Preparing for HIT

What you need to know about the federal incentive program

Barbara M. Drury, FHIMSS, President, Pricare Inc.

For some around the country, the "favorite" holiday gift of December 2009 was the 800 pages of rules for the federal Health Information Technology incentive program released by the Department of Health and Human Services (CMS and ONC) on December 30. Created as part of the American Reinvestment and Recovery Act of 2009 (ARRA) the incentives provide money (a maximum of $44,000 to $63,500, depending on the program) to non-hospital based physicians for "meaningful use" of a "certified" Electronic Health Record system. There also are consequences for non-adoption. (See box below, 'How much money?')

If you have already adopted an EHR or have been considering an EHR, you know from personal experience that the amount of incentive money is certainly helpful. But meeting the requirements to get the funds will take research, careful evaluation, planning and hard work on the part of physician practices.

What do I need to do to get the money? Sure to be added to the dictionary for 2010 is the term "meaningful use". This concept of using the technology versus having it installed and available in your office, was introduced in ARRA and further defined by advisory committees created as a result of the law. The government is taking public comment on the proposed rules until March 15, and an interim final rule is not expected until late spring or early summer, so some details could change. However, as proposed, there are five broad areas of use (criteria) that all measures are keyed to:

- Improving quality, safety, efficiency, and reducing health disparities;
- Engage patients and families in their health care;
- Improve care coordination;
- Improve population and public health;
- Ensure adequate privacy and security protections for personal health information.

Specific Care Goals were identified for physicians and for eligible hospitals. In support of those Care Goals, specific measures have been suggested as required for determining whether a professional is a "meaningful user" of the

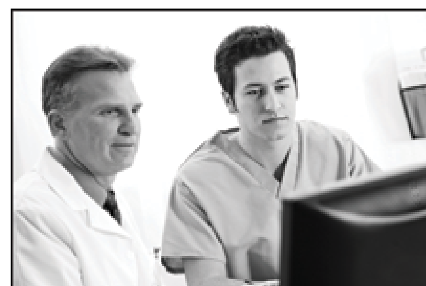
How much money?

Physicians must choose an incentive either through Medicare or Medicaid. Each physician may change once during life of incentive program.

Medicare incentives are based on the 75% of the allowable charges (Medicare, co-insurance, and patient share) over the reporting period (90 continuous days in Reporting Year 1, 365 days in Reporting Year 2-5). Maximum incentive of $44,000 over five years; more if in a health care shortage area.

Medicaid incentives are only available to professionals who meet an "eligibility" threshold of 30% of patient encounters (less for pediatricians). Maximum incentive of $63,500 over six years.

See **www.cms.org** for more details.



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certified technology. Some of the measures are required of all professionals before receiving any incentive monies, while others are specialty-specific.

The Stage one measures will be reported, in part, via claims data and in part via an attestation statement. CMS is unable to process clinical data that natively resides in an EHR, so this hybrid reporting will be the norm for Stage one criteria. The box "Achieving Meaningful Use" (right) demonstrates a sample mix selected from the full list of measures. You will observe that some measures required for any professional who wants to receive incentives are not particularly typical within the current workflow of a particular specialty. Some measures aren't even part of an EHR, such as eligibility checking or recording race and ethnicity. And for many measures, to be a meaningful user, 80% of all patients must meet that measure.

What is "certified" technology? The only entity currently recognized to certify EHR technology, pre-ARRA, is the Certification Commission for Health Information Technology (CCHIT). Some products have been pre-certified based on last July's definition of meaningful use. These and other products will need to be re-tested and re-certified based on the Rules published January 13, 2010. All parts of technology used to demonstrate that you are a meaningful user must be certified. This would seem to include new products that have never been certified, such as your practice management system, registries, patient-provider portals and health information exchange products.

