The government doesn't mind evaluating you through its EHR incentive plan. But as it moves past the two-year mark, it's time for us to evaluate the program's progress in getting physicians like you to adopt and use (meaningfully, of course) technology.

When family physician Christopher Tashjian attested for Stage 1 of CMS' "meaningful use" program bright and early on April 18, 2011, most other practices hadn't even picked out an EHR.

By April 2012, as few as one in five providers had attested, according to CMS' count. The purpose of the meaningful use program, and the stimulus dollars attached to it, was to digitize America's healthcare-recordkeeping system — creating a data-based boon, say proponents, for providers and public health advocates alike. But the program got off to a slow start, and questions have emerged about the efficacy of the program and its administration by the government.

Is the incentive program working as it was intended? Let's look at the details — past, present, and future — to find out.

**The EHR incentive: a look back**

CMS published the final rule for its Medicare and Medicaid EHR incentive programs to the Federal Register on July 28, 2010. Enacted in the Health Information Technology for Economic and Clinical Health (HITECH) Act — part of the American Recovery and Reinvestment Act of 2009, aka the federal stimulus — the nearly 300-page rule outlines how "eligible professionals" (EP) and hospitals can qualify for incentive payments for demonstrating meaningful use of a certified EHR.

The first step in receiving the money (a maximum of $44,000 paid over the course of five years) is to attest that during a 90-day reporting period, providers used their EHR in a meaningful way by fulfilling 15 core requirements (such as maintaining an active medication-allergy list for more than 80 percent of patients), five out of 10 menu set objectives (such as implementing drug-formulary checks), and six clinical quality measures (such as adult weight screening and follow-up).

This represents just Stage 1 of the three-stage program. To receive the full financial incentive, CMS requires the completion of all three stages. (CMS has also outlined a separate program for providers who wish to qualify through Medicaid. For details, visit [http://go.cms.gov/MedicaidStateInfo](http://go.cms.gov/MedicaidStateInfo).)

To help small practices, the government's Office of the National Coordinator for Health Information Technology (ONC), has so far awarded more than $720 million through 62 Regional Extension Centers. The RECs provide free and low-cost assistance to qualifying practices to ease their EHR transition and help them achieve meaningful use.

**EHRs by the numbers**

What does CMS have to show for all of this effort? The government's figures show it is now meeting its objectives, despite getting off to a slow start. CMS finished 2011 well below its stated objectives of at least 40,000 meaningful users attesting via the Medicare program and 21,100 meaningful users via Medicaid. The actual numbers at the end of last year: 15,361 for Medicare and 15,439 for Medicaid. But the government says it has already closed the gap between its projections and the reality: As of May 31, 2012, 110,000 providers (roughly one out of five eligible for the program) have received some portion of the more than $5.7 billion paid out so far to hospitals and providers under one of the two programs, according to CMS.

How did CMS go from about 30,000 meaningful users to more than 110,000 in only five months? It did not respond to our request for an explanation, but if its most-recent data are correct, then it is now on track to meet its goals of between 48,700 and 154,700 meaningful users under Medicare, and between 34,000 and 93,700 under Medicaid by the end of 2012.

If it meets its most ambitious objectives, about half of America's eligible providers will be meaningfully using an EHR by the end of the year.

**Adoption challenges**

Still, some observers, perhaps smarting from the government's slow start, have registered their disappointment with the pace of adoption. "When you think about all of the work that has had to go into both the definition of Stage 1
meaningful use, the certification of EHRs, the adoption and attestation, and work by the eligible professionals, I think all of us in the industry can say that [it] just doesn't feel like we're moving the needle enough," says David Henriksen, senior vice president and general manager, Physician Practice Solutions, for EHR vendor McKesson.

