EHR REPORT

Current EHR Initiatives Can Shape Buying Decisions

BY SARAH CORLEY, M.D., AND NEIL SKOLNIK, M.D.

This month's installment is adapted from the book "Electronic Medical Records: A Practical Guide for Primary Care."

The need to improve the quality of care while lowering its cost is at the root of every major initiative in health care today. While new models of care are evolving to meet this need, new technology applications are being developed simultaneously to make these models viable. The electronic health record is both the means and the end of these revolutionary processes.

An EHR's raison d'être is to collect and share data important for the treatment of patients. This seemingly simple function, however, rests on complex, multifaceted relationships that seek to balance caregivers' needs against information systems' capabilities. Driven forward by federal government mandates, the next several years promise to bring issues of EHR standardization, usability, and interoperability to the forefront of practicing physicians' collective awareness.

EHR Development: Where Is It Going, and Why

While change is constant in health care – and exponential in technology – three EHR developmental imperatives are emerging in response to industry trends, as well as existing and imminent federal requirements:

► **Interoperability.** Standardization – the prerequisite for sharing records between and among IT systems – has been an important, though hard-to-achieve, goal of EHR development since 1991, when the Institute of Medicine's report, "The Computer-Based Patient Record: An Essential Technology for Health Care," introduced the idea of "an electronic patient record … specifically designed to support users through availability of complete and accurate data, alerts, reminders, clinical decision support systems, links to medical knowledge and other aids."

Since that time, several organizations have worked to further the development of standards, with some success as evidenced by standardization of lab results, medication names, allergies, and demographic data. Other data elements, such as physician progress notes that require multiple concepts to express, are proving more problematic. The challenge: ensuring interoperability for public health reporting and research without hindering or further complicating the physician "conversation." Meeting this challenge demands ongoing, industry-level standards development.

► **Usability.** As federal mandates increase quality and reporting requirements, EHR solutions must evolve to help rather than hinder physicians' efforts to meet them. For example, an EHR that requires numerous "clicks" to order a single medication is not going to streamline a physician's workflow. The problem is finding ways to objectively measure something as seemingly subjective as usability.

However, the issue is now on the federal radar and fast becoming a must-have for EHR products. Certification organizations increasingly are looking for ways to measure and mandate usability of EHR products, from the National Institute of Standards and Technology's (NIST) search for sources "to fully develop and execute a project to create a usability framework for health information technology (HIT) systems" to the Certification Commission for Healthcare Information Systems' (CCHIT) 2011 Usability Testing Guide for Comprehensive Ambulatory EHRs.

► **Care coordination.** Despite spending one-sixth of our entire gross domestic product on health care, the United States falls far short of being the healthiest society in the world. One reason: We spend the majority of our resources treating the symptoms rather than the causes of disease. Care coordination across all elements of the complex health care system and the patient's community is essential to shift from treatment to prevention – and EHRs are essential to care coordination.

In addition, care coordination is a key characteristic of the patient-centered medical home, an emerging care concept based on evidence, driven by data, focused on health and wellness, and centered on the needs of the patient.

These three imperatives – interoperability, usability, and care coordination – are driving EHR development. As such, they also are key considerations in the selection of an EHR solution.

Functional Matters: Choosing an EHR Solution

The 2009 American Recovery and Reinvestment Act's (ARRA) HITECH Act may have brought EHRs to the forefront of health care discussion, but it did not alter their primary function – improving the quality of care. To ensure this result, physicians should look for the following in an EHR product:

► **Certification:** Certification assures a product has met core criteria considered essential by a broad range of stakeholders, which is key to maximizing the system's value. One-time certification is not enough; annual certification evidences the continual development necessary for the product's ongoing viability.

The sole organization designated by the Department of Health and Human Services (HHS) since 2006, CCHIT is the industry's leading EHR certification body and the de facto standard for usability and other criteria. However, with the advent of ARRA and the resulting need to preclude any conflict of interest, HHS now will oversee multiple certification organizations. The Office of the National Coordinator (ONC) for Health Information Technology is developing its own certification criteria with NIST.

Still, those that now possess CCHIT usability ratings and certification have positioned themselves in the forefront of the certification process.

► **Structured data:** Structured data reside in fixed fields within a record or file. These discrete data fields (for example, blood pressure, body mass index, and height/weight) establish the predetermined data types and understood relationships necessary for efficient quality reporting. Since 2008, the Centers for Medicare and Medicaid Services has allowed reporting of quality measures data to a qualified registry. As early as this year, CMS could begin accepting direct EHR-based quality reporting. As early as 2012, CMS could mandate it. EHRs built on unstructured data (as is found in many transcription/dictation systems) will not support compliance.

► **Meaningful use guarantees:** Incentives should not be the sole reason why physicians deploy EHRs, but the ability to secure incentives must not be overlooked. EHR vendors with a commitment to – and a plan for – meeting meaningful use criteria as they are established will offer guarantees to that effect.