What should I do next? If you've made it this far, you are to be commended. Hopefully, you are now more aware of some of the issues ahead of us all. If you really want to personally read the language and comment on it, the pdfs of the Federal Register are available at www.cms.org. If you are seriously considering participating in the incentive programs or adopting EHR technology, here's what you should do next:

- Determine exactly why you or your group has or will adopt EHR technology;
- Identify if your group's motivation aligns significantly or something less than significantly with the requirements to participate in the incentive programs as they are proposed;
- Evaluate how your people and your processes align with the EHR technology and the incentives;
- Develop an accurate budget and identify sources of money to pay your EHR technology obligations while demonstrating meaningful use. Your obligations will probably occur at least 18 months before you see any incentive monies;
- Consider the pros and cons of EHR technology for your patients and their health; and,
- Get outside help if you have the slightest twinge of 'butterflies'. It's very difficult to divorce your EHR technology after you've said "I do"!

Don't forget to investigate all the tools that the Colorado Medical Society and the component societies have developed for you. The incentives and the measures for meaningful use are new; your particular situation informs not only you but through broadening the interpretations with real-life, on-the-ground practices, makes the opportunity of EHR technology more useful to all. ■

Achieving meaningful use

Sample of stage one meaningful use criteria*

- Record orders in the EHR electronically
- Enable and implement drug-drug, drug-med allergy, drug-formulary checking
- Transmit permissible prescriptions electronically
- Maintain up-to-date problem list based on ICD9 or Snomed CT
- Perform eligibility checks electronically
- Record race, ethnicity, preferred language, gender, date of birth, insurance type
- Screen for tobacco use for age 13 and older
- Calculate and record BMI Sample of Stage 1 Quality Reporting Measures*
- Blood pressure measurement
- Avoidance of inappropriate drugs for age 65 and older
- Women age 40-69 with mammogram in past 24 months
- Age 50 and older with influenza immunization during flu season
- Prenatal screening for HIV

* For a full list of criteria and quality measures, including measures by specialty, see the HIT page at cms.org

Case study

Implementing EMR was "terrible," but this practice wouldn't go back

Laird Cagan, MD and Mary Poole, MD, Frontier Internal Medicine, LongmontFrontier Internal Medicine, Longmont

EMR: McKesson Practice Partner Start date: July 2006

Sara Burnett, Health Care Research/Project Specialist, Health Care Financing Division

Editor's note: Over the next year, Colorado Medicine will examine practices that have already implemented an EMR. Drs. Cagan and Poole start the series.

Why did you choose this EMR?
The price. After looking at many different EMRs, they decided all of the systems were very similar. So they went with the vendor that gave them the best deal. Some systems were three times the price, and didn't seem to be that much better, Poole said.

How would you describe the experience?
Implementing the new system was "terrible, as everybody says," Cagan said with a smile. "It's much more than simply switching from paper to an electronic system. Everything is changed."

There were many stressful days, and Poole had to cut her clinical time by about one-third during the first year of using the system just to deal with all the changes and problems that popped up. But over time, things began operating more smoothly.

Poole and Cagan say they still haven't seen a clear return on investment. In fact, they're still paying back the loan they took out to buy the system and all the hardware. But they say that seeking a return on their investment isn't why they made the switch. They wanted to provide higher quality care, and that is definitely happening, they say.

How is the support from the company?
"Variable," Poole said. "When it's good, it's good. But it's not always good."

Laird Cagan, MD and Mary Poole, MD

Do you have any words of wisdom for other physicians?

