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EHRs 101: Myths and Realities

The arguments for and cautions about the transition to electronic health records was presented to the members of the Denver and Arapahoe/Douglas/Elbert Medical Societies by Michelle Holmes, Senior Manager with ECG Management Consultants in Seattle, in a talk entitled *EHRs 101: Myths and Realities* on April 14th. The program was held at the Wellshire Inn and sponsored by NextGen. The presentation, intended to help physicians navigate the decision-making process concerning the transition to electronic health records, was originally planned prior to the announcement of the substantial financial incentives available to physicians under President Obama's new stimulus bill for the purchase and implementation of EHR technology. The April program, which focused primarily on the pros and cons of moving to EHR and included current information on the implementation of the stimulus package incentives, was the first of a two part series and will be followed by *EHRs 201: Selection and Implementation* on Wednesday, May 13. That program will focus on the steps to select an appropriate EHR for your practice and important aspects of the implementation process. For reservations contact DMS at (303) 377-1850 or dms@denvermedsociety.org.

According to the definition developed by the Healthcare Information and Management Systems Society, an EHR is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Working from that definition, Ms. Holmes described the ideal goal of EHR technology serving as an interface for practice management systems, electronic medical records, and personal health

records. A variety of forces, both internal and external to the medical practice, are driving the interest in EHR technology and include the desire to increase quality and efficiency, expand access, and manage the complexity of the current reimbursement and clinical data environments. Most experts see a national EHR infrastructure

as an essential foundation to any successful healthcare reform. Even prior to the stimulus bill, the Medicare Improvements for Patients and Providers Act of 2008 had established a five year program of incentive payments for "successful electronic prescribers", and new interpretations of the Stark laws have enabled hospitals to donate part of the cost of new EHR systems to community physicians. Under Stark, hospitals may donate EMR software licenses, connectivity, interfaces, training and software maintenance. Practice management software licenses can be donated if they are integrated and if there is a commitment to implement the EMR. Donations of hardware are excluded.

Ms. Holmes emphasized that the way in which an EHR system is implemented and used, as well as the functionality available in the system, will significantly influence the cost-benefit analysis for a practice. Simply installing an EHR will not achieve the hoped for



Michelle Holmes, speaker

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benefits if the practice does not clearly articulate its goals for the system and carefully examine both its business and clinical processes to ensure they allow maximum use of the benefits and functionality offered by the EHR.

When done properly, an EHR can result in increased efficiency and revenue generation with estimates of per physician revenue increases of up to 20% or more. The revenue cycle can also be enhanced through improved coding, a reduction in lost charges, and reduced service-to-charge entry time. Additional savings can be achieved through reduced medical records staffing and costs, including significant decreases in the number of chart pulls, copying and courier costs, and enhanced use of space that can be converted to revenue generating uses. Other operational enhancements can include decreases in

support staff, transcription costs, and discounts offered by some malpractice carriers for EHR use. Patient care enhancements can include reduced adverse drug events, more effective drug dosing, a reduction in redundant lab tests, reduced median response times for alerts on highly abnormal lab result values, and the potential for increased revenue through identification and outreach to patients who are overdue for tests and procedures.

The successful implementation and return on investment of an EHR can be foiled by failure to identify implementation goals and vendor contracts that do not provide incentives for the vendor to assist you in achiev-

ing those goals and in dealing with unexpected problems. Physician fears about conversion to EHR such as ongoing costs including productivity declines, documentation that doesn't reflect the "way physicians think", patient response, and obsolescence, can be minimized and potentially avoided by proper planning and carefully drafted vendor contracts.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 is the portion of the stimulus bill which provides for financial incentives for EHR adoption by physicians, hospitals, and other healthcare providers. The Act provides for \$19 billion to be made available over a five year period for the purchase and implementation of health information technology. These incentives will be provided through a formula based on Medicare Part B charges. For early adopters who are able to show meaningful use of an EHR in 2011 and 2012, a maximum of \$18,000 per

physician is available based on 75% of allowed Medicare Part B charges with reduced amounts in subsequent years. Beginning in 2015, providers who cannot show meaningful use of EHR will see a reduction in their Medicare payments, which will reach minus 3% in 2017 and beyond. Exceptions for significant hardship for practices unable to meet the standard will be defined by the Secretary of Health and Human Services. Practices that see large volumes of Medicaid patients may receive incentives through the Medicaid program, but providers cannot be receiving incentives through both the Medicare and Medicaid programs simultaneously.

