Practical Aspects of the Incentive Payments to Physicians for Electronic Health Record Adoption

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Incentives for adoption of electronic health record solutions

As your physicians may have called to your attention, the American Recovery and Reinvestment Act of 2009 (ARRA) includes incentives to physicians for the adoption of electronic health record (EHR) solutions.[i] The total amount of money possible -- up to $44,000 in incentive payments per physician for those whose adoption begins in 2011[ii] (up to $48,000 for physicians in rural areas[iii]) -- is often the sole focus of the discussion, to the exclusion of attention to the challenges of acquiring, implementing, and using an EHR.

Acquiring and adopting an EHR is a complex process, requiring attention to: the implications for physician practice workflow; the need for care planning before and during implementation; the potential trauma of transition from paper to electronic records; consideration on how the use of an EHR in the examination room alters the relationship with the patient; aspects of ongoing use and support of the software; the importance of data exchange capabilities with local hospitals, labs, and other providers; and, of course, the costs and affordability.

Incentives for EHR use

ARRA sets a number of criteria that must be met to qualify for the EHR use incentives. Many of these criteria, such as certified EHR and meaningful use, are subject to rule, which are to be issued by the Secretary of Health and Human Services.[iv] The way in which the incentives in ARRA are structured, there is an advantage to early EHR adoption. The maximum amount of money is available for physicians that begin using the EHR in 2011, though adoption by 2012 will preserve the majority of the incentive payments, as shown in the table below. While potential loss of $2,000 may be considered significant, if the choice of a system is rushed and there is insufficient time for a complete implementation, the slight gain of $2,000 may be outweighed by the longer-term costs to the physician practice.

In the table below, the left column sets forth the year in which the physician commences use of the EHR, the top row is the year for which payments are received.

		PAYMENT						
		2011	2012	2013	2014	2015	2016	TOTAL
Year of First Use	2011	$18,000	$12,000	$8,000	$4,000	$2,000		$44,000
	2012		18,000	12,000	8,000	4,000	2,000	44,000
	2013			15,000	12,000	8,000	4,000	39,000
	2014				12,000	8,000	4,000	24,000

The EHR adoption incentives, beginning in 2015 will turn into penalties. If a physician has not adopted an EHR by 2014, he will face, over the subsequent years, progressively reduced Medicare reimbursement.[v]

Practice Office Workflow

An EHR is not merely a means to automate the existing work of the physician practice. To be truly successful, the workflow of the practice and the duties of the individuals in the practice must be changed. In most cases, the time

and place when documentation is performed, and who performs it will change significantly. In the paper world, many physicians are accustom to making cursory notes during their time with the patient and then either dictating their notes later or completing the paper chart during breaks between patients, or at the end of the day.

An EHR has the potential to streamline the documentation process through the use of checklists and templates that guide the documentation process. However, this usually means that the physician is performing the documentation on a computer workstation in the examination room. Realtime documentation, while interacting with the patient, also allows the use of clinical decision support rules that are seen as one of the benefits of the use of EHRs. Clinical decision support rules can prompt the physician to cover preventive treatments options, remind of the need for vaccinations and tests, and highlight possible medication errors. Clinical decision support capabilities may be part of the requirements for a certified system.

Practice workflow optimization according to best practices should be obtained from the EHR vendor as part of the implementation services. These, and other implementation services, may be costly. Changing practice workflow is a key deliverable that should be spelled out in the agreement for the EHR. In some cases, the EHR vendor relies upon third-party implementors to deliver workflow reengineering and other implementation services; in which case the agreements need to clearly define the responsibilities of the physician practice, the EHR vendor, and any third-party service providers. The agreements between the parties should also preempt the usual finger pointing that often occurs in multi-party scenarios by clearly designating the EHR vendor as responsible for the delivery of the entire solution.

With proper planning, the drop in productivity associated with the adoption of the EHR may be controlled. Very few practices avoid this drop in productivity; however, after a short time, which varies by practice, productivity should return to pre-implementation levels. Many practices plan for reduced number of patients per day during the first few weeks of using the new EHR system. After that, physicians and staff may need to work extra hours for several more weeks to compensate for the ongoing learning process. Contractually, a portion of the vendor's payment may be tied to the practice returning to its former productivity level. Enforcing this provision requires that objective measures be agreed upon and documented before, during, and after system Go Live.

Implementation services

Beyond practice office workflow reengineering, there are a host of other services necessary for the successful implementation of the chosen EHR. A truism of healthcare software is that a good system poorly implemented may be worse than a mediocre system with a stellar implementation. Key elements of the implementation include: project planning and management, training, record conversion and loading, and hardware installation. A successful implementation requires the active participation of all parties.