What caused the halting beginning? Some blame the program's timeline and uncertainty about the rules in future stages. "There was a glitch in the law that said 'if you attest in 2011 you have to be at Stage 2 in 2013, and since Stage 2 was undefined, and there was no penalty for not attesting in 2011, a lot of people were advised not to attest," says Erica Drazen, a healthcare IT consultant who is senior adviser for the Scottsdale Institute. Perhaps as a reaction to that, CMS has extended the Stage 1 reporting period a full year as part of its proposal for Stage 2 of the program, which was released in February.

Another implementation hurdle: the amount of time it takes to do everything, especially for practices that were starting from scratch in 2010.

"If you didn't have an EHR, you had to figure out which one you wanted, then buy it, then implement it, and then use it for three months," says Drazen. "That's a pretty tight timeframe to achieve in a year."

And once an EHR is adopted, implementation requires significant changes in the work flows of physicians, and there is little information available to guide practices on how to make those changes, says Rosemarie Nelson, a consultant with the Medical Group Management Association.

But the biggest obstacle to adoption remains cost. According to our 2012 Technology Survey, sponsored by AT&T, taken by more than 1,300 physicians, practice managers, and others, 19 percent of those who own and host their own EHR software said the software alone cost them more than $10,000 per physician. About 29 percent of those who haven't adopted an EHR yet cited cost as the primary reason, more than any other factor.

"If a small practice is going to buy something new, it's going to come out of next week's paycheck," says Nelson. "It's very unusual for a practice to retain earnings and set some aside."

That being said, an increasing number of practices are opting for cloud-based EHRs that require a monthly service payment but little if any startup cash. About 30 percent of practices have gone the cloud route, a category that barely existed five years ago, and 81 percent of cloud EHR users pay less than $500 per month per physician.

Dorian Seamster, chief of health information services for CalHIPSO, one of three RECs representing California practices, says that in the second round of contracting with EHR partners, CalHIPSO is trying to identify lower-cost, cloud-based EHR vendors that could be a better fit for small or solo practices.

"We have found that the cost of the EHR is still a major issue, and figuring out how to finance that is still a challenge for providers," she says.

Finally, physicians have been spooked by tales of implementation nightmares at other practices. "It's easy to be scared by the horror stories of loss of production during implementation, and all the implementations that have gone awry," says Nelson.}

**Post-attestation life**

Hampshire OB-GYN adopted its EHR in 2004, years before CMS' meaningful use program began. Yet there were several time-consuming adjustments that even this EHR-savvy practice, in Northampton, Mass., had to make to comply with the Stage 1 rules.

"We had a few small obstacles," recalls practice administrator Gina Wall. "We had to figure out how we would handle the clinical summaries. Providers might perform a function but not click the box. We had to monitor that."

Also, the practice had not been collecting all of the demographic data required, so front-desk staff had to be retrained on a new work flow that would allow patients to privately answer or decline certain questions, such as ethnicity.

To help clinical staff, Wall tasked her practice's clinical manager to oversee the work flow changes and training of all providers and staff using the EHR, and to work with the billing supervisor to make the changes necessary to meet meaningful use.

The practice also examined its existing performance-based measures to see what would make sense for attestation.

But six months later, Wall says the practice is more focused than ever on objectives that improve patient care. For example, problem lists are up to date on all patients, not just OB patients.

"We can immediately see what comes up on a problem list, and provide patient care, such as screening of chlamydia, or counseling," says Wall. "Patients are getting a broader spectrum of necessary services that are more targeted."
Like Hampshire OB-GYN, Desert Ridge Family Physicians in Phoenix made several changes to how it was using its long-established EHR to meet meaningful use requirements. For example, Desert Ridge was also briefly tripped up by the race-and-ethnicity question, and it needed to implement a patient portal in order to provide an electronic copy of care plans to patients within three days of their physician encounter. Practice administrator Dan Nelson credits his vendor, NextGen, with simplifying the transition with its educational programs.

"The challenge for us was turning some of those components provided by NextGen into a new workflow for our practice, and getting used to the EHR's reports, and monitoring physicians," says Dan Nelson.

