Need Help Getting an EHR? Go to the Hospital

Many hospitals have financial endowments for expansion of EHRs, plus strong technical support.

BY ERIK GOLDMAN
Contributing Writer

WASHINGTON — If you've been thinking about implementing an electronic health record system but are daunted by the cost and complexity, you may have an untapped ally: your local hospital.

Many hospitals across the country have large and often untapped financial endowments for expansion of electronic health records (EHRs), to say nothing of strong technical support and considerable volume purchasing clout. As they compete for the allegiance of community-based physicians, some hospitals are finding that they can generate considerable goodwill by extending a helping hand to primary care doctors who want to digitize their practices.

"Doctors should contact the business development and community outreach offices at their local hospitals, and ask what they can do to help facilitate EHR adoption, advised Dr. Todd Rothenhaus, chief medical information officer for Caritas Christi Healthcare Systems, a six-hospital network in eastern Massachusetts.

Speaking at the fifth annual World Health Care Congress, Dr. Rothenhaus said community physicians are often pleasantly surprised to find out how much assistance they can obtain from area hospitals.

Nearly all of the nation's hospitals now have some form of EHR system in place. But broader adoption in solo and small group practices has been notoriously slow, a fact that vexes health care policy makers, hospital system administrators, and insurers who believe firmly that EHRs are the key to improving health care delivery.

To help remove some of the roadblocks to broader adoption, Congress modified the Stark antikickback regulations, creating "safe harbors" that enable hospitals to pay up to 85% of the EHR software costs for physicians practicing in their catchment areas.

"That's pretty good. And further, as hospitals we can also get volume discounts on hardware, so there's an extra 10%-15% savings," said Dr. Rothenhaus.

With an actual example from the Caritas Christi system, he explained that a two-physician, one-nurse practice going from paper records to full EHR on its own would spend roughly $28,000 for hardware, $25,000 for software, $1,500 for training, $4,500 per year for software maintenance, and $2,400 for a software support contract. The total would be over $61,000 in the first year.

With the help of a local Caritas Christi hospital, the hardware cost drops to $25,000, the software costs the practice only $3,375, the training goes down to $1,200, the software maintenance is only $810, and the support package goes down to $2,160, for a final cost of just over $42,545.

While that's hardly chump change, it does put full EHR implementation within reach of more small practices. Dr. Rothenhaus said the savings can be even greater for practices that want to purchase more costly software systems to read and store ultrasounds, echocardiograms, and other data-intensive diagnostic images.

There are nonfiscal advantages to working with a local hospital, Dr. Rothenhaus said. For one, you gain access to hospital-affiliated technicians and analysts who are usually geographically close to the practice, as opposed to anonymous tech support that might be in another state or even another country. Hospital-based IT analysts tend to be well versed in a wide range of applications, system designs, and software packages, so they can be of great help in choosing and configuring the right system for a given practice, he said.

In addition, hospitals usually have strong relationships with equipment and software vendors; not only do they get better prices on support packages, they also get faster and more attentive help when something goes wrong.

Dr. Rothenhaus said Caritas Christi has received roughly $6 million in grants from Blue Cross/Blue Shield, Harvard Pilgrim Health Systems, and other organizations interested in pushing EHR out into the trenches of community-based health care. This money is specifically earmarked for offsetting the hardware and software costs for doctors. "I cannot imagine we are the only ones doing this," he joked, noting that in many parts of the country, smaller hospital systems are competing fiercely for patient referral streams from physicians in their communities.

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The Stark laws expressedly prohibit any sort of direct financial inducements for referrals, hence there is no obligation for a physician who accepts EHR help to refer patients to that hospital. But hospital administrators recognize that they're much more likely to win the favor of community-based doctors if they try to help doctors deal with the challenges of running a solo or small group practice.

The hospitals themselves benefit from a well-wired network of doctors in their communities. For one, it makes it far easier to ensure that all patients' records make it back to the primary care physician. This, hospital administrators believe, will improve care, reduce medical errors, and save money by reducing duplicative tests.

