

California Medical Association & California Medical Association Foundation

Electronic Health Records Desk Reference

Funded by **The Physicians Foundation**



Produced by the



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The Physicians Foundation Website:
<http://www.physiciansfoundations.org/>

In order to continue to improve the information we make available to you, we ask that you provide us with feedback once you have read and used this resource. Your feedback will be essential in helping us continuously improve this toolkit and provide ongoing support and information around health information technology issues.

The online survey is available at:
<http://www.surveymonkey.com/s/C882SHY>

This desk reference is also available in an electronic format. If you would like to download a free copy, please visit the CMA HIT Resource Center website at <http://www.cmanet.org/issues-and-advocacy/cmas-top-issues/health-information-technology/>

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Preface



James G. Hinsdale, MD
President
California Medical Association

the selection, adoption, and implementation of an EHR feels like an overwhelming process. Some physicians may not know where to start or who to trust for accurate information. Other physicians may have concerns about meeting the requirements of “meaningful use” and connecting to a functioning health information exchange (HIE).

The California Medical Association (CMA) is pleased to introduce you to our Physicians EHR Desk Reference, which has been made possible by assistance from the CMA Foundation, the Texas Medical Association, and by generous support from The Physicians Foundation. This EHR Desk Reference is an easy to use resource developed in conjunction with practicing physicians to help other physicians and their staff members to make informed decisions about EHR selection, adoption, and implementation. This toolkit will help you to understand the federal EHR financial incentive programs and how to achieve meaningful use.

Dear Colleagues,

The widespread use of electronic health records (EHRs) has the potential to improve the efficiency and quality of the health care delivery system. Physicians who chose to implement an EHR have an unprecedented opportunity to take advantage of federal financial incentives. However, for many California physicians,

This Desk Reference is designed to provide you with practical information regardless of where you are in the process of EHR implementation and is meant to work in concert with the EHR adoption support provided by the federally designated regional extension centers (RECs). The Desk Reference is divided into chapters that address specific issues such as privacy and security, EHR selection, and meaningful use. You may choose to read the entire Desk Reference or simply select relevant chapters. We recommend that everyone read the first “getting started” section of this resource.

In order to continue to improve the information we make available to you, we ask that you provide us with feedback once you have read and used this resource. The online survey is available at <http://www.surveymonkey.com/s/C882SHY>. Once you feel you have had adequate experience using the toolkit, please take a few minutes to submit the survey. Your feedback will be essential in helping us continuously improve this toolkit and provide ongoing support and information around health information technology issues.

We thank you for your participation and applaud you for taking the initial step in this grand undertaking toward the future of healthcare.

Sincerely,

A handwritten signature in black ink that reads "James G. Hinsdale". The signature is written in a cursive, flowing style.

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Section 1

Getting Started



Background

In February 2009 Congress passed and the President signed the American Recovery and Reinvestment Act, also known as ARRA or the “Stimulus Act.” Included in ARRA was a federally funded incentive program to encourage physicians to implement electronic health records (EHRs) into their practices.

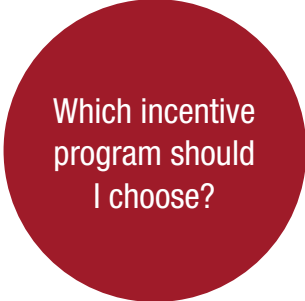
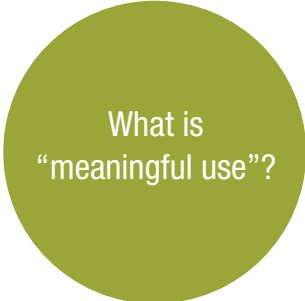


In general, almost all Medicare providers, regardless of whether they are in a specialty or primary care practice, are eligible to receive up to \$44,000 paid out over a five-year period for demonstrating meaningful use of an EHR system. Physicians who take Medicare also face penalties starting in 2015 if they have not achieved meaningful use of an EHR. Certain Medi-Cal providers who meet minimum patient volume standards are eligible to receive up to \$63,750 paid out over six years.

While many California physicians are excited about the opportunity awarded by the incentive payments, they are unsure about where to start in their own practices.

This desk reference is intended to help physicians and their staff answer these questions and many more. It includes information about the incentive programs and practical implementation tips for physicians who are beginning EHR Implementation.