But many practices that implemented EHRs after CMS' Stage 1 rule release have had a harder time. According to our Technology Survey, 18 percent of respondents said it took more than 18 months to implement their EHR after purchase, and 5 percent of respondents called the process of EHR implementation "traumatizing."

"It's an expense and it's a disruptive force in your practice," says Tashjian. "And while after three months, every doc I've ever met says 'I won't go back' [to paper], during those first three months [of implementation], it's a difficult transition."

Still, experts believe the sooner a practice attests for meaningful use, the easier it will be. Likewise, the longer a practice waits to attest, the lower their possible maximum incentive payment. What's more, in the final rule for Stage 1, CMS said it will penalize providers who have not demonstrated meaningful use with a 1 percent reduction of annual Medicare payments in 2015, that increases another 1 percent each subsequent year until the penalty reaches 5 percent.

**The stages ahead**

While Stage 1 is focused on getting healthcare professionals to use an EHR, Stages 2 and 3 will focus on how you use it. Specifically, CMS expects family physicians and other healthcare providers to use their EHRs to improve patient care, engage patients, and coordinate care with other healthcare providers. For example, three objectives tucked into the Stage 2 proposal include:

- Providing patients with the ability to view online, download, and transmit health information within four days of the information being available to the provider;
- Sharing medical images between organizations and patients; and
- Using health information exchanges (HIE) to share EHR data.

The tasks ahead for physician practices will be more daunting, as the measures move the focus away from mere information gathering and toward patient engagement and data-sharing, experts predict. You'll also be expected to finish what you started in Stage 1.

"Anything you deferred as a menu item in Stage 1 you know is going to be a requirement [in Stage 2]," says Drazen. "Start thinking about how you are able to do that, so when the rule comes out you can move forward."

**Easing into meaningful use**

Daunted by the magnitude of the requirements? If so, you're not only in good company, but you have the advantage of learning from the mistakes and successes of those pioneering professionals who are well past Stage 1.

Here are a few tips on how to ease into a life of meaningful use:

- **Examine your workflow.** "In the paper world, a physician will, in getting ready for a patient, pull out a thick chart, review that chart, ask staff to review that chart, carry that chart into the exam room, make notes in the chart, order some tests, then put that record on his or her desk, and then at the end of the day go through 20, 30, 40 different charts and make sure [notes are] complete," says EHR Association Vice Chairman Charles Jarvis, who is also the vice president of NextGen Healthcare. Getting out of that habit will be difficult, so it's important to consider how to use EHRs efficiently to accomplish the same goal.

- **Follow good examples.** Drazen suggests practices take a look at what physicians in their geographic area are using when picking an EHR. "In spite of the fact that we talk about interoperability, it's more difficult to exchange information from system X and System Y," says Drazen. "See if there's a dominant vendor in the area."

- **Get help.** Implementing an EHR can be a daunting task. And practices going at it alone, sans help from consultants, RECs, or their vendor may end up taking a lot longer and getting more frustrated with the process. "Doing it on your own in a vacuum, in isolation, I don't think is the best recommendation," says Henriksen. "There are a lot of cost-effective options for getting help such as regional extension centers, and low- to no-cost education materials from vendors."

**Successful attestation**
How many "eligible providers" (EP) have successfully attested that they have meaningfully used a certified EHR under of the government's two incentive programs? Here are the totals, through April:

In Summary
Thousands of providers have successfully attested to meaningfully using a qualified EHR since CMS released the final Stage 1 rule. But adoption rates are lower than the government had expected. Here's what your practice should expect in its quest to meaningful use:
• The biggest obstacles to EHR adoption are cost, fear, and time.
• In Stages 2 and 3 healthcare providers will be expected to use their EHRs to engage patients and coordinate care.
• Physicians who are ready to begin EHR implementation should seek help from their vendor or local REC.

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