1. Before you begin, visit an office that has an EMR and spend a day seeing how they use it, and how it changes things.
2. Be aware there will be significant changes in your practice, including an initial slowdown in billing. Be ready for the stress, be flexible, and know that hopefully, the new system will eventually improve your practice.
3. Have "champions" – preferably a physician and someone else in the office – who are able to manipulate the EMR so they can fix problems.
4. Purchase a fully-integrated system, which includes your records, billing and scheduling.
5. Ease into it. Start by doing one thing at a time, such as your notes. As you get comfortable, adopt the next thing until you are utilizing the system as fully as you can.
6. Don't copy all of your paper charts into the system. We started with just recent office visits and key tests such as colonoscopies and mammographies, and recent consultations. You can always go back and pull the paper chart if you need it.
7. Get all the financial support possible, whether from the hospitals, the government or labs.
8. To help decide which company to use, go with the company that will give you the best support. "A good support system from the software company is essential," Poole said. ■

Case study
The journey begins

Robert Doolan, MD, Denver Internal Medicine Group

EMR: GE Centricity Start date: April 1, 2010

Sara Burnett, Health Care Research/Project Specialist, Health Care Financing Division

Editor's note: Denver Internal Medicine Group selected an EMR last year and plans to go live on April 1. Robert Doolan, MD, one of seven physicians in the growing practice, has agreed to share the experience with Colorado Medicine readers over the next few months. This Q&A looks at how and why the practice selected its EMR and what it's done so far to get ready. Find out how it's going – and the lessons learned – in future issues. (This is an edited transcript).

Where are you in the process?
We have committed to an EMR (GE Centricity). We just had the hardware installed and some staff have started training modules. We are going to update our practice management software in the next week or so, and we plan to complete training and go live the first of April.

Why did you decide to implement an EMR?
A lot of reasons. With all the information we get on patients today, it's harder to keep track of things such as: When was the last colonoscopy? Are physicals up to date? Are my diabetics meeting their targets? So managing that information better and providing better patient care is one goal.

We also want to integrate with our Web site, so our patients can access some of their information that way. If a patient has to go to an emergency room out of town, they can log in or tell someone there how to access at least some basic information.

We also feel like it's important to get a system up and running now, so that as changes happen in the way that medicine is being reimbursed, we are at the forefront of being able to deal with that.

I fully expect that at some point down the road there's going to be a tiered payment system based mainly on particular outcomes, and if we can document how far ahead of the curve we are with all of these measurements, we should be able to be reimbursed at a higher level.

How did you choose GE Centricity?
The main reason is that five years ago we went with their practice management software and we liked that. We got comfortable using it and it's meeting our needs. What we didn't want to do is have one vendor for the practice management software and one vendor for the EMR, assuming the EMR was going to be fine, and we liked their EMR as well as any.

We also felt that this was a big company that's not going to go away, and that they are well positioned to ensure that their product will be able to meet meaningful use, which is going to be important to us down the road.

Do you expect that the incentives cover your costs?
Yes. As it's laid out now, we are expecting that after our second year of incentive payments, our system will be paid off completely.

Robert Doolan, MD

What advice do you have so far for your colleagues?

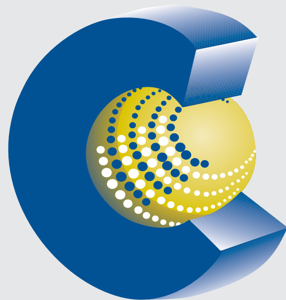
I think it's important to really take the time to look at your office and how it's set up. Look at a variety of systems to see which feels the most comfortable for you, because I think that many different systems can function equally well.

Also, it's really important to look at how you're going to pay for this system and to feel pretty comfortable that if you're going to use the government assistance, that you can meet those requirements, whatever they end up being.

I would not recommend physicians try to be their own IT person. We're using someone who has done three or four office-wide installations of the software we are using. And just from installing the hardware, he knows from problems they've had in other offices a couple of the things they need to put in and get going before we have the same problems. I think having that assistance is really important.

Any final words?

I don't think it's going to be easy. But we fully believe we need to do this because in the future, if we don't, we might not get paid. That's my worry. I think down the road, it's better for everybody. ■



Facilitating Health Information Exchange

Janice Whittleton, CORHIO Director of Business Development

CORHIO working with clinicians, communities

Just 10 years ago, e-mail was still relatively new, yet consider for just a moment how it has transformed your own life in such a short time.

