

Local Hospitals Offer Touchstone on EHRs

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 health care congress sponsored by the Wall Street Journal and CNBC, 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.

He noted that in many parts of the country, smaller hospital systems are competing fiercely for patient referral streams from physicians out in their communities.

The Stark laws expressly 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. ■

POLICY & PRACTICE

CMS Tests PQRI Measures

The Centers for Medicare and Medicaid Services said it will begin testing 11 new quality measures for future adoption into the Physician Quality Reporting Initiative. PQRI provides incentive payments to providers who satisfactorily report data on covered services furnished to Medicare beneficiaries. Through the new measures, The CMS said it intends to track quality of care in influenza immunization in chronic kidney disease, assessment for use of anti-inflammatory or analgesic over-the-counter medications in osteoarthritis, and care plans for pain in medical and radiation oncology. CMS also will test several melanoma- and radiology-related measures, in addition to measures dealing with cataracts and age-related macular degeneration. The CMS said that it encourages providers to submit data for these test measures on Part B claims from July 1 through Sept. 30, 2008. Providers will not receive financial incentive for reporting these test measures, CMS said.

AMA Launches Report Card

The American Medical Association in June launched a campaign to cut waste from the insurance claims process with a new health insurer report card. "To diagnose the areas of greatest concern within the claims processing system, the AMA has developed its first online rating of health insurers," said Dr. William Dolan, an AMA board member. The report card, based on a random sample pulled from more than 5 million services billed electronically to Medicare and seven health insurers, found that insurers reported to physicians the correct contracted payment rate only 62%-87% of the time. In addition, it found that there is extremely wide variation among payers as to how often they apply computer-generated edits to reduce payments—from a low of less than 0.5% to a high of more than 9%. Physicians spend as much as 14% of their total revenue to ensure accurate insurance payments for their services, according to the AMA.

Areas Chosen for EHR Demo

Twelve areas across the country, ranging from entire states to smaller cities, will participate in a national Medicare demonstration project that provides incentive payments to physicians for using certified electronic health records to improve the quality of patient care. The 5-year project has been designed to demonstrate the benefits of EHRs and help increase use of the technology in practices where adoption has been the slowest—at the individual physician and small practice level, the CMS said. The areas selected to participate include: Alabama; Delaware; Jacksonville, Fla.; Georgia; Maine; Louisiana; Maryland/ Washington; Oklahoma; Pittsburgh, Pa.; South Dakota; Virginia; and Madison, Wis. Over the course of the project,

financial incentives and bonus payments will be provided to as many as 1,200 primary care practices that use EHRs to improve quality, as measured by their performance on specific clinical quality measures. Total payments under the demonstration for all 5 years may be up to \$58,000 per physician or \$290,000 per practice, CMS said.

"Smart" IDs Given the Nod in Colo.

Colorado has become one of the first states to approve legislation mandating that all insurers in the state issue "smart" identification cards with standard, legible information about the patient, insurance product, and insurer. The cards, which must be issued by July 1, 2010, also must include machine-readable information encoded on a magnetic strip. The legislation, signed last month by Gov. Bill Ritter (D), helps reduce the potential for human errors and the data-entry burden posed by nonstandardized cards, according to the Medical Group Management Association, which is headquartered in Colorado. Dr. William Jessee, MGMA president, said in a statement that most insurance-claim rejections stem from incorrectly entered information about the patient or the insurance product, and the practice of photocopying patient ID cards and then typing the information into a database invites errors. A card with a magnetic strip on it costs about 50 cents to make, MGMA stated. Similar laws have been approved in Kansas, North Carolina, and Texas, the group said, and other states are considering legislation on the issue.

Drug Lobby Spending Up 32%

The pharmaceutical and medical device industries had yet another banner year for spending on lobbying in 2007, according to a new report by the Washington-based Center for Public Integrity. Last year, the pharmaceutical industry alone spent at least \$168 million on lobbying members of Congress, a 32% increase from 2006, according to the report. Forty companies and three trade organizations—the Pharmaceutical Research and Manufacturers of America, the Biotechnology Industry Organization, and the Advanced Medical Technology Association—accounted for 90% of the spending. PhRMA led the way, spending \$23 million in 2007. Amgen Inc. and Pfizer Inc. were the two biggest individual spenders, at \$16 million and \$13 million, respectively. Most efforts went into blocking drug reimportation, protecting patents, and on free-trade agreements. The industry also went to bat for reauthorization of the State Children's Health Insurance Program and extensions of the Prescription Drug User Fee and Best Pharmaceuticals for Children acts, according to the center's analysis of lobbying records submitted to the Senate Office of Public Records.

—Jane Anderson