

# Introduction

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○ Volume 6   ○ Spring   ○ 2009

Hello All,

Welcome to the Spring 2009 edition of *EHRscope*. I am proud to announce that we currently list over 200 products, and believe that this is the largest compendium of EHR software available anywhere.

While the United States spends more money per citizen on its healthcare than any other country, and while its physicians are extraordinarily well trained and capable, it is widely acknowledged that the quality of the healthcare provided in the United States is inferior to that of many other countries. It is furthermore assumed, and we believe correctly, that the utilization of a nationwide, connected healthcare information infrastructure will both significantly reduce costs as well as drastically improve patient safety.

Signed into law on February 17<sup>th</sup>, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) provides \$19 billion in federal funding to facilitate widespread EHR adoption. Understanding the rules and regulations concerning how that money will be spent is critical to be able to make appropriate healthcare information technology decisions in the near future. Having said that, there remains a number of cloudy issues which will only be clarified with time.

First, let's discuss some terminology. While absolute consensus has not yet been achieved on the difference between an EHR (Electronic Health Record) and an EMR (Electronic Medical Record), and these terms are frequently used interchangeably, there is a growing trend towards the following interpretation, and the terms will be utilized in this document as follows:

## Terminology

EMR or Electronic Medical Record is a computer software program that is utilized in an individual physician's office to manage the medical care of a patient. By its nature, it does not interface with Electronic Medical Records of other physicians, or with any Hospital Information Systems. It may, or

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may not, connect to the local laboratory and/or pharmacy.

EHR or Electronic Health Record is a network of computer software programs that is utilized to document the healthcare of an individual patient across the continuum of care, interconnecting the physicians' offices, hospitals, pharmacies, clinics, out-patient operative suites, out-patient radiology facilities, laboratories, and essentially any other entity which touches upon the patient's health. It is likely to include a patient portal, as well as a personal health record.

Please note that all of the federal legislation being enacted in 2009 addresses EHRs and while "Electronic Health Record" is mentioned no fewer than 40 times, and "EHR" is mentioned 100 times, the terms "EMR" and "Electronic Medical Record" are entirely absent in ARRA. Please see the full text of the signed legislation at [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h1enr.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.txt.pdf) .

Going one step further, EHR is frequently qualified as "Certified EHR Technology" with that phrase being found over 40 times. So, what is Certified EHR Technology? We find the following definition from the above on page 358.

**CERTIFIED EHR TECHNOLOGY DEFINED** - For purposes of this section, the term 'certified EHR technology' means a qualified electronic health record (as defined in 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

While I have been unable to find crystal clear document that clarifies "Certified EHR Technology" to be synonymous with CCHIT Certified®, I think it is widely believed that CCHIT Certification is currently the gold standard and all but guarantees that your technology will be acceptable to those who will be providing financial incentives to implement an EHR. Thus, while there have been a number of discussions concerning the pros and cons of certification, it appears rather self-evident that in order to be able to take full advantage of the available funding, acquiring a CCHIT Certified product may be required. Furthermore, there do not currently appear to be any reasonable alternatives to CCHIT, with the possible exception of NIST or the National Institute of Standards and Technology found at [www.nist.gov](http://www.nist.gov).

As for what is a "Qualified EHR," we need to turn to page 115 to learn more.

"(13) QUALIFIED ELECTRONIC HEALTH RECORD. - The term 'qualified electronic health record' means an electronic record of health-related information on an individual that -

(A) includes patient demographic and clinical health information, such as medical history and problem lists; and

(B) has the capacity -

(i) to provide clinical decision support;

(ii) to support physician order entry;

(iii) to capture and query information relevant to health care quality; and

(iv) to exchange electronic health information with, and integrate such information from other sources."

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Since Certified EHRs need to be Qualified EHRs, it becomes apparent that to be considered appropriate, the software you acquire must, at a minimum, maintain problem lists, provide for decision support, allow for physician order entry, allow for querying information regarding health care quality and both send information to other sources, and in fact integrate the health information from other sources.

## When should you acquire this technology, or if you're already using it, what actions should you take?

As of early 2009, these are difficult questions to answer with any specificity, since there has been no clear elaboration upon the methods of its expected implementation. However, there are certainly some guidelines that can be proffered, and most of them point to rather immediate action on the part of physicians.

First, a major component of the \$19 billion in funding will be provided as additional payments to physicians when providing patient treatments covered by Medicare. More specifically, there will be additional funding in the form of "Incentive Payments" in the following amounts, on the following schedule, for physicians who meet the required criteria, which criteria has been generally defined as "Incentives for Adoption and Meaningful Use of Certified EHR Technology," as seen starting on page 353 of ARRA.

Medicare Payment Year	HITECH Act Physician Reimbursement Schedule under Medicare										
	Reimbursement <sup>1</sup> or Penalty <sup>2</sup> for each provider based on their first qualifying year										
	Adopt 2011 or earlier <sup>5</sup>	Adopt 2012	Adopt 2013	Adopt 2014	Adopt 2015	2016	2017	2018	2019	2020	No EHR Adopted
2011	\$18,000	-	-	-	-	-	-	-	-	-	-
2012	\$12,000	\$18,000	-	-	-	-	-	-	-	-	-
2013	\$8,000	\$12,000	\$15,000	-	-	-	-	-	-	-	-
2014	\$4,000	\$8,000	\$12,000	\$12,000	-	-	-	-	-	-	-
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0	-	-	-	-	-	-
2016	\$0	\$2,000	\$4,000	\$4,000	\$0	\$0	1%	1%	1%	1%	1%
2017	\$0	\$0	\$0	\$0	\$0	\$0	\$0	2%	2%	2%	2%
2018	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	3%	3%	3%
2019	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	3-4% <sup>3</sup>	3-4%
2020+	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	3-5%
<b>Totals<sup>4</sup></b>	<b>\$44,000</b>	<b>\$44,000</b>	<b>\$39,000</b>	<b>\$24,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	

<sup>1</sup> - Maximum reimbursement authorized, the actual amount is 75% of charges for professional services under Medicare.

