoption, we were prepared to combine energies towards achieving the meaningful use qualification for institute physicians.

## New workflow: smart sets

The first step was to identify the measures and to build them into the workflow of the Epic EHR on an institute basis. A clinical support analyst was hired to educate, assist, and bridge the urologists and nephrologists into a combined program to have every staff member qualified within the first year.

“Smart sets” were developed to facilitate documentation, diagnosis entry, and computerized physician order entry (CPOE) in one or two motions. This allowed standardization where appropriate and decreased duplication of data entry. Finally, pharmacy data were entered and confirmed for each patient by the employee staff prior to all visits.

The next step was to educate both nephrologists and urologists in building the three meaningful use measures (e-prescribing, AVS, and problem list maintenance) into standard workflows. Early experience was challenging, as many physicians had difficulty following all three, but starting months before the measures became official allowed us to have most physicians qualified as the program began in the fall of 2011.

Monthly reports were supplied to all physicians letting them know how close they were to achieving meaningful use status. Stragglers received one-on-one assistance with the COA until all were qualified.

Across all three departments ( Nephrology , Urology , Regional Urology), a total of 98% of physicians qualified by the first quarter of 2012. One major lesson learned was that physicians were slowest to adopt e-prescribing, one of the common features made available in the decade of EHR adoption.

But once they used it for just short spans of time, few considered returning to paper prescriptions based on the efficiency, accuracy, and legibility of e-prescribing. Notably, most physicians perceived that patients would resist letting go of paper prescriptions, but fewer than 5% of patients requested written versions.

## Paid incentives and outcomes

Even more remarkable was the positive impact on the organization. Providers were awarded on

average $16,498, and the institute expects a slightly higher amount in 2012. This success was mirrored across Cleveland Clinic.

Notably, Cleveland Clinic employs only 0.35% of all eligible providers, but 7.7% of all qualifying funds in the United States went to Cleveland Clinic, demonstrating dedication to qualification across the organization. Fully 12% of all qualifying urologists in the United States were from the Glickman Institute.

The major lesson was that infrastructure was critical to this success. This took time and labor investment up front, but at this point all the steps in each encounter are quick and our prescribing process is incomparably improved, including the accuracy of medication reconciliation throughout the enterprise.

As more measures are introduced, we will build on this infrastructure to further harness the evolving EHR, with the hope that it will be able to improve population outcomes as well as those for individuals.

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