Project Planning

Implementation of the chosen EHR means that the practice staff have a great deal of work to do. The project plan should clearly spell out a realistic timeline for implementation of the EHR and the responsibilities of the practice office staff and clinicians. The timeline must take into account that all of the practice staff still have their *day job* to do while simultaneously participating in the implementation. The vendor should staff the project with a project manager, and appropriate technical resources. The practice needs to designate a point person to serve as the primary interface with the vendor project team and to coordinate the work of all of the practice;s clinicians and staff. During the implementation, and through the post Go Live transition period, the success of the EHR implementation must be the primary and most important focus of the practice's point person.

Early on, the vendor (or third-party service provider) should meet with the practice leadership and cogently discuss the alternatives for how the system will be used. Decisions made at this stage will affect how the EHR will be utilized in the over the subsequent years and the overall success of the EHR implementation. The agreement should clearly spell out the vendor's responsibility to guide this process and to provide the practice with the ability to make informed choices relating to best practices based upon information provided by the vendor.

Controlling cost surprises

Other elements of the initial planning discussion include the hardware to be used -- such as desktop computers, tablets, and even small handhelds (e.g., smartphones, PDAs) and wireless network connectivity requirements. At this stage it is critical to recheck the list of equipment to identify any items which may have been left off the initial parts list. If sufficient due diligence has not occurred upfront, there may be surprises when the true cost of equipment and infrastructure is *discovered* at this later stage. To avoid such surprises, the agreement should put the onus on the ven-

dor to have perform a thorough readiness assessment prior to finalization of the parts list. If possible, making the vendor financially responsible for any additions to the parts list that should have been uncovered by the vendor's readiness assessment can help to avoid surprises.

Training

Too often, the training provided as part of the implementation is inadequate. The causes vary from generic and rushed training provided by the vendor, lack of sufficient attention by practice staff, to a reluctance to pay for sufficient training in an attempt to reduce the cost of the overall system. If the staff does not understand how the system works, not only will they not be efficient in utilizing the chosen EHR, but often the necessary decisions on how the system will be configured and used will be made incorrectly. Carefully tracking to assure that all individuals receive proper training is essential. Contractually, it may be advisable to allow any practice member to retake training at no additional costs; this should not impose a high cost on the vendor, especially when so much of the training is provided by computer-based methods.

The practice should consider advanced training courses to be taken by practice staff after Go Live or that should be taken by the practice staff who will be assigned significant technical or support roles in the ongoing use and management of the system. The agreed upon implementation services should also include one-on-one training for physicians in the use of the system; which ideally would be provided in-person, onsite.

The practice should also designate one or more employees who will serve as superusers. The superuser is often the first line of response when individuals in the practice are having difficulty with using the system. The superuser should receive additional training and be included in all discussions on the deployment and use of the system. Contractually, the vendor may be required to provide an evaluation of the skills and mastery of the superuser as part of the deliverables and to outline a program to assure that the superusers' skills are sufficient once Go Live has occurred.

Over time staff turnover will occur. The agreement should set forth the costs of having new staff trained and the frequency of training classes. As upgrades to the software occur, the vendor should be required to provide supplemental training materials that focus on the changes in the system and any changes in the manner in which the user interacts with the EHR.

Ongoing Support and Outages

Once the practice has fully transitioned to the EHR, it will be heavily dependent upon the system being available and functioning properly. The ongoing support provided by the vendor is a critical component of assuring the uptime and function of the system. The agreement should clearly state the response time to be provided by the vendor to requests for support. In assessing the acceptability of the the promised response times, the practice must determine how long it can continue to provide quality care to the patients without EHR access. This also may open a discussion as to what downtime procedures should be put into place as part of the implementation.

If the EHR is run from a computer server within the practice, then the agreement with the vendor may also need to address the vendor's responsibility for hardware maintenance and replacement of defective equipment. The need for the practice to have trained information systems personnel available to assist in remote vendor support service during outages also should be clearly stated in the agreement. If a third-party service provider is the first line of support for the practice, then the responsibilities of the parties in the agreement need to be clearly defined to avoid any finger pointing when time is of the essence.

The burdens of local back-end servers and storage may lead the practice to consider a more comprehensive solution, in which the data and back-end processing are maintained by the vendor. This is often seen by small practices as a more comfortable alternative. As recent outages of major cloud computing solutions (e.g., Google, Salesforce.com) have shown, even the largest service providers can suffer extended outages.[vi] Legal counsel often looks to contractual penalties for extended outages, though individual physician practices may have little to no leverage to achieve meaningful penalties in the agreement. Whether using in-house servers or relying upon a cloud computing solution, the practice may wish to consider reviewing their business insurance for appropriate business interruption coverage due to loss of use of the EHR system.

Software Updates and Meaningful Use

Another ongoing expense is the right to receive software updates. Software updates usually add functionality and correct deficiencies in the software. The agreement should clearly spell out if there are any limitations on the prac-

tice's ability to receive updates to the software. In some cases, vendors define certain major functionality improvements as being outside of the improvements available under basic software maintenance.