<sup>2</sup> - "Penalty" is a reduction in payments for professional services under Medicare, 2% means you get paid 98% earned payment

<sup>3</sup> - The Penalty may increase starting in 2019 if the Secretary finds that the proportion of certified EHR users is less than 75%, however, it can never be greater than 5%

<sup>4</sup> - Physicians operating in a "provider shortage area" will be eligible for an incremental increase of 10% in their bonus payments

<sup>5</sup> - In order to get reimbursed for your EHR in 2011, you will most assuredly need to select, purchase and implement your EHR prior to 2011

Note: Figures in this Table are subject to interpretation by ONCHIT. Please see: <http://content.nejm.org/cgi/content/full/NEJMp0901592v1>

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Please note that even a cursory review of the table shows that there will be financial penalties for physicians who do not adopt appropriate technology by 2016.

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“Meaningful Use of Certified EHR Technology” is further clarified on pages 356 of ARRA. This definition leaves a substantial amount of interpretation up to the Secretary (of Health and Human Services), but will include electronic prescribing, information exchange and reporting.

The meaning of electronic prescribing appears to be rather self-evident. However, this is not necessarily so for “Information Exchange” nor for “Reporting” so let’s address each of them in more detail. Again on page 356 we find the following:

“(ii) INFORMATION EXCHANGE. - The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.”

So, ‘connected’ appears to be an absolute requirement. Thus, a ‘document creation program’ that does a wonderful job creating medical records, but that does not ‘connect’ to other programs is clearly deficient, and physicians using such a program will not be able to demonstrate “meaningful use.”

Promoting care coordination may be subject to a bit more interpretation. However, it most likely will require the ability to have your EHR interface not only with pharmacies (since electronic prescription writing is among the cornerstones of this act), but also with other care providers, because only in this fashion will ‘care coordination’ be possible.

However, one major obstacle exists in this regard, and that concerns the state of the art for connecting EHRs from one vendor with those of another vendor. While this has been the subject of intense study and development, it has not yet been satisfactorily accomplished on a widespread basis, outside of a select number of RHIOs (Regional Health Information Organizations). It may be expected that the ability of a physician to satisfactorily demonstrate to the Secretary said interconnection would be improved if one were to adopt an EHR that was already widely utilized in their community, rather than attempting to connect their EHR to those with divergent technology.

Can one infer from this concept that it would be beneficial for a small group of physicians (in a tightly knit referral community) to adopt a specific EHR as potential group purchasers? This will afford the interconnection among each other’s EHR, allowing for the electronic exchange of health information? We don’t believe that this is mandatory. However, we do believe that it would be both prudent and potentially cost-effective. In this fashion there may be both the ability to utilize the larger purchasing power of an otherwise unaffiliated group, as well as the economy of scale in producing interfaces to your local pharmacies, hospital information systems, radiology facilities, etc. To a lesser extent, travel expenses imposed by the vendors for training as well as other ancillary vendor-imposed expenses may be diminished.

Next, relating to the final requirement to be eligible for the up to \$44,000 in incentive payments, here is the exact wording concerning Reporting on Measures, again from page 356 of ARRA:

(iii) REPORTING ON MEASURES USING EHR.- Subject to subparagraph (B)(ii) and using such

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certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

Certainly it could have been left more vague as of February 17<sup>th</sup>, 2009, but that might have been difficult. One thing is clear: physicians, once again, will be required to use Certified EHRs in order to have their reporting be meaningful. And, just in case leaving the door open for alternative interpretation has not been accomplished adequately by the above, we further find this:

The Secretary may provide for the use of alternative means for meeting the requirements of clauses (i), (ii), and (iii) in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary shall seek to improve the use of electronic health records and healthcare quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

So, while the specific requirements that are to be imposed upon group practices is left totally unspecified, it is clear that physicians in general will be held to ever increasing standards, in order to be eligible for the Incentive Payments.

This is rather similar to the pattern developed during the past 3 years, as it relates to CCHIT Certification®. The criteria in 2006 were, by current standards, rather easy to comply with. Each year the criteria becomes increasingly difficult to meet, thus increasing the amount of effort required on the part of the EHR vendors to do so.

Based upon this expectation of increasingly stringent criteria for eligibility for the Incentive Payments, and on the reality that selecting and implementing technology that complies with this moving target is frequently a process that takes years, it would be our recommendation that you embark upon this journey as soon as possible, if you have not already done so. We believe that it is unlikely that physicians will be able to start the selection process, purchase, implement and be considered to be 'meaningfully using' certified EHRs within the course of a single year. If you have not adequately implemented your EHR by the end of 2010, you will not likely be able to take advantage of the \$18,000 available in 2011. And, as the federal fiscal year starts October 1<sup>st</sup>, in order to take maximum advantage of the incentive payments, the deadline for adoption may be as early as September 30<sup>th</sup>, 2010.

Yours,

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