Once physicians go electronic, they discover many benefits, said Charles Parker, vice president and chief technology officer for Masspro, a health care performance improvement organization founded by the Massachusetts Medical Society. "In 99% of clinics, you can see return on investment in EHR within 2 years. And in some best cases, you see ROI in 90 days."

In studying physician practices in Massachusetts, he said the big savings come from reduced need for transcription services, fewer redundant lab tests, swifter claims processing, and fewer days for claims in accounts receivable. He also noted that Medicare and Medicaid in his state include financial incentives for physicians to comply with formulary guidelines, and this is far easier to do and to document in an EHR-based office.

Doctors using EHRs also spend, on average, less time on the phone with patients, and staffers spend markedly less time tracking down lost records or missing bits of information. "All the information is always at everyones' fingertips," Mr. Parker said.

Participation in pay-for-performance plans also requires digitized information, and some of these plans will help foot the bill for physicians to implement EHRs.

Mr. Parker, and many other EHR advocates, believe EHRs will increasingly become a central feature in the "medical home" construct, which is now a very hot idea among health plan administrators and big employers.

He noted that the National Business Coalition on Health's widely touted Bridges to Excellence program will be preferentially rewarding clinics that meet their definition of a medical home. Electronic capabilities are part of those criteria. He said that he believes that incentive structure may very well be the strongest incentive to move primary care physicians to embrace EHRs, and he called on vendors to pay more attention to this feature.

"You need to enable doctors to get the medical home assignation at the end of the process. You need to enable them to realize real revenue increases as a result, or there's simply no incentive. EHR companies are usually only focused on selling EHRs, but they fail to attend to the full-blown aspects of practice assessment and care redesign," he said. "EHRs are really a tool for practice redesign. You really can improve the efficiency of care." ■

Personal Health Records Should Ensure Privacy, Panel Says

BY MARY ELLEN SCHNEIDER
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Privacy should be the top priority when developing certification criteria for personal health records, a task force created by the Certification Commission for Healthcare Information Technology has recommended.

Adequate security and interoperability also must be included in certification efforts, according to the task force.

The Certification Commission for Healthcare Information Technology (CCHIT) will use these recommendations as it prepares to begin certifying personal health records (PHRs) next summer.

Since the PHR field is still "rapidly evolving," the task force said that certification requirements should not be so prescriptive that they interfere with the progress of the technology.

The task force recommended that the voluntary certification process should apply to any products or services that collect, receive, store, or use health information provided by consumers. Certification should also apply to products or services that transmit or disclose to a third party any personal health information.

This would allow the CCHIT to offer certification to a range of products and applications, from those that offer a PHR application and connectivity as an accessory to an HER, to stand-alone PHRs.

CCHIT hopes that, just as it did in the EHR field, certification will create a floor of functionality, security, and interoperability, said Dr. Paul Tang, cochair of the PHR Advisory Task Force and vice president and chief medical information officer for the Palo Alto (Calif.) Medical Foundation.

The task force called for requirements to maintain privacy in monitoring and enforcement, and for consumer protection that would allow patients to remove their data if certification is revoked.

The group also recommended that standards-based criteria be developed that would require PHRs to send and receive data from as many potential data sources as possible, including ambulatory EHRs, hospital EHRs, labs, and networks.

If done right, certification would have significant benefits for both physicians and patients, Dr. Tang said. A PHR could provide physicians with better access to secure, authenticated data that could help them make decisions, while patients would have more control over their own care, he said. "The physician benefits by what benefits the patient," Dr. Tang said.

In July, the task force made its recommendations and handed over responsibility for PHR certification to a CCHIT work group. That work group will develop the actual certification criteria that will be used to test PHR products starting next July, according to Dr. Jody Pettit, strategic leader for CCHIT's PHR work group.

Offering certification for PHR platforms and applications could help spur consumer acceptance and adoption of PHRs, Dr. Pettit said. "The consumer wouldn't feel so far out on a limb in terms of putting in their data," she said. ■