ASA Analysis and Recommendations for Meaningful Use Requirements, Stage 1
A Roadmap to Potential Achievability for Surgical Anesthesiologists

This chart reflects the applicability and potential achievability of MU requirements for an anesthesiologist who:
- Provides surgical anesthesia and writes fewer than 100 outpatient prescriptions per year
- Provides well over 10% of their covered services in an outpatient or ASC setting using POS code 22 or 24
- Works in entities with multiple facilities (hospitals and ASCs), with various ownership arrangements, that are traditionally responsible for supplying the anesthesia equipment, including technology, for each facility
- Uses EHRs, if available, that may or may not interface with the other facilities where the anesthesiologist works

For those EPs not meeting the above description, such as those who provide anesthesia solely in an ASC or an office-based setting, these requirements will be more difficult, if not impossible, to meet because there is no facility-based EHR to back them up, nor are such products currently commercially available.

Key for Measures
Green = Could meet as defined
Yellow = Could meet with slight modifications
Red = Can't meet or is completely not applicable

**For those requirements that are not applicable to anesthesiologists, ASA requests exemptions from both the reporting requirements and the requirements to purchase a system capable of meeting such requirements.

Stage 1 Meaningful Use Criteria for EPs, Eligible Hospitals, and CAHs: Core Set

	Objective		Measure	Exclusion	Meet MU?	Applicability to Anesthesia
	Eligible Professionals (EPs)	Eligible Hospitals and CAHs				
1	Record the following demographics: (A) Preferred language, (B) Gender, (C) Race, (D) Ethnicity, (E) Date of birth	Record the following demographics: (A) Preferred language, (B) Gender, (C) Race, (D) Ethnicity, (E) Date of birth, (F) Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 50% of all unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data	None	Y	**Applicable** AIMS could meet by drawing on a hospital's EHR or be the primary source if captured in a pre-op interview package. Frequently, pre-op nurses enter much of this data during the pre-op evaluation or the data is available in the system and is transferred from the hospital's EHR where it would have been entered by someone other than an anesthesiologist.
2	Maintain an up-to-date problem list of current and active diagnoses		More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data	None	Y	**Applicable** System in ASC or office-based setting wouldn't necessarily be linked in a way that would capture all PT Data. In the hospital setting, the pre-op evaluation is often the most thorough and reliable in the patient's record and is transferable to the hospital EHR
3	Maintain active medication list		More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	None	Y	**Applicable** Generally captured as part of a pre-op package
4	Maintain active medication allergy list		More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	None	Y	**Applicable** Generally captured as part of a pre-op package. The anesthesia med/allergy list usually ends up being the most reliable and frequently referenced because a physician edits it to an accurate end point
5	Record smoking status for patients 13 years old or older		More than 50% of all unique patients age 13 years or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	EPs, eligible hospitals or CAHs who do not see patients 13 years or older.	Y	**Applicable** Generally captured as part of a pre-op package. Some practices even document "smoking cessation discussed." Note that "follow up" to smoking cessation discussion as required by the CQM is not possible given the nature of the PT encounter.
6	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule	None	Y	**Applicable** An example would be a reminder for pre-op antibiotic administration. Many others possible with guidance from ASA.
7	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities		Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	None	Y	**Applicable**

