Executive Summary

Healthcare providers are trying to demonstrate the meaningful use of electronic health records in a rapidly changing environment that simultaneously requires them to adapt to new reimbursement and care delivery models. To accomplish all of this, provider organizations need a robust, flexible, scalable solution that can help them achieve meaningful use — no matter where they are today on the technology spectrum. This solution may encompass a traditional EHR, but it must also include health information exchange and population health management capabilities that are not typically found in EHRs. The ideal combination of health IT tools and services must also enable providers to coordinate care and improve quality so that they can demonstrate the enhanced value that patients and payers are seeking.

The policy makers who formulated the meaningful use program always intended that it would help to change the healthcare delivery system in ways that emphasize collaborative, patient-centered care. But the traditional EHR alone is incapable of making that transition. To prepare for accountable care while showing meaningful use, healthcare providers should use a collaborative care platform that augments or replaces their electronic health records and that expands their ability to connect online with their patients and with all the providers who care for those patients.
Meaningful Use: Past, Present and Future

The American Recovery and Reinvestment Act (ARRA) of 2009 contains a section that provides up to $27 billion in incentives for eligible hospitals (EHS) and eligible professionals (EPs) that demonstrate “meaningful use” of electronic health record (EHR) systems. This part of the law, known as the Health Information Technology for Economic and Clinical Health (HITECH) Act, authorizes the Department of Health and Human Services (HHS) to award these incentives through the Medicare and Medicaid programs.

According to HHS, “the goal of meaningful use is to promote the spread of electronic health records to improve health care in the United States.” Among the benefits of meaningful use are:

- Complete and accurate information. Providers have the information they need to provide the best possible care.
- Better access to information. EHRs help providers diagnose health problems earlier, which can improve patient outcomes. EHRs also allow providers to share information more easily, leading to better care coordination.
- Patient empowerment. EHRs can empower patients to take a more active role in managing their own health if patients are given access to their electronic records and the ability to communicate with providers online.

The Centers for Medicare and Medicaid Services (CMS) has specified three stages of meaningful use over five years, and Farzad Mostashari, MD, National Coordinator of Health IT, recently mentioned a possible fourth stage. Eligible providers (EPs) and eligible hospitals (EHS) that start to participate in the program later will receive smaller incentives. Those that don’t begin showing meaningful use by 2014 will see their Medicare reimbursement cut in future years.

For EPs and hospitals seeking EHR incentives through Medicare, stage 1 began in 2011, but providers can still earn incentives by entering the program in 2013 or 2014. Stage 2 will run from 2014 to 2015, and stage 3 covers only 2016. The maximum award that an EP can receive through the Medicare program is $44,000. Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program is $44,000.5 Hospital incentives are calculated using a formula that is based on their number of discharges through the Medicare program.

If at least 30% of an EP’s practice consists of Medicaid patients (20% for pediatricians), that professional can receive up to $63,750 in Medicaid incentives over a six-year period that may begin at any time through 2016 and may end as late as 2021. These EPs can apply for Medicaid or Medicare incentives, if they qualify, but not both. Hospitals, in contrast, can receive awards through both programs.

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EPs and hospitals that are eligible for Medicaid incentives have up to three years to show stage 1 meaningful use. In the first year, they need only meet the adopt/upgrade requirements for getting incentive payments; but in the second year, they must start to demonstrate meaningful use.

In each stage of meaningful use, providers must meet all of the criteria to receive incentives. However, these criteria are divided into a set of core requirements and a menu from which providers can select other requirements to meet. In stage 2, for example, there are 20 measures for EPs (17 core and three of six items on the menu) and 19 measures for hospitals (16 core and three of six menu entries).

Navigating the Stages

According to HHS, stage 1 of meaningful use focuses on “data capture and sharing.” Stage 2 addresses “advanced clinical processes,” and stage 3, “improved outcomes.” The table below delineates the main aspects of the three stages.

The major challenges for hospitals in stage 1 include computerized physician order entry (CPOE) and quality reporting. At the end of 2012, 38% of hospitals had CPOE—nearly twice as many as two years earlier. But CPOE, which affects operations across the entire hospital, remains a big barrier for many providers. Quality reporting has been difficult for many institutions because their EHRs may generate inaccurate data and/or because some of the information they need to gather is not in structured data fields.

