HealthIT.gov
National Learning Consortium
Advancing America's Health Care

Vendor Meaningful Use Compare Tool

Presented By: The National Learning Consortium (NLC)
Developed By: Health Information Technology Research Center (HITRC)
Vendor Selection and Management Community of Practice

Version: 1.0
Date: October 21, 2011
Description: The Vendor Meaningful Use Compare tool is focused on evaluating functionalities of the Meaningful Use guidelines within an electronic health record (EHR) using a rating scale from 1 (poor) to 5 (excellent).
Table of Contents: Vendor MU Compare

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs (REC, Beacon, State HIE) and through the Health Information Technology Research Center (HITRC) Communities of Practice (CoPs).

The following resource is a tool used in the field today and recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

Vendor Meaningful Use Compare Tool

Instructions: Score each vendor on a scale from 1 (poor) to 5 (excellent) on each item. Total up your ratings for each vendor to help make your comparisons. Write the names of the vendors you are comparing in the watermark space provided in vendor columns. Use the blank rows at the end of the worksheet to ask your own questions.

Vendor	Vendor 1	Vendor 2	Vendor 3	etc.			
1 Demographics / Care Management							
1.1 The system has the capability to record demographics including: Preferred language, insurance type, gender, race, ethnicity, and date of birth.							
2 Patient History							
2.1 The system has the capability to import patient health history data from an existing system.							
2.2 The system presents a chronological, filterable, and comprehensive review of patient's EHR, which may be summarized and printed, subject to privacy and confidentiality requirements.							
3 Current Health Data, Encounters, Health Risk Appraisal, and Coordination of Care							
3.1 The system can exchange key clinical information among providers of care and patient authorized entities electronically.							
3.2 The system obtains test results via standard HL7 interface from: laboratory.							
3.2.1 The system obtains test results via standard HL7 interface from: radiology/ imaging.							
3.2.2 The system obtains test results via standard HL7 interface from: other equipment such as Vitals, ECG, Holter, Glucometer.							
3.3 The system can record and chart changes in vital signs including: heights, weight, blood pressure, calculate and display BMI, plot and display growth charts for children 2-20 years including BMI.							
3.4 The system provides a flexible, user modifiable, search mechanism for retrieval of information captured during encounter documentation.							
3.5 The system provides a mechanism to capture, review, or amend history of current illness.							
3.6 The system enables the origination, documentation, and tracking of referrals between care providers or healthcare organizations, including clinical and administrative details of the referral.							
3.7 The system can track and provide a summary care record for each transition of care and referral visit.							
4 Encounter – Progress Notes							

4.1 The system records progress notes utilizing a combination of system default, provider-defined templates.							
4.2 The system includes a progress note template that is problem oriented and can, at the user's option be linked to either a diagnosis or problem number.							
5 Problem Lists							
5.1 The system creates and maintains patient-specific problem lists of current and active diagnoses based on ICD9/10 CM or SNOMED CT.							
5.2 For each problem, the systems has the capability to create, review, or amend information regarding a change on the status of a problem to include, but not be limited to, the date the change was first noticed or diagnosed.							
5.3 The system can record smoking status for patient 13 years or older.							
6 Care Plans							
6.1 The system provides administrative tools for organizations to build care plans, guidelines, and protocols for use during patient care planning and care.							
6.2 The system generates and automatically records in the care plan document, patient-specific instructions related to pre- and post-procedural and post-discharge requirements. The instructions must be simple to access.							
7 Prevention							
7.1 The system has the capability to display health prevention prompts on the summary display. The prompts must be dynamic and take into account sex, age, and chronic conditions.							
7.2 The system includes user-modifiable health maintenance templates.							
7.3 The system includes a patient tracking and reminder capability (patient follow-up) updatable by the user at the time an event is set or complied with.							
7.4 The system has the capability to send reminders to patients per patient preference for preventive/follow up care.							
8 Patient Access to Personal Health Information/Patient Education							
8.1 The system can provide patients with an electronic copy of their health information.							
8.2 The system can provide patients with timely electronic access to their health information.							
8.3 The system can provide clinical summaries to patients for each visit							
8.4 The system has the capability to create, review, update, or delete patient education materials. The materials must originate from a credible source and be maintained by the vendor as frequently as necessary.							
8.5 The system has the capability of providing printed patient education materials in culturally appropriate languages on demand or automatically at the end of the encounter. Please provide current list of available languages.							
9 Alerts / Reminders							
9.1 The system includes user customizable alert screens/messages, enabling capture of alert details.							
9.2 The system has the capability of forwarding the alert to a specific provider(s) or other authorized users via secure electronic mail or by other means of secure electronic communications.							
10 Orders							