	Objective: Eligible Professionals (EPs)	Objective: Eligible Hospitals and CAHs	Measure	Exclusion	Meet MU?	Applicability to Anesthesia
8	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines		More than 30% of all unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE	EPs who write fewer than 100 prescriptions during the EHR reporting period; None for eligible hospitals and CAHs.	Y/EX	**Not applicable - but likely exempt based on definition of outpatient prescriptions** Most anesthesiologists who provide surgical anesthesia do not write prescriptions so they would be exempt. Those who do, generally are writing controlled substances for the control of post-op pain, which should not be included. Anesthesiologists instead carry our their own orders for medications in the OR which could be captured in AIMS. Orders elsewhere in the hospital could be done through the hospital's EHR. **Recommendation: Allow documentation of medications administered in the perioperative setting to count toward both hospital and EP MU. For example, > 30% of patients have medications delivered in the OR documented in an AIMS.**
9	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient-authorized entities electronically	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient-authorized entities electronically	Perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information	None	N	**Applicable** Interoperable exchange with the hospital's EHR system is currently limited in ability to exchange structured data in commercially available systems.
10	Implement drug-drug and drug-allergy interaction checks		The EP, eligible hospital or CAH has enabled this functionality for the entire EHR reporting period	None	N	**Applicable, but would require changes to NIST drug-drug testing script** Some systems have drug-allergy checks as well as contaminated/use syringe and expired drug checks. Since clinical anesthesiologists don't usually "order" drugs prior to administration, drug-allergy checks will need to work differently than for most other physicians and clinical situations. More important, however, is the fact that there is currently no drug-drug interaction script available to accomodate drugs administered in the OR. **Recommendation: Exempt anesthesiologists and AIMS from drug interaction checks until specific changes, such as the creation of an NIST drug-drug testing script, are made and commercial systems can incorporate these capabilities.**
11	Record and chart changes in vital signs: (1) Height, (2) Weight, (3) Blood pressure, (4) Calculate and display the body mass index (BMI), (5) Plot and display growth charts for children 2 to 20 years old, including BMI*		For more than 50% of all unique patients age 2 years or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data	EPs who do not see patients 2 years old or older. EPs who believe that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice can attest and be excluded. None for eligible hospitals or CAHs.	N	**Applicable with exception of growth chart*** Growth charts have no relevance to anesthesia and perioperative systems do not have capability to capture or create such charts. Could be information included from hospital EHR but shouldn't be a part of anesthesia meaningful use. **Recommendation: Exempt anesthesiologists and AIMS from requirement to plot growth chart.**
12	Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States	Report hospital clinical quality measures to CMS or, in the case of Medicaid eligible hospitals, the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation. For 2012, electronically submit the clinical quality measures.	None	N	**Applicable but need to change NIST script to not require capability to report all CQMs within AIMS.** Only 1 of the current core and alternative core CQMs is applicable to anesthesia (recording vital signs). Therefore, anesthesia EPs would not be able to meet the CQM requirements. Additional measures for the perioperative setting need to be included or CMS should exempt anesthesiologists from inapplicable measures. **Recommendation: Select and apply an alternate set of core CQM from those anesthesiology measures currently used in the Physician Quality Reporting System (PQRS).**

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	Eligible Professionals (EPs)	Eligible Hospitals and CAHs				
13	Generate and transmit permissible prescriptions electronically (eRx)		More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	EPs who write fewer than 100 prescriptions during the EHR reporting period.	N	**Not Applicable** Outpatient prescriptions are almost never written by anesthesiologists providing surgical anesthesia in the hospital setting, and those that are written are generally for controlled substances. AIMS alone could not provide this function. Therefore, to meet this requirement, anesthesiologists would have to rely on the hospital providing an eRx function (which they are not required to have) or purchase an eRx system that would never be used just to document that they have one. **Recommendation: Ensure that the exemption would not require that anesthesiologists purchase an eRx system.**
14	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request	More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days	EPs, eligible hospitals or CAHs that do not have any requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.	N	**Not Applicable** Patients rarely, if ever, request their health record from the individual anesthesiologist. Instead, requests generally go through the hospital. **Recommendation: Anesthesiologists should be exempt from requirements.**
15	Provide clinical summaries for patients for each office visit		Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	EPs who have no office visits during the EHR reporting period.	N/EX	**Not Applicable - Potential for exemption** With the exception of pain specialists, clinical anesthesiologists do not maintain offices or conduct traditional "office visits." Therefore, in theory, they should be exempt. The question is, what constitutes an "office visit?" Anesthesiologists often provide anesthesia services in an office-based setting and submit the claim using POS code 11 but they are providing the service for the physician conducting the procedure in his/her office. Are anesthesia sevices provided in an office-based setting considered office visits? If yes, they shouldn't be. If no, then anesthesiologists should not have to attest to or install a certification requirement that is never used. **Recommendation: Anesthesiologists should be exempt from requirements.**