This reference is constructed to help physicians regardless of where they are in their EHR implementation process. Some physicians may be in practices that are completely paper based and need help assessing their readiness to make the transition to an EHR. Others may already have a functioning EHR and need assistance deciphering the rules of the federal incentive programs, in order to achieve meaningful use. This reference can be helpful for both. ■

You may have questions, such as:

-  Which incentive program should I choose? **page 14**
-  What is “meaningful use”? **page 23**
-  Which EHR system is right for me? **page 34**
-  Where do I start? **page 32**

Introduction

What is an Electronic Health record (EHR)?

At the most basic level, an electronic health record (EHR) is a computer database used for storing clinical information about the care and treatment of your patients. Storing patient information in digital format makes it efficient and easy to find information and to track patient care across time and different treatment locations.

EHRs also generally contain additional tools that promote quality improvement and efficiency of your practice. They may contain or can be connected to a practice management system that contains scheduling software and a billing system, or other computer based practice tools. They may also contain clinical decision support tools, such as alerts to notify you if a drug you are about to prescribe has a known interaction with another drug the patient is already taking.

When fully implemented, EHRs will eliminate much of the paper in your practice and potentially allow you to reallocate staff time from administrative tasks to more productive pursuits.

Why Make The Switch?

There is no doubt that making the transition to an EHR can be very daunting for most physicians. You may have heard many horror stories from your colleagues who have sunk thousands of dollars and countless hours of time into an EHR system that did not improve their practice or show any positive return on investment. You may believe that you are too close to the end of your career to make a major transition like this right now.

There are many reasons that physicians choose to make the switch.

Electronic Medical Record (EMR) vs. Electronic Health Record (EHR):

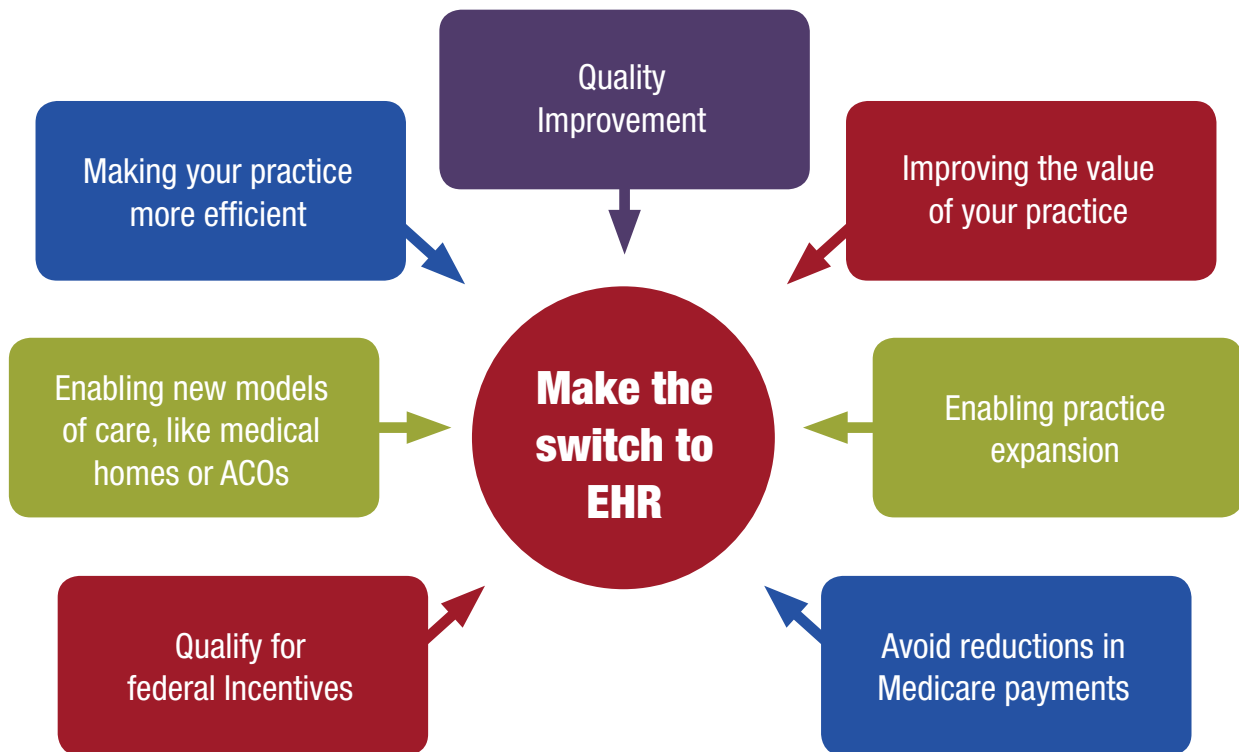
Is there a difference?

