COMMENTARY

Meaningful Use Criteria: What’s Missing?

BY CHRISTOPHER NOTTE, M.D., AND NEIL SKOLNIK, M.D.

ince the passage of the Health In-
formation Technology for Eco-
nomic and Clinical Health (HITECH) Act in February 2009, there has been a tremendous amount of dis-
cussion about the idea of “meaningful use.” Associated with the meaningful use criteria are financial incentives for those who adopt an electronic health record and care for Medicare and Med-
icaid patients. Such incentives might total more than $40,000-$60,000 per provider. Those who fail to meet the cri-
teria will find their reimbursements re-
duced beginning in 2016.

Despite the abundance of commentary and speculation over meaningful use, un-
til recently the term had not actually been defined. And now that the full set of rules for meaningful use is available, it might surprise some to know what has actually been excluded from the criteria.

In explaining the meaningful use con-
cept at the beginning of this year, the U.S. Department of Health and Human Services laid out several objectives and priorities centered on improving the quality, safety, efficiency, and accessibili-
ty of care. Any aspects of electronic health record (EHR) implementation that do not meet those goals have been specifically left out of the criteria. In do-
ing so, the intent is to challenge health care providers to move forward toward the goal of EHR implementation, while acknowledging the limitations of the technology currently available.

The first and most fascinating exclu-
sion is any requirement for encoun-
ter note generation. While most EHR prod-
ucts emphasize electronic note genera-
tion, the authors do not think this provides a significant benefit over hand-
written charting in meeting the goals of HITECH (Federal Register 2010;75:1843-
2010). Still, it might be difficult to im-
plement an EHR without this piece, as once an office becomes dependent on the technology, workflow can be sig-
ificantly hindered by searching for docu-
mentation that is not in the electronic record.

To address this, some practices have chosen to scan in handwritten notes. Unfortunately, this might preclude criti-

cal data points from being captured by the system, and it make it impossible to meet some of the quality reporting goals laid out elsewhere in HITECH.

A second intentional omission in the criteria is the requirement that providers make educational resources available to patients. Although the authors admit that proper information and education are critical, they are reluctant to make this a necessity, saying “there is current-
ly a paucity of knowledge resources that are integrated within EHRs, that are widely available, and that meet [our] cri-
teria, particularly in multiple languages.”

As it turns out, many EHR products do integrate patient education resources, but these often are limited in quality and come at an additional fee. As an alternative, online resources available through Web sites such as familydoc-
tor.org and emedicene.com provide nu-
merous educational tools that are free and peer reviewed.

Another anticipated requirement that’s been excluded from the criteria is the need for orders to be transmitted electronically from care provider to test-
ing, diagnostic imaging, or treatment fa-
cilities. It should be noted that Comput-
erized Physician Order Entry (CPOE) is greatly emphasized under HITECH, with the objective that 80% of orders be entered through the EHR.

CPOE is defined as “the provider’s use of computer assistance to directly enter medical orders (for example, medication, consults with other providers, laboratory services, imaging studies, and other auxiliary services) from a comput-
er or mobile device.” But in the criteria released so far, the requirements “will not include the electronic transmittal of (those orders) to the pharmacy, labora-
tory, or diagnostic imaging center.”

Seemingly contrary to this, the guidelines do require e-prescribing to meet criteria, so further clarification is needed to de-
termine which orders must be sent elec-
tronically and which do not.

A review of these exclusions makes it apparent that no one is completely sure how the meaningful use criteria will affect the day-to-day practice of medicine. But with the lofty goals of improving the qual-
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gen the status quo and yet maintain a practical perspective on what is possible with the resources at hand. Many physi-
cians will remain skeptical of any govern-
ment intervention in health care but can at least now be assured that the financial incentives are attached to a fairly practical set of requirements.

The Other Face of ADHD: Inattentive Type

BY BARBARA J. HOWARD, M.D.

he children most likely to be diagnosed with atten-
tion-deficit/hyperactivity disorder are the obvious ones: stirred crazy after a bit of time in the waiting room, or mobile device.” But in the criteria released so far, the requirements “will not include the electronic transmittal of (those orders) to the pharmacy, laboratory, or diagnostic imaging center.”

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essor of family and community medicine at Temple University, Philadelphia. Dr. Notte is in private practice in Clifton, N.J. They are partners in EHR Practice Consultants, helping practices move to EHR systems. Contact them at info@ehrpc.com.

Far and away, the most common missed diagnosis and frequent bedfall of inattentive-type ADHD is anxiety. Although it feels like our practices are filled with children with ADHD, anxiety is a more common pediatric disorder. It is present in 12%-13% of the pa-
tients we see, compared with 4%-12% with ADHD. Anxiety is heritable and highly treatable, but may be interwoven with other disorders and difficult to tease out. When I see combined anxiety/ADHD, inattentive type, I might treat the ADHD first, simply because re-

ponsor to stimulants is quicker and might enable a more comprehensive approach to the child’s anxiety.

Keep in mind that medication management of ADHD children with predominantly inattentive type is somewhat different from the standard regimens for chil-

dren with hyperactivity and impulsivity. The stimulant family is still often used first, but the most efficacious dose might be lower and trickier to spot, and initial choices should be the least anxiety-provoking medica-
tions. Some clinicians prefer with this population to try extended-release atomoxetine (Strattera).

With these children, I start low and go slow, getting frequent, objective feedback from parents and teachers to try to stop within a narrow window of maximum efficacity for imitation.

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