► **Clinical decision support:** Evidence-based practice is the inevitable future of health care. EHRs with clinical prompts and reminders support best practice and systemize the use of evidence at the point of care.

► **Support for coordinated care:** Increasingly, EHRs will serve as the foundation for data registries, health information exchange, and other means to assure patients get the indicated care when and where they need and want it, and in a culturally and linguistically appropriate manner. Expanded patient data access – via secure communication portals, for instance – also will require more robust data controls to ensure secure data exchange, but it will enable more patient-centric care.

Health care is a dynamic industry, driven by the needs – changing and continuous – of its stakeholders. Developing, choosing, and deploying EHRs will continue to challenge. Keeping standardization, usability, and interoperability as the prime focus of all development and purchase decisions ultimately will smooth the path for everyone.

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Bipartisan Group Pushing Bill to Avert DXA Payment Cuts

BY MARY ELLEN SCHNEIDER

Without Congressional action, Medicare payments for dual-energy x-ray absorptiometry will be cut in about half at the beginning of 2012.

But a small, bipartisan group of lawmakers in the House and Senate is pushing to extend DXA payment rates, which were passed as part of the Affordable Care Act and are set to expire at the end of this year, through 2013. Under the ACA, Congress instructed officials at the Centers for Medicare and Medicaid Services to increase DXA payments to 70% of the rate paid by Medicare in 2006.

The Preservation of Access to Osteoporosis Testing for Medicare Beneficiaries Act of 2011 (H.R. 2020/S. 1096) was introduced at the end of May; it would keep the current DXA payment rate in place for 2 years.

Rep. Michael Burgess (R-Tex.), one of the bill's sponsors, said that cutting DXA payments is shortsighted. "As a physician, I diagnosed and treated many patients during my 25 years of practicing medicine in Texas, and I saw firsthand the way osteoporosis affects patients and their families. The more we can do to promote and encourage education, awareness, and prevention, the better. Why Medicare will pay for a fracture, but not reimburse a reasonable amount for a scan that can prevent that fracture, is beyond me," he said in a statement.

Medicare began cutting DXA payments in 2007, after Congress included bone densitometry among a group of high-cost imaging services that were slashed as part of the Deficit Reduction Act of 2005. Since then, physicians have been

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IMPLEMENTING HEALTH REFORM

Community First Choice Option

The Community First Choice Option is among the lesser-known provisions of the Affordable Care Act. Formally known as Section 2401, this program offers states additional Medicaid funding to provide home- and community-based attendant services and other support to low-income disabled Americans, keeping them in the community and out of nursing homes.

Under the program, states can get a 6-percentage-point increase in federal Medicaid matching payments to cover costs associated with providing community-based services such as assistance with activities of daily living and instrumental activities of daily living, as well as health-related tasks. States also would have the option of paying for transitions costs, such as the first month's rent when a person moves from a nursing facility back to the community.

Eligibility and requirements associated with the program were outlined in a proposed rule in February; the program is scheduled to begin in October.

Kate Wilber, Ph.D., a gerontology expert at the University of Southern California, Los Angeles, explained how the program could help keep more disabled people in the community.

RHEUMATOLOGY NEWS: Who will be eligible for assistance under the Community First Choice Option?

DR. WILBER: Potential participants must live in a state that offers the program, qualify to receive medical assistance under their state's Medicaid program, and have an income below 150% of the federal poverty line. Individuals with higher incomes may participate if they are eligible for a nursing facility level of care that would be covered by the state Medicaid program. Right now, it is unclear how many states will choose to offer the program.

RN: About 35 states already provide some type of personal care services through Medicaid. Is the increased federal payment likely to expand this much?

States might take a 'wait and see' approach to offering a new entitlement in the current economic climate.

DR. WILBER

DR. WILBER: Close to half of the states have expressed interest in the program. The use of the increased federal match as an incentive is attractive. However, in contrast to waiver services with limited slots, this program is an entitlement, meaning it must be offered to everyone who is eligible. States that have concerns about offering a new entitlement in the current economic climate might take a "wait and see" approach.

RN: What impact will this have on nursing home care?

DR. WILBER: The resident mix in nursing homes has changed dramatically over the last decade or so, driven by several different factors that support expanded community options. In the 1999 Olmstead decision, the U.S. Supreme Court ruled that institutionalizing individuals who prefer to live in a community setting is discrimination, and that services should be provided in the most integrated and least restrictive setting. Over the last decade, the Centers for Medicare and Medicaid Services sought to reduce the Medicaid bias toward institutionalization by "rebalancing" funding toward more home and community-based service options. One initiative to promote rebalancing, known as "money follows the person," offers state incentives to transition long-stay residents out of facilities and into the community. States have also taken advantage of Medicaid waiver programs that permit individuals who are eligible for a nursing home level of care to use community-based services instead. The federal government has also funded demonstration programs to test the effectiveness of programs that offer consumer direction by providing cash benefits to purchase services. The Community First Option draws on and expands these options.