Some physicians have also encountered difficulties in stage 1. Among the criteria they have found challenging are providing 50% of patients with clinical care summaries and electronically prescribing medications for at least 40% of patients.

Stage 2 has considerably stiffer requirements than stage 1. While some of the criteria merely increase the thresholds for meeting the same requirements that were in the previous stage, there are also new objectives that EPs and hospitals find problematic. Among these are the requirements related to information exchange at transitions of care and the view/download/transmit objective, which requires providers to ensure that 5% of their patients actually view or use their electronic records.

Certified EHR technology

For purposes of showing meaningful use, EPs and hospitals must use “certified EHR technology” (CEHRT) that meet the requirements set forth by the Office of the National Coordinator (ONC) of Health IT. The 2011 certification standards, listed in a final rule that ONC released in August 2010, can be used to meet meaningful use stage 1 objectives. CEHRT that complies with a second set of certification standards, known as the 2014 Edition, must be used in stages 2 and 3, and can also be in used in stage 1.
CEHRT does not necessarily have to be a complete EHR from a single vendor. According to the final rule for 2011 certification and standards, the following type of system is qualified for meaningful use: “A combination of EHR Modules in which each constituent EHR Module of the combination has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary, and the resultant combination also meets the requirements included in the definition of a Qualified EHR.”

The important point to bear in mind for the following discussion is that CEHRT components can be combined to show meaningful use. In addition, complete EHRs can be integrated with other CEHRT modules to meet certain meaningful use objectives.

**Where Do Providers Go From Here?**

Through the end of 2012, CMS distributed a total of $10.7 billion in EHR incentives to hospitals and EPs. About 70% of EHs had received Medicare and/or Medicaid payments by Dec. 31, 2012, but many of those hospitals received Medicaid payments only without showing meaningful use.18-19 (Providers who seek incentives through the Medicaid program, in the first year they apply, need only show they have adopted, implemented or upgraded EHRs.) Moreover, less than half of the recently surveyed hospitals said they were confident about their ability to show meaningful use in stage 2. For other facilities, the pain points included training and change management, lack of a monitoring process to ensure continuous compliance, and privacy and security requirements.

Many providers doubt that their current EHR vendors will be able to keep up with the new government requirements for certification,20 and quite a few are unhappy with their current systems. Surveys show that a third of community hospitals are dissatisfied with their EHRs21 and that 35% of ambulatory care practices intend to switch to new EHRs. Some doctors have seen their vendors sunset their products and will be forced to purchase new EHRs to show meaningful use in future years.

Meanwhile, providers are facing rapid changes in regulatory requirements apart from meaningful use. For example, they must prepare for the very challenging transition to the ICD-10 diagnostic code set in 2014. Also, CMS recently began to penalize hospitals that have an excessive number of readmissions by lowering their Medicare reimbursement. Accountable care organizations (ACOs), patient centered medical homes (PCMHs), bundled payments, and financial risk arrangements are all demanding the attention of physicians and hospitals.

**An Alternative To The Conventional EHR Model**

To assure they can meet or continue to meet the meaningful use criteria and also prepare for healthcare reform, providers need a flexible, robust, scalable solution that can help them move forward, regardless of where they are today on the spectrum of health information technology (HIT) adoption. This type of solution consists of certified EHR modules that work together smoothly and seamlessly on a cloud-based care collaboration platform that includes a health information exchange (HIE).

Such a platform must be able to present all of the key clinical information about a given patient in a single view. But it does not have to aggregate the data in a central repository; instead, a record locator service and peer-to-peer networking can assemble the data from disparate sources when it is needed at the point of care or for analytic purposes.

This federated solution can be used as a modular EHR or can be piggybacked on a traditional EHR. Pre-integrated applications from CEHRT vendors can be combined with the core functionality of the platform to show meaningful use. Alternatively, particular features, such as patient portals and analytic tools, can supplement a conventional EHR to meet program requirements.

**Get Providers on the Same Page**

The AT&T Healthcare Community Online care collaboration platform enables eligible providers – regardless of their degree of technical sophistication – to meet the meaningful use criteria, while helping them build the infrastructure they’ll need for accountable care. At the core of this cloud-based platform is a state-of-the-art health information exchange (HIE) and messaging hub.

