Stage 1 Meaningful EHR Use via RevolutionEHR
Core 11 – Clinical Decision Support

Overview

EHR technology is expected to provide for at least one clinical decision support rule to be implemented. The rules implemented are to be relevant to the provider's specialty or to point out a matter of high clinical priority.

MU Objective and Calculation

The provider must have implemented at least one clinical decision support rule for the entire EHR reporting period. The provider must attest YES to satisfy this objective.

Meaningful Use Discussion

For the purposes of certification, EHR technology is expected to create a clinical decision support alert based upon data kept in a patient's demographics, diagnosis list, medication list, and lab test results. Within the context MU, the provider is expected to use the EHR to develop clinical decision support alerts that use general and patient-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care."

CMS only says that the determination of appropriate clinical decision rules is left to the provider who will consider their workflow, patient population, and quality improvement efforts. RevolutionEHR developed the Clinical Decision Support process to analyze the details of the patient record specific to the certification standards. In the current state, RevolutionEHR does not allow users to create clinical decision support rules based upon examination test results, but will include that in the future.

Establishing these rules in RevolutionEHR is done by any user with administrative privileges. Under Administration, the System Rules section includes a Clinical Decision Support set-up screen. An example of a rule might include a reminder that a patient should undergo a dilated fundus examination if the patient's diagnosis list includes any diagnosis of diabetes.

After rules are established, they will only appear within patient encounters if the Clinical Decision Support screen is added to the encounter templates for the practice. This screen should be considered for addition in the Assessment/Plan workflow step, and might be best located after the Assessment screen where the Today's Diagnoses entries are added to the encounter. All set-up must be done prior to the first day of the provider's MU reporting period, since this objective requires that this rule be in place for the entire reporting period.

It should be noted that the support offered by drug-drug and drug-allergy interaction functionality of RxNT cannot be used to meet this Stage 1 MU objective.

Conclusion

Meeting this objective is not expected to be difficult if users contemplate the variety of rules that might be appropriate for their care of patients. Attestation is simply stating that a rule has been in place during the entire reporting period.