RN: How can primary care physicians direct their disabled patients toward these programs?

DR. WILBER: Many primary care physicians are not familiar with long-term care services and supports, and the pathway from providing primary care to these services is not easy to find. Some physicians working in larger systems will have access to social workers who can assist with broader care planning for patients with complex conditions. Physicians are probably most familiar and most comfortable with skilled nursing facilities and home health care. Beyond that, there are a variety of programs with complex eligibility requirements, various levels of quality, and different funding sources. This is the system that the Institute of Medicine described as "a nightmare to navigate." Although the ACA attempts to address fragmentation, programs such as Community First will be shaped at the state level. Different states will have different approaches, with some choosing not to pursue the program at all. We will know more about what these programs will look like as states begin to develop their approaches.

RN: The program requires a "person-centered planning process" and gives individuals the authority to hire, fire, and train their attendants. How does that improve the care provided?

DR. WILBER: Long-term care services and supports are "high touch," highly intrusive personal services that deal with many facets of a person's life, often for many hours a day over a long period of time. For those receiving these services, it helps to have control over who provides them. Self-direction means care receivers have the authority to tailor their services according to their preferences, needs, cultural expectations, habits, and other life-style requirements. Evidence from self-directed care, such as the "Cash and Counseling" demonstrations have found that these services have good outcomes for the care recipient and caregivers, and are cost effective as well. ■

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struggling to cover their costs as reimbursement steadily declined from around $148 per scan in 2006 to about $54 in 2010. Exacerbating the problem is that private insurers have largely followed Medicare's lead, ratcheting down their reimbursements as well. The ACA brought DXA payments up to about $98.

Physicians' organizations, including the American College of Rheumatology (ACR) and the American Association of Clinical Endocrinologists, are urging lawmakers to pass an extension of the current DXA payment rate.

Dr. Timothy J. Laing, government affairs committee chair for the ACR and a rheumatologist at the University of Michigan, Ann Arbor, said that if the reimbursement for the test falls below current levels, it will become economically unsustainable for physicians to provide the test in their offices.

Patients still will be able to get a DXA scan in the hospital, but there are downsides to that limited access, Dr. Laing said.

Patients are far more likely to get the test if it can be done at the time it is recommended, he said, adding that providing DXA scans in the office also provides an opportunity for on-the-spot, in-depth counseling from a physician who is knowledgeable about both interpreting the test and treating osteoporosis.

Getting the legislation passed this year will be an uphill battle. "Right now, Congress is deadlocked over the budget, so any bill that is introduced that adds costs to anything is going to be difficult," Dr. Laing said. ■

CMS Aims to Ease E-Prescribing Rules

BY ALICIA AULT

The Centers for Medicare and Medicaid Services has proposed modifying e-prescribing rules so more physicians could claim exemptions from the criteria and therefore avoid being penalized in 2012.

In a conference call, agency officials said the change was in response to indications from providers and professional societies that many prescribers might not be able to meet the requirements of the current incentive program.

"Today's rule demonstrates that CMS is willing to work cooperatively with the medical professional community to encourage participation in electronic prescribing," Dr. Patrick Conway, chief medical officer at CMS and director of the agency's Office of Clinical Standards and Quality, said in a statement.

"These proposed changes will continue to encourage adoption of electronic prescribing while acknowledging circumstances that may keep health professionals from realizing the full potential of these systems right away," he said.

Under the current incentive program, eligible prescribers were due to get a 1% bonus payment for 2011 and 2012 and a 0.5% bonus in 2013. For prescribers who did not meet the criteria, there would be a penalty imposed in 2012. The penalty would escalate in 2013 and 2014.

The final Medicare Physician Fee Schedule for 2011 contains exceptions, along with two hardship exemptions. Practices are exempt if they are in a rural area without high-speed Internet access or an area without enough available pharmacies for electronic prescribing.

Under the proposed rule, prescribers who use certified EHRs can now claim this as a "qualified" e-prescribing system. The move was designed to more closely align the e-prescribing program with the program that offers incentives for meaningful use of EHRs.

The proposed rule would also create four additional hardship exemption categories. Prescribers would have to show that they have:

- ► Registered to participate in the Medicare or Medicaid EHR incentive program and have adopted certified EHR technology.
- ► An inability to electronically prescribe due to local, state, or federal law (this primarily applies to prescribing of narcotics).
- ► Very limited prescribing activity.
- ► Insufficient opportunities to report the electronic prescribing measure due to limitations on the measure's denominator.

Prescribers also would be granted an extension, until Oct. 1, 2011, to apply for the hardship exemption. ■