No more waiting days for an important piece of mail to be delivered or standing around the fax machine to ensure a confidential fax is not lost or viewed by the wrong set of eyes. With e-mail, each of us may view our mail through a different program. Yet, regardless of whether we use Gmail, Yahoo, an iPhone, Blackberry or Outlook, we see the same information (subject, to, from, body text, images, signature, etc.).

Now, imagine if you could transform your medical practice to include some of the same efficiencies you gained from e-mail. Welcome to the decade of health information exchange (HIE) and electronic health records (EHRs). HIE is much like using e-mail to exchange information, but in a more sophisticated and secure manner. It's not unrealistic to believe that the terms "HIE" and "EHR" will be used as commonly by clinicians in the next decade as "e-mail" is used by many people today.

The Colorado Regional Health Information Organization (CORHIO) is the state's designated entity to facilitate health information exchange (HIE) across Colorado. It is our goal to ensure that the right information is available at the right time and place for each patient across Colorado. CORHIO does that by collaborating and convening within and among communities and providing technical services where HIE capacity doesn't exist today. CORHIO is committed to helping all providers in Colorado draw down the federal stimulus funds that become available in 2011 for use of electronic health records.

CORHIO, currently funded by a grant from The Colorado Health Foundation and anticipated federal stimulus funds, is facilitating HIE by creating an information highway with interfaces (think on and off ramps) that connect each physician's EHR to regional and statewide HIEs. For those without EHRs, the same data can be sent through the system to a fax machine or printer as an interim approach to facilitate data exchange within the current office workflow. Or better yet, CORHIO is offering an EHR "light" product to provide basic EHR functionality for those not ready to bite off a full EHR implementation but who want to try it out.

Already participating in HIE on the Western Slope through Quality Health Network (QHN)? No problem! CORHIO and QHN are working closely together to ensure the entire state will be interconnected.

CORHIO is in the final stages of selecting an HIE vendor to create and launch the Colorado-wide HIE highway starting this summer. The state-wide goal is to connect over 85% of physicians, hospitals, long-term care organizations, clinics, imaging centers, labs and pharmacies into Colorado's HIE highway by 2015. To achieve this, CORHIO is working with communities across Colorado to help them assess their needs as they organize to implement HIE. If you'd like to learn more about HIE in your community or how you can bring HIE to your community, contact CORHIO at info@corhio.org.

One way CORHIO will be helping primary care physicians in small practices and safety net providers in particular, is by coordinating the Colorado Regional

> **Want to learn more about how HIE is already working on the Western Slope?**
>
> Listen to a podcast with Gregory Reicks, DO, president of the Mesa County IPA, as he discusses the Quality Health Network. A link to the podcast is on the CMS/Component Socieities' HIT Web page at:
>
> **www.cms.org/HIT/1HITHome.html**

Extension Center (CO-REC). Services offered by CO-REC are focused on supporting you and your practice in selecting, implementing and using an electronic health record (EHR) so that you can connect to the HIE highway to meet the federal "meaningful use" standards and qualify for stimulus incentives. CORHIO has applied to the federal government to serve as Colorado's REC. To learn more about CORHIO, please visit www.corhio.org. ■

Frequently asked questions about CORHIO

What is CORHIO?

CORHIO (Colorado Health Regional Health Information Organization) is a not for profit organization, designated by the Governor, to receive and coordinate Health Information Technology (HIT) funds available through the American Recovery and Reinvestment Act (ARRA). CORHIO's mission is to facilitate health information exchange to improve the health of all Coloradoans.

Where does CORHIO get its HIE funding?

CORHIO is the recipient of two grants focused on building community based health information exchanges that tie into a statewide exchange. The grants include a private grant from The Colorado Health Foundation and an anticipated public ARRA grant from the Office of the National Coordinator (ONC). While grant funding will alleviate some of the provider and community cost burden to launching HIE, CORHIO's long-term sustainability is dependent upon a fee-based subscription model.

