ACP Pushes Quality as Key Role for EHRs

BY MARY ELLEN SCHNEIDER

FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS

TORONTO — For electronic health records to have real value, physicians must use them to improve quality, not just to ease documentation and coding.

That's the message the American College of Physicians is sending to doctors, policy makers, and the health information technology industry with the release of a position paper on EHR-based quality measurement and reporting. The paper outlines several objectives to maximize the use of EHRs for reporting quality measures, such as using only those measures that are clinically relevant and help improve outcomes.

The ACP advised that any EHR-based measurement should be based on information routinely collected during a visit. This will likely require EHR systems to include new functionalities that are not part of today's standard systems, such as practice-based registries that allow reporting on a population of patients, as well as connections to patient portals.

The collection of information must not create another administrative burden for physicians, said Dr. Michael S. Barr, ACP's vice president for practice advocacy and improvement. "If we layer additional processes onto the daily workload of doctors, especially without taking away other responsibilities, we won't get the potential of EHRs because physicians will not implement them," he said.

The paper also emphasizes the need for EHRs to provide real-time clinical decision support systems that are linked to quality reporting. This would allow physicians to get patient-specific recommendations after entering routine clinical information into the system.

This kind of real-time feedback has been lacking in current quality reporting programs such as Medicare's Physician Quality Reporting Initiative (PQRI), said Dr. Joseph W. Stubbs, ACP president. He said there is often a long lag time between when physicians report on measures and when they receive reports on their performance under PQRI. For example, he submitted his final 2008 quality measures in December 2008 and did not receive any feedback until October 2009. "That kind of feedback … is not a very helpful thing," Dr. Stubbs said.

Most current EHR systems can't provide the level of functionality described in the ACP's policy paper. But technology is not the major obstacle, Dr. Barr said. A bigger barrier is the cultural change required of each member of the clinical team in rethinking the office workflow as part of EHR implementation, he said.

Another hurdle is the physician payment system. The current volume-based system doesn't allow physicians to be paid for actually improving quality, Dr. Stubbs said. "Without the business model for practicing better quality of care, it's an extraordinarily expensive prospect for physicians, particularly in small groups, to think about putting in an electronic health record," he said.

Despite these obstacles, the ACP is encouraging its members to adopt EHRs, and is launching new resources for evaluating the technology. At the annual meeting, the ACP demonstrated its new AmericanEHR Partners program (www.americanehr.com), a Web site that will provide comparisons of EHR products, information on physician experiences with the technology, and opportunities for online social networking. The resources will be free and open to all physicians, not just ACP members, and is expected to be live by early June.

The focus on using EHRs for quality comes as the federal government is finalizing regulations on what constitutes "meaningful use" of EHRs, the standard for qualifying for Medicare and Medicaid incentive payments under the HITECH (Health Information Technology for Economic and Clinical Health) Act. Physicians who demonstrate meaningful use of certified EHR technology can earn up to $44,000 in bonus payments under Medicare starting in 2011. A similar program under Medicaid allows eligible physicians to earn nearly $64,000 in incentive payments.

Dr. Stubbs said the federal incentives could be a big boost for physicians looking to purchase EHR systems. But the success of the program depends on whether the meaningful use criteria can actually be achieved. The worst thing would be for physicians to invest money up front to purchase EHRs, but find out later that they fell short of meaningful use by one measure and thus won't get any incentive dollars. "That would do more to destroy the effort than anything," Dr. Stubbs said.

As written, the proposed rule on meaningful use is not achievable, said Dr. Peter Basch of MedStar Health in the Baltimore-Washington area.

The overall goals of meaningful use are reasonable, he said, but the details in the proposed rule raise concerns. Some of the metrics and thresholds in the rule contain "unintended trip wires" that even advanced users of EHRs probably can't overcome, he added. But Dr. Basch, who also is a member of the ACP's Medical Informatics Subcommittee, said he is hopeful that the Centers for Medicare and Medicaid Services will modify the requirements in the final rule that is expected later this year, so that the average physician can achieve meaningful use in 2011 or 2012.

"These are dollars they do want to pay out," he said. "They do want to make this reasonable for doctors to do." ■

The ACP position paper is available online at www.acponline.org/advocacy/where_we_stand/health_information_technology/ehrs.pdf.

Small Practices Have Smaller Return on Investment From EHRs

The return on investment that physicians can expect to see after implementing an electronic health record is likely to differ greatly based on the size of their practice, according to one health information technology expert.

In large practices, physicians can anticipate significant cost reductions from elimination of chart pulls and improved intra-office communication. And such practices are likely to achieve savings from improvements in process throughput, coding, elimination of transcription, reductions in physician-to-staff ratios, and increased productivity, Dr. Basch said.

But the return on investment equation is quite different for small practices, Dr. Basch said. For example, small practices can't bank on saving much by reducing or eliminating chart pulls, because they typically keep charts right in the office and don't pay $8-$15 per chart pull the way large practices do. Small practices have the potential to reduce some staff following EHR adoption, but that won't happen immediately. Also, if the practice is already fairly lean there may not be much trimming of staff costs, he said.

The greatest potential for savings comes from better coding and the elimination of transcription. "Most of us tend to undercode, and EHRs can help us with coding," Dr. Basch said.

Small practices have additional obstacles when implementing an EHR, he noted. They generally don't have sufficient capital to invest in an expensive system, so they have to borrow money or take a reduction in income during the initial start-up period. Practices that aren't interested in taking out loans or reducing their income can consider an application service provider model, which essentially allows them to lease an EHR system. This isn't a good fit for every practice, Dr. Basch said, but it is attractive because it doesn't involve a large cash outlay upfront.

For practices considering the leasing approach, the monthly cost will be important. Those costs have typically ranged from $500 to $1,000 per month, but they appear to be coming down, Dr. Basch said. "As those monthly figures begin to move down because of market pressure, this could certainly make an EHR investment a lot more affordable for many, many people," he said.

—Mary Ellen Schneider

Feds Issue Rule on HIT Certification, Meaningful Use

BY ALICIA AULT

The federal government has published regulations that will allow for temporary certification of electronic health records—the first step in helping physicians and other providers get the software and hardware required to be eligible for bonus payments under federal health programs.

According to the Office of the National Coordinator for Health Information Technology (ONC), the rule "establishes processes that organizations will need to follow in order to be authorized by the National Coordinator to test and certify [electronic health record] technology."

"We hope that all [health information technology] stakeholders view this rule as the federal government's commitment to reduce uncertainty in the health IT marketplace and advance the successful implementation of EHR incentive programs," said Dr. David Blumenthal, national coordinator for health information technology, in a statement.

Certification means that the EHR package has been tested and includes the required capabilities to meet the "meaningful use" standards issued by ONC. Hospitals and physicians will have the assurance that the certified EHRs can help them improve the quality of care and qualify for bonus payments under Medicare or Medicaid. The incentive payments were authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the Recovery Act.

"By purchasing certified EHR technology, hospitals and eligible professionals and hospitals will be able to make EHR purchasing decisions knowing that the technology will allow them to become meaningful users of electronic health records, qualify for the payment incentives, and begin to use EHRs in a way that will improve quality and efficiency in our health care system," Dr. Blumenthal said.

This rule, published June 18th, was for a temporary certification program. A final rule on permanent certification of EHRs will be issued in the fall. ■

For more information about the temporary certification program and rule, please visit http://healthit.hhs.gov/certification.