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	Objective: Eligible Professionals (EPs)	Objective: Eligible Hospitals and CAHs	Measure	Exclusion	Meet MU?	Applicability to Anesthesia
Menu Set (Select 5 for Stage 1)						
1	Incorporate clinical lab-test results into certified EHR technology as structured data		More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	EPs who do not order lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period. None for eligible hospitals or CAHs.	Y	**Applicable**
2	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research and outreach		Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition	None	Y	**Applicable** AIMS provides the capability to sort patients by a specific condition.
3	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate		More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources	None	N	**Applicable** Anesthesiologists will currently need to rely on the hospital EHR to meet this requirement. **Recommendation: AIMS should be exempt until modifications to currently available commerical products can be made.**
4	The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation		The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)	EPs who were not on the receiving end of any transitions of care during the EHR reporting period. None for eligible hospitals or CAHs.	N	**Applicable** In the hospital setting, full medication reconciliation is generally a pharmacy or nursing function, either in the pre-op or inpatient setting. However, in the OR setting, transitions between anesthesia providers occur regularly. AIMS could capture reconciliation of medications administered in OR or they could upload full reconciliation information included in the hospital EHR. **Recommendation: (1) Clarify the intent and definition of medication reconciliation and (2) exempt intraoperative transitions of care from requirements of performance of medication reconciliation.**
5	The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care should provide summary of care record for each transition of care or referral		The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals	EPs who do not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period. None for eligible hospitals or CAHs.	N	**Applicable** Anesthesiologist rarely discharge patients from a facility. However, they do transition patients to other settings within the same facility (e.g. from OR to PACU). The NIST script will need to be changed to incorporate OR-specific content. While the anesthesia record is an integral part of any copy of records that go to an outside facility, it is generally the responsibility of the hospital, not the anesthesiologist to transfer the records. **Recommendation: (1) Modify requirements with respect to NIST testing script to incorporate anesthesia-related transitions and (2) exempt intraoperative transitions of care from MU requirements.**
6	Implement drug-formulary checks		The EP, eligible hospital or CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period	EPs who write fewer than 100 prescriptions during the EHR reporting period; None for eligible hospitals and CAHs	N/EX	**Not Applicable - Exempt** Anesthesiologists determine whether something is on formulary by whether it is available in their OR carts or in their medication dispensing machines. This measure is more relevant to outpatient Rx covered under a PBP. More important, there is currently no NIST script available to cover drugs administered in OR.
7	Send reminders to patients per patient preference for preventive/follow-up care		More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period	EPs who do not have any patients 65 years or older or 5 years or younger with records maintained using certified EHR technology.	N	**Not Applicable** Anesthesiologists typically do not maintain offices and patients do not see them for preventive or follow-up care. This is generally a function of the surgeon. Anesthesiologists should not be required to purchase or document usage of a system with this requirement. **Recomendation: Anesthesiologists should be exempt from requirements.**

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	Eligible Professionals (EPs)	Eligible Hospitals and CAHs				
8	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP		More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information	EPs that neither order nor create any of the information listed during the EHR reporting period.	N	**Not Applicable and would require changes to NIST testing script** Patient requests for records generally go to hospital and not the individual anesthesiologist. Therefore, anesthesiologists should be exempt from having to install or attest to having a system with this functionality, as this is a function more relevant to hospitals. If this is not possible, changes to the NIST scripts will be required so that the information provided is relevant to the perioperative setting. **Recommendation: Anesthesiologists should be exempt from requirements.**
9	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice*		Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	EPs, eligible hospitals and CAHs that have not given any immunizations during the EHR reporting period. EPs in a group setting using identical certified EHR technology would only need to conduct a single test, not one test per EP.	N/EX	**Not Applicable** Not within the scope of practice for anesthesiologists and not supported by AIMS. This would be an inappropriate measure to include in AIMS. Anesthesiologists should not be required to purchase or document usage of a system with this requirement. **Recommendation: Anesthesiologists should be exempt from requirements.**
10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice		Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	EPs who do not collect any reportable syndromic information on their patients during the EHR reporting period.	N/EX	**Not Applicable** This would be a function of a hospital's EHR. The only reportable data related to anesthesiology practice would be reporting malignant hypothermia episodes or difficult airway to a registry but these are not public health repositories. Anesthesiologists should not be required to purchase or document usage of a system with this requirement. **Recommendation: Anesthesiologists should be exempt from requirements.**