Which communities is CORHIO working with today?

CORHIO is facilitating commitment to and implementation of community wide health information exchanges in the San Luis Valley and in Boulder. In addition, CORHIO is working with numerous communities east of the continental divide to assist in developing community commitment to HIE. CORHIO is also collaborating with Quality Health Network in Grand Junction to support community HIE development west of the continental divide that will function as part of the statewide HIE.

What other initiatives have CORHIO undertaken to support HIE?

As the state designated entity for ARRA HIT funds, CORHIO is collaborating with 12 organizations statewide to offer Regional Extension Center (REC) services, which will be funded through a grant from the ONC as part of ARRA. REC services are intended to meet Colorado's goal of having 85% of primary care and safety net providers using an EHR that includes health information exchange of patient data by 2015.

What data is CORHIO planning to transmit as part of HIE?

CORHIO has identified three stages for the roll-out of HIE data transfer capabilities in Colorado.

1. Clinical messaging:
   - Exchange of secure messages for results, reports, referrals, lab/imaging orders, and ePrescribing
   - Public health notifications and alerts
2. Point of care inquiry:
   - Longitudinal access to patient records at the point of care needed by a clinician
3. Advanced clinical analytics:
   - Advanced clinical analytics and reporting
   - Connecting patients and families

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For more information contact Andi Johnston at:

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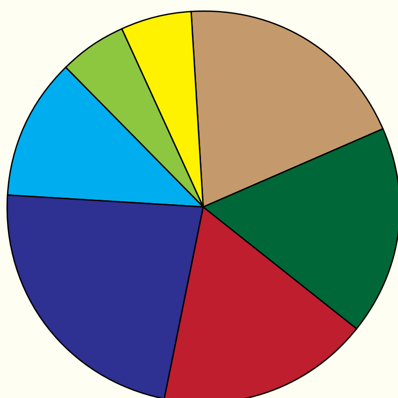
Practices-like-mine: Practice "symptoms" for EHR winners

Barbara M. Drury, FHIMSS, President, Pricare Inc.

Do you ever wonder what makes the difference between a practice that successfully and happily implements and uses an electronic health record (EHR) and another office, with the same EHR, that has a miserable and unsuccessful EHR experience?

Since 1994, the Healthcare Information and Management Systems Society (HIMSS) Nicholas E. Davies Award of Excellence has recognized excellence in the implementation and value from health information technology, specifically EHRs. This prestigious national award has been given to 19 independently-owned practices around the country, ranging from solo practitioners to 80+ physicians, in all demographic settings and including primary care plus subspecialties. Daniel Griffin, MD, formerly of Alpenglow Medical in Fort Collins, was a 2006 Davies Ambulatory Award recipient. Judged by a committee made up of previous Davies recipients and other experts, the award recognizes over-the-top EHR and technology implementations – not just 'surviving' the EHR.

In an approach somewhat like a popular patient-centric Web site, a new book available from HIMSS in April 2010 titled "EHR: Your Guide to Implementation" compares "signs-symptoms-treatments" gleaned from the experiences of these unique winning users of EHRs. In all practices, someone in the office identified pain points and thought that an EHR would alleviate some of the issues around them. However, while some pain points or needs are common among the winners and others were unique, nearly all of these winners share organizational attributes that helped them look to the EHR as a potential solution and helped them weather the many issues encountered along the way.



These organizational attributes can be inferred to be readiness indicators for other physician offices as they consider their own readiness to become users of this technology. Following is the list of organizational attributes among these winners:

- Leadership environment;
- Budget and funding capacity;
- Clinician with business or technology training or prior EMR experience;
- Experience with computerized billing and scheduling;
- Willingness to look at workflows;
- Willingness to change courses;
- Willingness to accept local responsibility;
- Recognition that care delivery is also a business;
- Recognition of the value of data above digitized documents; and,

- Practice culture of patient population management prompted by initiatives from payers, national groups and/or research efforts.