This HIE allows providers to gather key patient information instantly at the point of care from a variety of sources. These data sources may include their own EHR or a certified EHR “lite” that combines data from the certified EHR modules that run on the platform. Clinicians can access all of this information in a single view of a patient’s health record on a care management portal.

The portal can display information from disparate systems in a single patient context because a mapping tool converts all incoming data to a unified, viewable dataset with standardized terminology. This normative database can then be used for a variety of purposes, ranging from registries and analytics to highly secure clinical messaging – all of which are required to demonstrate meaningful use.

When a provider needs to provide a clinical summary during referrals or other transitions of care, the messaging hub translates the pertinent data in a standardized summary of care into the data type used in the receiving provider’s EHR, such as a CCD ( Continuity of Care Document). The receiving system can then consume the summary and place the data in discrete fields.

Users of the AT&T Healthcare Community Online platform can also exchange information with providers that are not directly connected to the HIE. They can use the eHealth Exchange (formerly the NhIN Exchange) and/or the Direct Project secure messaging protocols to push clinical data to physicians and hospitals outside of their immediate healthcare community.

Within the community, the highly secure online messaging used to exchange data between disparate EHRs can also be used to send results or referrals to providers who don’t yet have EHRs. This capability can be important in meaningful use, where providers must provide summaries to other clinicians in at least 10% of transitions of care and referrals. And it can be used in referral management to track visits to specialists.
For the many physicians who have discovered their EHR does not meet their needs and/or will not be able to keep up with later stages of meaningful use, a major advantage of a modular, cloud-based solution is that it can be flexible enough to adapt to new government requirements. This model also makes it easier to update the software so that the system won’t become obsolete. And a collaborative care platform can supply many of the components that providers need to build ACOs and conduct population health management.

Health Information Exchange
The ability to exchange data among healthcare providers is a key component of meaningful use, and one that is increasingly emphasized in stage 2.26 Health information exchange (HIE) is also essential in ACOs and patient centered medical homes (PCMH), both of which require this capability to improve care coordination. In meaningful use stage 1, EPs and hospitals must show the capability to exchange key clinical information, such as a patient’s diagnoses, medications and allergies, “among providers of care and patient authorized entities.” Additionally, EPs and hospitals have to provide a “summary of care record” for more than 50% of transitions of care and referrals in both stages 1 and 2.

In stage 2, providers must also use their certified EHR technology to electronically transmit the care summary to other providers either directly or through a HIE in 10% of transitions and referrals. And they must perform a test of data exchange with a provider that has an EHR from a different vendor or with a CMS-designated test EHR.

The Direct project, supported by the Office of the National Coordinator (ONC) and Centers for Medicare and Medicaid Services (CMS), is an initiative aimed at promoting the adoption of a secure person to person email protocol for the healthcare industry. For many, Direct was initially seen as a threat to the sustainability of HIEs, a way for providers to avoid having to participate in a HIE. In truth, while Direct has a specific purpose and addresses a major gap, it merely plays a partial role in a fully functional HIE or accountable care organization’s communication strategy.

An HIE that is part of a care collaboration platform can do far more than meet these meaningful use requirements. By aggregating data from disparate clinical and administrative systems and mapping it to a normative dataset to create a single patient view, this kind of HIE can also allow multiple providers caring for the same patient to see at a glance what has been done for that patient without leaving their EHR workflow.

Besides this free-flowing data exchange, a care collaboration platform also provides the ability to share information with patients, provide patient reminders, enable clinical decision support, reconcile medications, and provide data for public health. All of these are essential ingredients of meaningful use.

Sharing Information with Patients
In stage 1, EPs must give more than half of their patients electronic copies of their health information within three business days if they request it. In addition, they have to provide 10% of the patients they saw during the reporting period with timely electronic access to their health information. Hospitals must supply 50% of patients who request it with electronic copies of their hospital and/or emergency room (ER) records, and also must provide patients discharged from the hospital or ER with electronic copies of discharge instructions upon request.

In stage 2, besides providing 50% of patients with electronic access to their health records, EPs must also ensure that 5% of the patients they saw during the reporting period view, download or transmit their information to a third party. Hospitals must do the same, and the discharge instruction requirement for stage 1 is folded into this criterion.

