

Developing an Inpatient Action Plan for EHR Meaningful Use

By Alan Portela, President, CliniComp, Intl.

With Medicare and Medicaid financial incentives for meaningful use of certifiable electronic health records (EHRs) becoming available to eligible hospitals and physicians in the government's fiscal year 2011, which starts Oct. 1, 2010, providers must act rapidly to establish eligibility and quality for the maximum incentive money. To realize these objectives providers should leverage their existing information technology infrastructure, use a best-of-breed strategy, and partner with vendors offering risk-sharing approaches.

While the American Recovery and Reinvestment Tax Act (ARRA) does not mandate EHRs, it deploys a "carrot-and-stick" approach to drive inpatient and outpatient use of EHRs by 2015. The carrot is that the earlier facilities begin using EHRs, the greater the amount of incentives they will be eligible for. Based on the number of annual discharges and other factors, early adopters can receive a minimum of \$2 million to a maximum of \$11 million payable over four years.

The stick is twofold. First, institutions that start using EHRs in 2014 and 2015 will receive lower incentive payments for three and two years, respectively. Second, and more importantly, those that fail to adopt or use EHRs after 2015 will have Medicare reimbursement reduced by 1 percent annually starting in 2015 and can reach up to 5 percent in 2018 and beyond.

Given that the initial incentive kicks off in October 2010, hospitals and health systems that already have adopted or are on the path toward adoption are best positioned to receive higher incentives. Organizations in the preliminary stage of considering EHRs can catch up by acting aggressively. Though the definition of meaningful use is being defined, providers will be better off buying an EHR now instead of later, particularly since ARRA incentives will enable them to blunt the shrinking effect the recession has had on their IT budgets. Further, there is no reason to risk delay in qualifying for incentives when vendors will upgrade systems to meet meaningful use criteria, regardless. In fact, the primary question for providers is how to create an ARRA-qualified EHR. The easiest and most expedient way for facilities is to piggyback on their existing infrastructure, using it as a foundation.

Reversing course

Fortunately, this strategy won't be too jarring for many organizations, as it will simply reinforce a development that already is underway at many facilities.

A prominent trend among providers over the past decade has been to look for a single-vendor solution. But a number of failed attempts has caused several of those organizations to restart the process by looking for a different vendor or pursuing more cost-effective, best-of-breed solutions. The credit crunch has accelerated this development, making it difficult for facilities to access capital and leading them to reduce budgets. Approximately 80 percent of hospitals have stopped, postponed or scaled back projects such as facility upgrades, as well as clinical and information technology planned or already in progress, according to a survey released last April by the American Hospital Association.

In the current economic environment a single vendor strategy is economically unfeasible. ARRA's staggered meaningful use deadlines leave hospitals little margin for error if the vendor encounters technical difficulties or fails to come through. Consequently, it makes more sense for organizations to use their existing infrastructure as a baseline platform while adding proven, best-of-breed clinical solutions to address areas of need.

Another reason this approach is the right choice is that vendors of large hospital information systems (HIS) historically have struggled to automate high acuity areas such as the emergency department, intensive care units, labor and delivery units, neonatal intensive care units, operating rooms, and post-anesthesia care units. Meaningful use can only be achieved by collecting and distributing meaningful data that reside primarily in those high acuity areas. Ironically, most EHR vendors lack high acuity solutions. Since the recession has forced EHR vendors to institute layoffs and slash R&D budgets, this is a deficiency they will not be able to cure in the near term.

Choosing the right technology partner

Thus, when selecting EHR vendors, hospitals would be wise to partner with either HIS companies that have acquired best-of-breed high acuity solutions through mergers or partnerships, or with companies that specialize in automating clinical documentation solutions they need, e.g., perinatal, ICU, etc. The bottom line is that whatever HIS vendor enterprise EHR a facility selects must interoperate with best-of-breed high acuity solutions and vice versa.

To further minimize risk and ensure optimal IT investment, facilities should:

- **Seek vendors willing to enter into risk-sharing or performance-based pricing models.** This new model ties payment to performance on metrics such as decreased average length-of-stay, improved staff efficiency and retention, reduced costs and other clinical improvements.
- **Use the revised recommendations of a workgroup that the federal HIT Policy Committee approved in July as a guideline for evaluating EHRs.** Under the proposed requirements for 2011, organizations among other things must use CPOE for 10 percent of all orders of any type and provide patients with an electronic copy of their health information upon request. The U.S. Department of Health and Human Service will use the recommendations to develop a proposed administrative rule to implement the incentives. The rule, which was released in January 2010, provides greater detail and clarity about meaningful use requirements.
- **Prioritize areas for automation.** The growing need for high acuity applications must be balanced with the hospital administrator's challenge of deciding where to begin implementing those solutions. An ideal approach is to group clinical modules around "functional clusters" or strategic functions or initiatives.

The big picture

As providers craft their strategy for ARRA, they must be careful not to get locked into a mindset whereby they miss seeing the forest for the trees. Incentives certainly are an important consideration, but hospitals ultimately will be best served by creating a HIT infrastructure emphasizing outcomes-relevant, connected and simple use of enterprise EHR systems for mobile and busy clinicians. This means putting the power of patient information, a streamlined ordering process, easy access to drug/clinical decision support database information, and medical device interface interoperability at the clinician's fingertips.

Because the goal is to reach 100 percent clinician adoption, EHR functions must be intuitive — appearing as a unified and interconnected whole — allowing clinicians to move between tasks and locations regardless of where they are located within or outside the hospital walls.

Industry observers have predicted for years that it was a matter of time before the industry used technology to improve quality and eliminate inefficiencies that cost the health system billions of dollars.

Progress has been made but at an agonizingly slow pace over several decades — only 1.5 percent of hospitals have adopted a comprehensive EHR, according to a New England Journal of Medicine survey. By providing \$17.2 billion in incentives to encourage hospitals and physicians to use EHRs, the government is addressing the financial barrier that has kept providers from automating care delivery. As HHS moves to finalize meaningful use requirements, facilities, vendors and other stakeholders must collaborate to meet meaningful use requirements and improve the quality, safety, and cost effectiveness of care. ARRA is a golden opportunity to finally modernize the health system. It must not be squandered.

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