We expect or have already heard about the impact for some of these attributes: leadership, budget, workflows and care management. However, some of the other attributes may not have as much visibility. Yet these winners' experiences indicate they made a difference. Excerpting from the list, let's look specifically at a few.

Willingness to change courses

These winners had the ability to have a plan, assess how the plan was working from a process, a people (patients and staff) and a technology perspective, develop an alternative plan based on information and actually change course in the middle of a process. This entails not only flexibility within the practice but also informed decision-making around the original plan and the optional plan.

From Virginia Women's Center, 2009: *"It was difficult to accept failure and financial burden of the unused technology (bubble-sheets and scanners). Knowing when to quit was a challenge. As EHR was implemented, it became clear that when providers utilized the developed tools correctly, very little keyboard entry was needed. Voice recognition became less important and was ultimately discarded. We quickly learned that durability is a major factor with tablet PCs. We abandoned the initial tablets for the much sturdier models and equipped with wireless cards to allow universal access to the network regardless of nationwide location."*

Willingness to accept local responsibility

Selecting and implementing an EHR is definitely not a passive experience. These recipients jumped into the process with both feet: local team, local expectations, local user needs, local customization and engagement with the vendor. They owned the whole process and accepted responsibility for doing what was necessary without blame. One of the themes of taking local responsibility included, for better or worse, the practice making noise and staying engaged with the vendor. That means articulating, confronting and acknowledging that it takes both parties at the table to make a successful EHR implementation. In some cases, that meant complaining but articulating a problem, or developing content, or serving on user groups, or acting as a reference site, or pushing the vendor to include priority items in research and development. It meant that these practices had the attention of their vendor; the vendors knew them by name and each practice was actively demonstrating the increasing use of the vendor's product. The message? Be brave and speak up!

Recognition of the value of data over digitized documents

These winners (13 out of 19) frequently mentioned the use of discreet data rather than simply a computerized document. Some had the foresight to plan for the use of data while others grew, some painfully, into understanding the significance of data in the local practice as well as with other entities in the business of care delivery.

From Evans Medical Group, 2003: *"Finally getting the clinical information in the exam room in a form that would allow it to affect real-time decisions was a major step toward becoming truly computerized. It was this process that taught me that the real impact of EHR would not be as a record-keeping device, but as an interactive database. I began to imagine having 100% immunization rates, top-quality disease management, and being able to share that information with both payers and patients. We now regularly search the database for all patients who are overdue for shots. An example search would be: show me all of the patients who are 3 months old, have not had their first DTaP, and do not have a scheduled appointment."*

If you want to see how your practice compares with other practices that are outstanding users of EHRs and technology, the Organizational Attributes chapter in the new HIMSS book is full of other examples of organizational attributes that made a difference in the successful and happy use of EHRs for these practices. Whether you're considering an EHR or already using the EHR, you'll want to understand how your office's "symptoms" might impact your success with an EHR.

(Note: Some material excerpted from "EHR: Your Guide to Implementation" (c) HIMSS 2010. To read each complete recipient application, see www.himss.org/davies/pastrecipients_ambulatory.asp).

Davies Award
NICHOLAS E. DAVIES

TRANSFORMING HEALTHCARE THROUGH IT ™

EHR: Your Guide to Implementation

Margaret Schulte, DBA, FACHE, CPHIMS, Editor
Published by HIMSS, Available May 2010, at www.himss.org/store

Lessons Learned: A succinct and very usable book that can serve as a reference point for health care organizations and provider practices who are considering the implementation of an EHR and for those who are expanding the functionalities of their current information systems. The book focuses on the practical lessons the Davies Award recipients have shared and pulls those lessons into a "manual" that will help providers to develop the business case for the EHR and to address leadership, management, process and adoption.