To comply with these requirements, experts agree, most providers will need a patient portal – although it may not necessarily be one built by their EHR vendor. They could use a third-party portal that is interfaced with their EHR or a portal attached to an HIE/care collaboration platform.

The advantage of using a patient portal on a care collaboration platform is that it can combine data from multiple providers caring for the patient. If a hospital or physician practice has a patient portal, data flowing to that portal can also be integrated with data from other sources on a care collaboration platform. When lab results or other records are made available to the patient, they appear to come directly from the provider.

Besides the ability to share health records, a patient portal should also have features that facilitate care management and promote patient engagement. These features can include:

- Appointment requests or the ability to schedule appointments
- Prescription refill requests
- Health coaching
- Secure online messaging
- Patient educational materials

Of these components, meaningful use requires only secure messaging with patients. But online appointment scheduling and refill requests can help increase practice efficiency and can induce patients to use the portal. Some hospitals also employ patient portals for online bill payments. Portals may also include other features likely to attract patients, such as the ability to complete intake or other forms online before an office visit.

In addition, meaningful use requires hospitals and EPs to furnish online educational materials to 10% of patients seen by the providers. A portal could be used to supply these patient-specific materials, which might come from a specialized vendor or could be created using specialized authoring tools.
Get Patients to View Their Records

One of the most vexing requirements in meaningful use stage 2 is the one mandating that providers ensure that at least 5% of their patients view, download, or transmit their electronic health records. To meet this requirement, most providers will use patient portals, but that doesn’t guarantee that patients will take advantage of those portals.

The AT&T care collaboration platform has a patient portal that providers can use for a variety of purposes, including the sharing of health information with patients. To show meaningful use, it would be sufficient to share only the data in a provider’s EHR; but the AT&T Healthcare Community Online platform also enables providers to create a comprehensive record that includes data from hospitals, physician offices, labs, imaging centers, and post-acute providers if the patient has provided consent to share amongst all of his/her other providers. So the information shared with patients also encompasses a larger universe of information. This information is largely the same as that available to clinicians, but is delivered in a more patient-friendly format and in more understandable, non-technical terms.

Other features that might help attract patients to the portal, include the ability to request appointments and prescription refill, obtain educational materials, and get non-urgent clinical questions answered. The highly-secure online messaging and the availability of pedagogic materials also help providers to meet meaningful use criteria for providing patients with preventive care reminders and education.

The AT&T Healthcare Community Online patient portal also features a variety of health coaching programs that are essential in care management and patient engagement and adherence to care plans. Some of these programs can also involve the use of telehealth or remote patient monitoring technology to connect with patients on their mobile devices and at home.

Per HIPAA, patients always maintain control over their own health information. That means they have the freedom to opt out of the health information exchange and can restrict access to certain types of data, such as those related to a sensitive diagnosis such as HIV/AIDS or a mental/behavioral health treatment. With the patient’s permission, the aim is to allow the information to flow freely among treating providers and between physicians and their patients to provide better outcomes that are coordinated around the patient, not a single medical discipline.

Patient Reminders

In stage 1, EPs must send reminders about preventive or follow-up care to more than 20% of patients who are older than 65 or younger than five. Stage 2 takes that imperative to the next level, requiring EPs to identify patients who should receive reminders for preventive or follow-up care and provide those reminders to more than 10% of patients with two or more office visits in the last two years. Linked to this requirement is another mandating that EPs and hospitals use their EHRs to generate at least one report listing patients who have a specific health condition.

Clearly aimed at promoting population health management, these requirements will be difficult for many providers to achieve because their EHRs are not designed for that purpose. Even if these systems can generate diagnosis, medication and allergy lists, and integrate lab results as structured data, as required for meaningful use, they might not be able to combine those data points in a way that allows them to identify patients who have care gaps. Also, the EHRs might not have the capability to trigger automated messaging to patients who need preventive or follow-up care.

Because of these shortcomings in their EHRs, some providers use third party registries to keep track of patients’ health conditions, what services they’ve received, and what care they’re due for. Such registries can be interfaced with EHRs and practice management systems, which automatically feed data to them.

