EHR REPORT

The EHR Stimulus Plan: Reaping the Rewards

BY NEIL SKOLNIK, M.D. AND CHRIS NOTTE, M.D

The much talked about stimulus package has spurred legislation that is aimed at promoting the use of health care technology. The question is whether the goals of the legislation will truly help practicing physicians stem the rising costs of delivering effective care, or if—even with the financial incentives the legislation offers—it will turn into a financial burden to most practices.

The Health Information Technology for Economic and Clinical Health Act, or HITECH, was signed into law in February. Included in this bill is about $50 billion in funding that is designated to promote the adoption of electronic health record systems in all physician practices by 2015.

That money is to be spent in a number of ways, including incentives to individual physicians, development of HIT (Health Information Technology) Regional Extension Centers, education of HIT professionals, and state grants to promote health information exchange. According to the current bill, that cash will start flowing in 2011. How can doctors in private practice get their hands on some of it? That is where things become somewhat vague.

According to HITECH, physicians who are making "meaningful use" of a certified EHR will qualify for up to $44,000 in incentives that will come in the form of Medicare or Medicaid reimbursements paid out over 5 years.

Priority will be given to individual physicians or to small practices focused on primary care, as well as not-for-profit hospitals and health care centers in underserved communities. Ostensibly, these incentives are designed to offset the cost of full EHR adoption and encourage the use of high-quality EHR software.

Look a little closer at the definition of "meaningful use," however, and you will find a complex matrix of objectives and quality measures.

Released in June, the "Meaningful Use Matrix" is organized around five major objectives: improving care quality, safety, and efficiency, and reducing health disparities; engaging patients and families in the care plan; improving care coordination; improving population and public health; and ensuring the privacy and security of health information.

Specific objectives are further delineated under each of these headings, with targets set for years 2011, 2013, and 2015.

Examples range from basic functions such as maintaining an updated patient problem list and ensuring computerized documentation to more complex functions such as instituting decision-support tools at the point of care and reporting public health data.

The application of these goals will not be straightforward, and, as with so many other government publications, there is plenty of room for interpretation. Over time, the implications will need to be further delineated and individual physicians will need to rely on EHR consultants and individual vendors to help make sense of it all.

Another concern is determining which vendors will qualify as offering certified EHR systems. The HIT Policy Committee has made it clear that the certification process will differ from that of the Certification Commission for Health Information Technology (CCHIT), the current standard in EHR approval.

This could help to open up the playing field for companies that offer lower-priced software packages, but it also could lead to yet another set of unwieldy qualifications. The final definition of a certified system could have a profound impact on the true value of the cash incentives offered under HITECH.

For smaller practices choosing a modest, moderately priced EHR package, $44,000 could represent a substantial sum. However, it may be an insignificant amount if the standards limit the certified options to only high-end EHR products costing $200,000 or more.

Either way, every practice must have the expectation that the adoption of an EHR is going to be a costly undertaking. Will the initial expense be offset by the perceived convenience benefits or theoretical cost savings? Only time will tell.

Although the cost of compliance may still elude us, the consequences of noncompliance do not. HITECH is clear that providers who are not making meaningful use of a certified EHR will face financial penalties, beginning in 2015. Those providers who have resisted the switch to EHRs because they could not afford it will soon find their reticence unaffordable.

One encouraging sign is that many physicians are already on their way to the goal. According to the National Center for Health Statistics (a division of the Centers for Disease Control and Prevention), there has been a steady and significant increase in the number of physicians making full or partial use of an EHR.

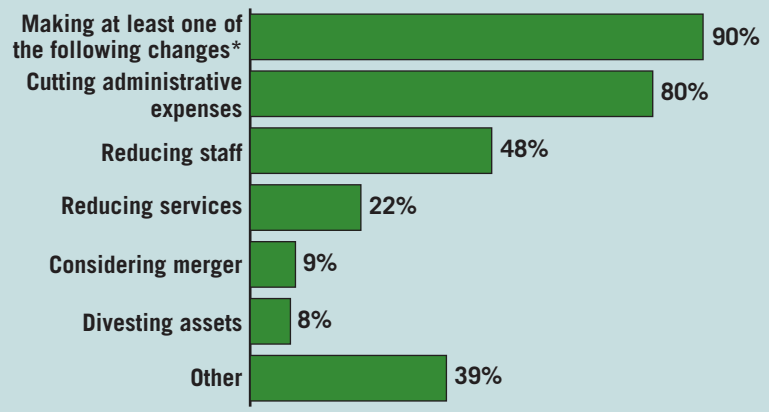
In 2008, the NCHS reported that about 38% of physicians were making some use of an EHR, though about half of those admitted their system is only minimally or partially functional. This is up from 29% making some use of an EHR in 2006, and it seems that, even without government stimulus, progress is being made.

In spite of initial skepticism about government involvement in patient care, it is difficult to deny the appeal of a little extra money in your pocket. In the end, though, the success of HITECH will not be determined by philosophical goals or Medicare reimbursements. Instead, let's hope the true value of the program will be seen in better patient outcomes and improved physician satisfaction. ■

DR. NEIL SKOLNIK *is associate director of the family medicine residency program at Abington (Pa.) Memorial Hospital and a professor of family and community medicine at Temple University in Philadelphia.* Dr. Chris Notte *is in private practice in Chalfont, Pa. They work with EHR Practice Consultants (www.ehrpc.com), assisting practices in the transition from paper to EHR systems. Contact them at info@ehrpc.com.*

VITAL SIGNS

Most Hospitals Addressing Economic Downturn



* Percentage of hospitals making changes since September 2008.
Note: Based on 1,078 survey responses from community hospitals in March 2009.
Source: American Hospital Association

ELSEVIER GLOBAL MEDICAL NEWS

FDA Commissioner Outlines Plan to Bolster Enforcement

BY MARY ELLEN SCHNEIDER

The Food and Drug Administration is vowing to get tougher and act faster when it comes to protecting public health.

The changes aim to make FDA "as transparent as possible about our expectations [while] industry commits to working in as responsive a way as possible to address our concerns," said Dr. Margaret A. Hamburg, the agency's new commissioner. Over the past several years, the FDA's enforcement activities have declined significantly, and those enforcement actions taken have been hamstrung by delays, mostly due to internal red tape, she said.

Speaking at a Food and Drug Law Institute conference, she outlined six steps to streamline the way the FDA handles enforcement across all regulated areas—drugs, devices, and food.

In cases where agency officials deem that public health is at risk, the FDA is prepared to take enforcement action before issuing a formal warning letter. Agency officials will also work with state, local, and international regulators to determine who can act fastest in an emergency.

The FDA also plans to change some of its internal processes, Dr. Hamburg said. The agency will establish a 15-day deadline for industry to respond once a significant problem is identified during an inspection. In addition, it will aim to get warning letters out the door more quickly by limiting review to significant legal issues.

Prompt follow-up on warning letters and other enforcement actions is also part of Dr. Hamburg's plan. The FDA will move more quickly in assessing corrective actions taken by industry after a warning letter is issued or a major product recall occurs. And in an effort to motivate industry to act quickly, the FDA is developing a formal warning letter "close-out" process. Once the FDA has confirmed that a firm has fully corrected its violations, the agency will issue a close-out notice and post the information online. ■