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EHR Overview—Myth Versus Reality	
Myth	Reality
All information systems are the same.	Features and functions are highly variable.
There are benefits (financial and otherwise) to system implementation.	Desired benefits need to be planned, evaluated, and mapped into the implementation to be achieved. Efforts should not be underestimated.
Outsourcing is cost-effective.	Outsourcing may create a dependency from which it is difficult to recover.
An integrated system is always better than an interfaced system.	Many integrated systems are actually interfaced, or there are gaps in the integration.
Vendors provide assistance in system adoption.	Vendors assist in implementing the system but do not necessarily ensure full system adoption.
Companies are stable.	The vendor market is volatile.
Newer technology is better.	Newer products may not be as feature-rich as established products.
IT is not strategic.	Providing IT to practices is the new strategy.
An EHR will enable P4P.	Reporting requires discrete data points.

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Current e-prescribing incentives will not be payable to those providers who are receiving incentives through the EHR program, but penalties for non-e-prescribing will be phased out in 2014 so that only one penalty will be applied to Part B reimbursements for non-users.

In order to satisfy the requirement of “meaningful use”, providers must demonstrate that they are using the technology in a meaningful way, can demonstrate electronic exchange of health information that improves quality, and submit required clinical quality measures. The demonstration of meaningful use and information exchange will be defined by HHS and may include attestations, reporting, survey response or other means still to be defined. Meaningful use must include electronic prescribing capability, and the EHR technology must be certified. Currently, certification criteria have been implemented by the Certification Commission for HIT (CCHIT), and the Secretary of HHS is required to develop further uniform electronic standards by December

31, 2009. Existing standards for EHR certification include the ability: to create an EHR that includes patients’ demographic and clinical information; to provide clinical decision support; to support physician order entry;

to capture relevant healthcare quality information; and to exchange and integrate electronic health information from other sources. It is anticipated that certification requirements will evolve over the next several years, and practices should ensure that their vendor will be able to meet these evolving standards.

The stated goal of the HITECH Act is to have “utilization of a certified electronic health record for each person in the U.S. by 2014” and to have 90% of physicians using EHR by 2019. There will clearly be a big push by both government bodies and vendors to move physicians toward EHR adoption on an aggressive time frame. Physicians will need to be thoughtful and cautious in examining their practice’s needs and concerns.

Federal Stimulus EHR Incentives for Physicians		
First Payment Year	First Payment Year Amount, and Subsequent Payment Amounts in Following Years	Reduction in Fee Schedule for Non-Adoption/Use
2011	\$18k, \$12k, \$8k, \$4k, and \$2k	\$0
2012	\$18k, \$12k, \$8k, \$4k, and \$2k	\$0
2013	\$15k, \$12k, \$8k, and \$4k	\$0
2014	\$12k, \$8k, and \$4k	\$0
2015	\$0	-1% of Medicare fee schedule
2016	\$0	-2% of Medicare fee schedule
2017 & beyond	\$0	-3% of Medicare fee schedule

Going “Electronic” - Why? Return On Investment (ROI) Potential

The way in which an EMR is implemented and used, and the functionality available, greatly influences the cost-benefit equation.

	Provider Hands-On (Full EMR)	Provider Hands-Off (Paper-Reliant)
Description	<ul style="list-style-type: none"> • Use of the EMR at the point of care by all physicians and clinicians. • Scanning/abstracting of key documents by clerical and/or clinical staff. • Interfaces with other systems (transcription, e-physician, medical manager, etc.). 	<ul style="list-style-type: none"> • Nurses and MLPs enter orders and other information into the system (vitals, allergies, etc.). • Physicians continue to use dictation/transcription (documents interfaced to EMR). • Mini-chart is printed before each visit. • Other documents are scanned.
Pros	<ul style="list-style-type: none"> • Potential reduction in clerical staff and chart storage space over time. • Point-of-care cost savings. • Reminders/alerts at point of care. 	<ul style="list-style-type: none"> • May reduce clerical staff and chart storage space over time. • Relies on coding benefit via PDA. • May transition to physician use later. • Has less impact on physician work flow.
Cons	<ul style="list-style-type: none"> • Requires a change in physician work flow. • Affects short-term provider productivity. 	<ul style="list-style-type: none"> • Cost of printing/destroying documents. • Coding not tied to encounter documentation. • No point-of-care reminders/alerts. • No point-of-care cost savings.