A care collaboration platform may include a pre-integrated disease registry that physicians can use alongside their EHRs with a single sign-on. One advantage of such a registry is that it can incorporate data from sources outside a particular physician office or healthcare organization. Information from reference labs, other physicians or hospitals, and other facilities provides a more comprehensive view of the care a patient has received. Integration of payer claims data, where available, can help round out the picture. Moreover, the collaborative care platform can supply the analytics needed to identify which patients have care gaps and send them alerts to make appointments for necessary preventive or chronic care.

Clinical Decision Support

The stage 2 criteria also require the implementation of at least five clinical decision support (CDS) interventions related to four or more clinical quality measures at the point of care. For example, if the quality metric is the percentage of diabetic patients who have had HbA1c tests in the past year, the decision support tool might include links to studies about the recommendations for ordering these tests.27

By comparison, stage 1 requires use of only one CDS intervention, so the stage 2 criterion is a significant step up. In addition, EPs and hospitals must perform drug-drug and drug-allergy interaction checks to help prevent adverse drug events in stage 2.

The drug and allergy interaction checkers are usually part of electronic prescribing applications, whether standalone or part of EHRs. But other types of clinical decision support, such as health maintenance reminders and guideline compliance alerts, require not only medication data, but also lab results and other kinds of information in an EHR or a registry.

While a care collaboration platform doesn’t typically store data, it can apply clinical decision support rules to data in a provider’s EHR, data warehouse or registry. The data needed for a particular patient visit is gathered from multiple sources, and a pre-integrated clinical decision support tool analyzes that data to supply alerts at the point of care.

EPs can also use a care collaboration platform to meet computerized physician order entry (CPOE) requirements. In stage 1, these measures include electronically ordering medications for 30% of patients who
Medication Reconciliation

In stages 1 and 2, both EPs and hospitals must perform medication reconciliation at transitions of care for at least 50% of patients to help avoid adverse drug interactions. This can be a time-consuming and difficult process, because many patients don't remember what medications they're on, and because some of their drugs were prescribed by other providers. Moreover, the process cannot be automated if providers caring for the same patient are on different systems that are not interfaced.

A care collaboration platform can facilitate medication reconciliation. When disparate systems are connected to the platform, their data can be mapped to a normative database. The platform allows a clinician to see all of a patient's prescription medications in a single view and reconcile them in the EHR.

Public Health

The requirements for data submission to public health agencies are divided between core and menu items in both stages of meaningful use. Reporting to immunization registries is a core item for EPs in both stages; it progresses from testing in stage 1 to ongoing reporting in stage 2. Submission of syndromic surveillance data — used to track disease outbreaks — to public health agencies follows the same route, but is a menu item in both stages. Other menu items in stage 2 include the ongoing submission of data to cancer registries and other kinds of specialized registries.

Hospitals must also submit data to immunization registries in both stages, and submission of syndromic surveillance data is a core requirement for hospitals. In addition, a hospital must perform a test of its EHR's ability to submit electronic data on reportable lab results to public health agencies and must continue to send this data if the test is successful. In stage 2, EHs have to submit this information on an ongoing basis.

Some public health agencies are still unable to accept electronic data from providers. A big part of the problem is the lack of interfaces between different states' computer systems and various kinds of EHRs.

Some government officials have proposed that HIEs be the conduits for submitting data to public health agencies using the HL7 messaging format, which is standard in healthcare.27 One flaw in this reasoning is that not all state computer systems are able to accept HL7 messages. But a care collaboration platform with the right software can translate HL7 into whatever format a public health agency is using and provide two-way connectivity between providers and agencies.

Conclusion

Meaningful use is not just about "checking the boxes" to obtain financial incentives. The government designed the program so that providers must tap the potential of EHRs to improve the quality of care and care coordination. Therefore, EPs and hospitals that achieve meaningful use will be better prepared for the future than those that don't. But providers must also build the infrastructure needed for population health management to make a successful transition to the new care delivery models that are starting to emerge under health reform.

From this perspective, a logical path is to use a care collaboration platform that can both help providers achieve meaningful use and enable them to perform population health management. With a single

Identify Patient Care Gaps

Starting in meaningful use stage 1 and to a greater extent in stage 2, providers must identify care gaps and message patients about needed preventive and follow-up care. To satisfy these requirements, providers need registries and analytic software that may not be part of their EHRs. The AT&T care collaboration platform offers access to both. Providers can choose from AT&T Healthcare Community Online's pre-integrated applications for registries and analytics.