10.1 The system includes an electronic Order Entry module that has the capability to be interfaced with a number of key systems depending on the health center's existing and future systems as well as external linkages, through a standard, real-time, HL7 two-way interface.							
10.2 The system displays order summaries on demand to allow the clinician to review/correct all orders prior to transmitting/printing the orders for processing by the receiving entity.							
11 Results							
11.1 The system has the capability to route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.							
11.2 Results can be easily viewed in a flow sheet as well as graph format.							
11.3 The system incorporates clinical lab-test results into EHR as structured data							
11.4 The system accepts results via two way standard interface from all standard interface compliant/capable entities or through direct data entry. Specifically – Laboratory, Radiology, and Pharmacy information systems.							
11.5 The system includes an intuitive, user customizable results entry screen linked to orders.							
11.6 The system has the capability to evaluate results and notify the provider.							
11.7 The system allows timely notification of lab results to appropriate staff as well as easy routing and tracking of results.							
11.8 The system flags lab results that are abnormal or that have not been received.							
12 Medication							
12.1 The system identifies drug interaction warnings (prescription, over the counter) at the point of medication ordering. Interactions include: drug-drug, drug-allergy, drug-formulary, drug-disease, and drug-pregnancy.							
12.2 The system alerts providers to potential administration errors for both adults and children, such as wrong patient, wrong drug, wrong dose, wrong route, and wrong time in support of medication administration or pharmacy dispense/supply management and workflow.							
12.3 The system supports multiple drug formularies and prescribing guidelines.							
12.4 The system provides the capability to generate and transmit permissible prescriptions electronically (eRx) pharmacy and other appropriate organization for dispensing.							
12.5 The system creates and maintains active medication list.							
12.6 The system is able to keep a history of Rx changes for a specific drug a patient is taking, and this is visible both to the clinician and to an auditor / QA person.							
12.7 The system maintains active medication allergy list.							
12.8 For maintenance drugs for chronic conditions the system can remind the provider about any prescriptions expiring or running out.							
12.9 The system has capability to perform medication reconciliation at relevant encounters and each transition of care.							
13 Confidentiality and Security							

13.1 The system provides privacy and security components that follow national standards such as HIPAA and PHI.							
13.2 The system provides privacy and security components that follow Nebraska state-specific laws and regulations.							
13.3 The system hardware recommendations meet national security guidelines.							
13.4 The system protects electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.							
13.5 The system has hardware recommendations for disaster recovery and backup.							
14 Clinical Decision Support/Quality Improvement							
14.1 The system provides the capability to implement a minimal of 5 clinical decision support rules relevant to specialty or high clinical priority.							
14.2 The system has ability to generate lists of patients by specific condition to use for quality improvement, reduction of disparities and outreach.							
14.3 The system offers prompts to support the adherence to care plans, guidelines, and protocols at the point of information capture.							
14.4 The system triggers alerts to providers when individual documented data indicates that critical interventions may be required.							
15 Reporting							
15.1 Are standard clinical reports built into the system for the user to query aggregate patient population numbers?							
15.2 The system can generate lists of patients by specific conditions to use for quality improvement.							
15.3 The system has the capability to report ambulatory quality measures to CMS or the state.							
15.4 The system supports disease management registries by:							
15.4.1 Allowing patient tracking and follow-up based on user defined diagnoses.							
15.4.2 Providing a longitudinal view of the patient medical history.							
15.4.3 Providing intuitive access to patient treatments and outcomes.							
15.5 What reporting engine is utilized within the software?(ex. Crystal Reports, Excel, proprietary).							
15.5.1 If utilizing Crystal Reports do you provide a listing of all reportable data elements?							
15.6 Does the end user have the ability to create custom reports?							
15.7 Can reports be run on-demand during the course of the day?							
15.8 Can reports be set up to run automatically as well as routed to a specific person with in the office?							
16 Cost Measuring/Quality Assurance							
16.1 The system has built-in mechanism/access to other systems to capture cost information.							
16.2 The system supports real-time or retrospective trending, analysis, and reporting of clinical, operational, demographic, or other user-specified data including current and future UDS reports.							
16.3 The system allows customized reports or studies to be performed utilizing individual and group health data from the electronic record.							
16.4 The system will provide support for third-party report writing products.							

17 Chronic Disease Management / Population Health							
17.1 The system can submit immunization data electronically to immunization registries.							
17.2 The system can provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.							
17.3 The system provides support for the management of populations of patients that share diagnoses, problems, demographic characteristics, etc.							
17.4 The system has a clinical rules engine and a means of alerting the practice if a patient is past due.							
17.5 The system generates follow-up letters to physicians, consultants, external sources, and patients based on a variety of parameters such as date, time since last event, etc. for the purpose of collecting health data and functional status for the purpose of updating the patient's record.							
17.6 At minimum, the system is able to generate a variety of reports based on performance measures identified by the Physician Consortium for Performance Improvement (AMA/Consortium), the Centers for Medicare & Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA) for chronic diseases. Information on these measures can be found at: http://www.ama-assn.org/ama/pub/category/4837.html. The system follows measures approved by NQF (national quality form) and prompted by the AQA (ambulatory quality alliance) as well as those identified by the HRSA's Health Disparities Collaborative http://www.healthdisparities.net/ .							
18 Consents, Authorizations, and Directives							
18.1 The system has the capability for a patient to sign consent electronically.							
18.2 The system has the capability to create, maintain, and verify patient treatment decisions in the form of consents and authorizations when required.							
18.3 The systems captures, maintains, and provides access to patient advance directives.							
19 Billing							
19.1 The system provides a bidirectional interface with practice management systems.							
19.2 The system can check insurance eligibility electronically from public and private payers. List clearinghouses with which this functionality exists.							
19.3 The system can submit claims electronically to public and private payers.							
20 Document Management							
20.1 The system includes an integrated scanning solution to manage old charts and incoming paper documents.							
20.2 Scanned documents are readily available within the patients chart.							
20.3 Scanned documents can be attached to intra office communication and tracked.							
20.4 The system has the ability to bulk scan and easily sort old patient charts for easy reference later.							
20.5 Images and wave files can also be saved and stored in the document management system.							
20.6 Insurance cards and drivers license can be scanned and stored in patient demographics.							
20.7 Scanned documents can be attached to visit notes.							

20.8 In a multiple location environment can each office scan in the same manner?							
Total Score							