ARRA requires that the Secretary of Health and Human Services (HHS) to continue to improve the definition of meaningful use.[vii] Thus, the practice must assure itself that not only is the practice entitled to any software updates required to retain the ability to be a meaningful user of the EHR, but that the vendor is also committed to the timely provision of the necessary updates. A parallel consideration is that the vendor must also commit to maintain the certification of the EHR, according to the requirements set forth by HHS.

Past the incentive period, ARRA contains provisions that will penalize the physician for failure to be a meaningful user of a certified EHR.[viii] As it is not a simple matter to pick up and switch EHR solutions -- given the costs and challenges of record conversion, training, re-implementation, and resultant loss of productivity -- failure of the vendor to continue to provide a complaint solution will have real and material implications for the practice. Even if the vendor would agree to contract terms that make the practice whole for the loss of Medicare reimbursement and the costs of moving to another solution, this promise may not be recoverable as any vendor whose product was no longer viable may also be without the assets to male good on this obligation to reimburse the practice. Thus, while a contractual commitment binding the vendor to provide all updates required for the practice to maintain the ability to meet the meaningful use requirements is essential, the practice must recognize that there may be less than ideal recourse if the vendor is unable to meet this commitment.

Information Exchange

Another requirement for receipt of EHR-use incentive payments (and avoidance of the later reductions in Medicare reimbursement) is that the EHR is connected in a manner that provides for the exchange of health information.[ix] Unlike many other aspects of meeting the requirements set forth in ARRA, health information exchange requires both the practice and others outside of the practice to cooperate. These external parties may include the hospitals that provide laboratory and other diagnostic services, laboratory service providers, pharmacies (critical for electronic prescribing), and other physician practices.

Traditionally, interfaces between computer systems have been a significant expense and have required active and ongoing management. There also may be ongoing transaction-based charges for transfer of data over health information exchange networks. The agreement should clearly set forth the responsibilities of the practice and the vendor, as well as third parties (e.g., hospitals, laboratory service providers, other practices), in initial implementation of the necessary interfaces and their ongoing management. Where possible, the practice may wish to lock in any per transaction costs for a number of years to avoid or defer future price increases.

Money makes the world go around

We began this consideration of EHR adoption by looking at the incentives provided under ARRA. As identified above, there are a large number of moving parts associated with the acquisition, implementation, and ongoing use of an EHR. Most of these have non-trivial costs; all of which adds up to real money that the practice must allocate in advance of receiving the incentives set forth in ARRA. Many of the costs will be incurred upfront -- during the implementation phase.

Contrary to what physicians may believe, the EHR incentive payments will not only be spread over several years,[x] but will also likely be made in arrears -- subsequent to the year of qualification. While ARRA delegates to the HHS Secretary the authority to determine whether the payments will be made in one single payment for each year or a series of periodic payments, [xi] it appears inescapable that the payments will lag the demonstration of meaningful use, as the physician must comply with and HHS must evaluate the submission of the requisite proof of meaningful use. All of this means that the physician will need to invest the necessary funds himself or finance the initial costs.

Once past the incentive period, which ends in 2015, the physician will need to continue to pay the ongoing costs of the EHR, with no additional incentive payment to partial cover the costs of the system. Thus, it is imperative that the practice undertake a cash flow analysis of the timing of the expenditures and incentive payments over ten years in order to gain a solid comprehension of the costs involved. For many practices, the multiple-year cash flow will not be positive: understanding this upfront may avoid later recriminations.

In conclusion, the acquisition of an EHR is likely to have significant implications for the practice. Proper attention, especially in the implementation phase, is critical to not only achieving a successful EHR environment, but is also critical to the ongoing success of the practice. To the extent possible, the agreement for the acquisition and ongoing support of the system should attempt to mitigate risk and clearly delineate responsibilities, thus contributing to the desired success. However, even the best agreement cannot necessarily address or mitigate all of the potential risks. Nor can the agreement alter the inexorable outcome that over the long-term, the EHR may be another expense of doing business.

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[i] Public Law 111-5, 123 STAT. 115, 467

[ii] 123 STAT. 115, 468

[iii] *Id*.

[iv] At the time of writing, these, and a number of other rules had not been issued. The definition of certification requirements and meaningful use may impose other requirements on the physician practice that may affect workflow and use of the chosen EHR solution.

[v] 123 Stat. 115, 472

[vi] J. Nicholas Hoover, *Outages Force Cloud Computing Users To Rethink Tactics*, Information Week (18 August 2008) available at http://www.informationweek.com/news/services/saas/showArticle.jhtml?articleID=210004236 (last accessed 3 May 2009).

[vii] 123 Stat. 115, 470

[viii] 123 STAT. 115, 467

[ix] 123 STAT. 115, 470

[x] See table, above

[xi] 123 Stat 115, 469