With a single sign-on, a provider using the AT&T Healthcare Community Online platform can easily switch into a registry to view to see in-depth information about an individual patient's care gaps. The system can be set up to send automated messages to patients about the need to make a follow-up appointment or have a test done. A tool called Visit Planner brings the physician up to date on a patient's main health conditions, her health status, and whether or not she is meeting each pre-established care plan goal or needs to be on a corrective path or is overdue for a specific test.

The registry also generates reports on specific segments of a patient population. Analytics tools can be used to stratify the population by health risk to help care managers prioritize interventions. Other analytics measure provider performance and can be used for quality reporting to help meet that meaningful use requirement.

Clinical decision support, emphasized in meaningful use stage 2, requires the use of health maintenance prompts and clinical guideline alerts. Registries and analytics on the AT&T platform can be used with traditional EHRs or as part of a modular EHR to meet the CDS requirement. At the same, pre-integrated electronic prescribing applications on the platform include the drug-to-drug and drug-to-allergy interaction checkers needed to show meaningful use.

are prescribed drugs; in stage 2, EPs must use CPOE to order more than 60% of medications, 30% of lab tests, and 30% of imaging tests. An EP could prescribe electronically on a care collaboration platform, using either his EHR or a standalone e-prescriber, and send his prescriptions online to pharmacies via Surescripts. In addition, the EP could transmit lab orders to a hospital or reference lab connected to the platform and receive results back the same way.

This would also be helpful to hospitals that want to deliver results online to their physicians but can't afford to build interfaces for multiple EHRs. And it could enable doctors who don't yet have EHRs to exchange orders and results with hospital labs, using secure clinical messaging.

A stage 2 menu objective requires hospitals to send 10% of discharge prescriptions electronically to community pharmacies. This will be hard for most hospitals to do, because their CPOE systems are normally set up to send orders to their in-house pharmacies but not to outside entities. If a CPOE system is online with a care collaboration platform, however, the hospital can use it to connect to Surescripts and transmit orders to community pharmacies as well.
sign-on, physicians can use the pre-integrated applications on this kind of platform as a modular EHR that is certified for meaningful use, including diagnosis and medication lists, e-prescribing, clinical decision support, and a patient portal. Alternatively, they can select whichever platform utilities they need, including decision support, analytics, and registry functions, and apply those to the data in their own EHR. At the same time, they can use the platform’s health information exchange and data mapping capabilities to assemble a comprehensive view of patient data and exchange data with other providers. All of these functionalities can help them achieve meaningful use in stage 1 and stage 2, and should also serve them well in stage 3.

While it is not yet clear what will be in the third stage, stage 2 places a strong emphasis on interoperability among provider systems, patient engagement, and patient-provider communications. A collaborative care platform can assist EPs and hospitals in all of these areas while offering the flexibility that will be required both for meaningful use and new care delivery models.

In this rapidly changing environment, hospitals and physicians must avoid being locked into a static, limited type of EHR that can swiftly become obsolete. They should be cautious about a single vendor approach that tries to force them into only using its applications, whether or not those serve their needs. A vendor-neutral, cloud-based platform that allows them to mix and match applications, including the EHR they’re already using, can provide the flexibility they need to adapt to whatever changes come along.

Hospitals, health systems, and physician practices come in all shapes and sizes, with a wide variety of technical competencies and resources. No EHR fits all providers, and all EHRs have gaps in functionality that can pose difficulties in achieving meaningful use at various stages. A care collaboration platform that includes a range of certified EHR modules and care management tools is best suited to support providers all along this spectrum as they build their health IT infrastructures.

For forward-looking physicians and hospitals, the journey to meaningful use is also the journey to collaborative care. By using a care collaboration platform designed for quality improvement, care coordination, and patient engagement, providers can more easily show meaningful use and prepare for the future of healthcare.

**Notes**


5. Medicare and Medicaid Incentive Program Basics.


7. Medicare and Medicaid Incentive Program Basics.


For more information contact an AT&T Representative or visit www.att.com/healthcare.