

I've been **thinking**...



Meaningful-Use Definitions—Wet Cement?
October 2009

I've been thinking about Roy Rogers, meaningful use, and wet cement.

I made my first cognitive visit to Grauman's Chinese Theater on Hollywood Boulevard in the late 1950's. Roy Roger's hands, boots, and six-shooter, next to Triggers front feet, danced off the sidewalk and into my soul as I traced my fingers through the TV stars' impressions. A seed was planted. Someday. Somewhere. Somehow.

My heart raced the morning a cement mixer stopped in front of our house. A star was born that afternoon when I left my handprints in the freshly poured driveway. Thank God, I didn't wait longer than I did. Cement dries quickly, you know. My impressions (below) were not as deep as Roy's. But, hey, they're still there at 3945 Carlin Ave, Lynwood CA.

When it comes to the meaningful-use (MU) criteria hospitals must satisfy to qualify for HITECH Act incentive payments, many people assume the cement has hardened, that the comment period has come and gone. Indeed the period has passed for commenting on the Health IT Policy Council Recommendations to National Coordinator for Defining Meaningful Use—August 2009. However, final MU definitions are still wet cement.

In his October 1, 2009 update, National Coordinator for HIT, Dr. David Blumenthal, explains:

CMS is expected to publish a formal definition of meaningful use, for the purposes of receiving the Medicare and Medicaid incentive payments, by December 31, 2009. At that time, the public will be able to comment on the definition, and such comments will be considered in reaching any final definition of the term.

The Summary of Public Comments on HIT Policy Council recommendations, issued September 14, 2009, includes input from 165 hospital organizations. While reading the 19-page summary, two elements danced off the pages.

First, I was elated by a change in language related to 2013 Hospital Objectives. "Conduct closed-loop medication management, including eMAR and computer-assisted administration" in the recommendations' document, had been troweled into "Conduct medication administration using bar coding" in the summary of comments. While many of us presumed the objective implied bar coding, it is thrilling, finally, to see the term used.

Second, it is noteworthy, though not surprising, that 64 of the 165 hospital organizations offering comments, said they believed the 2011 timeline for CPOE was too aggressive and should be moved further out. They weren't sure that driveway was ready for pour. None said it should be moved closer in.

The ONC is currently weighing the HIT Policy Council's recommendations and the public's comments. It will be interesting to observe how things may reform. In the forthcoming formal MU definitions, will CPOE be moved out to 2013? If so, might medication bar coding be moved up to 2011? I'd vote for both. All I know is that the cement is wet until comments close in early 2010. I'm keeping my trowel out and busy.

Even if MU definitions don't change, now is the time to draft plans and pour the foundations for building your bar-coding system. Nothing will serve you better to this end than The unSUMMIT for Bedside Barcoding to be held May 5-7 in Atlanta.

Meanwhile, should you plan on visiting Southern California, let me know and I will Google up some directions for you to Grauman's Chinese driveway.



What do you think?

A handwritten signature in cursive script, appearing to read "Mark Neuschwander".

Mark Neuschwander

mark@hospitalrx.com
<http://twitter.com/hospitalrx>

Copyright 2009 The Neuschwander Company