When discussing digitizing your practice, you will likely hear two different terms—electronic health record (EHR) and electronic medical record (EMR). In common practice, the two are used interchangeably. Technically, the two are not the same. EMR only refers to the digital version of the traditional, paper-based patient record. EHR is a more comprehensive term that refers to a complete system. An EHR will usually contain a patient “portal,” along with clinical decision support tools.

Because the federal provider incentives require a system with comprehensive capabilities, this reference will use the term EHR throughout.

- 1. Federal incentives/reductions in payment** - Right now, many physicians who transition to an EHR are motivated by receiving federal provider incentives, or the wish to avoid future payment reductions in the Medicare program. These incentives, although temporary, represent a one-time opportunity to receive federal funding to transition to an EHR. If you've ever considered implementing an EHR in your practice, now is the time.
- 2. Enabling new models of care, like medical homes or ACOs** - The federal health reform bill creates or expands federal programs for supporting new models for patient care. The two most well-known models are the medical

Some benefits of making the switch

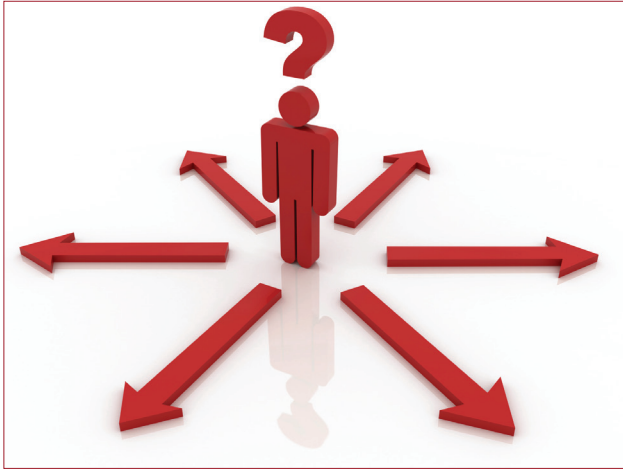


home and the accountable care organization (ACO). Both of these models will involve your practice taking a more active role in coordinating care with other health care providers and hospitals. In order for this to be possible, you will almost certainly have to have a fully implemented EHR.

3. Making your practice more efficient - With an EHR, many tasks can be automated, and office clutter can be reduced. Tasks like billing, sending patient reminders and notifying patients of lab results can be done digitally, saving your practice time and money. Also, you may find that the claims you send to health plans will be more accurate and that your practice cash flow improves. For example, many physicians who have successfully implemented an EHR have commented that one of the immediate noticeable benefits they have seen is the “phones stop ringing.” Tasks such as pharmacy refills, which would have been done by phone and often involve

numerous calls if different formularies are involved, are now accomplished by messaging, which is automated and inherent in most EHRs. Studies have shown that non-automated busy practices may require part-time staff for messaging who, in an automated office, would be available for other clinical duties.

4. Quality Improvement - EHRs contain important tools that can improve the quality of even the best practices, by giving doctors more information about their patients and their patients’ health. For example, clinical decision support tools can provide real-time support for things like alerting you to possible negative interactions between drugs. In a consumer-driven marketplace, EHR reportable patient care documentation, such as childhood immunization rates, give automated practices a competitive edge.



5. Improving the value of your practice - If you're an older physician, you may think there is no reason for you to transition your practice, or that you won't have time to recoup your investment. Before you make that decision, think about your plans for the future. Are you going to try and sell your practice? Are you going to try and recruit a younger physician to take it over? Having a properly implemented EHR will make your practice much more appealing to a potential buyer or partner.

6. Enabling practice expansion - If you're planning to expand your practice, either by adding more staff or by opening more locations, EHRs can facilitate the process. An EHR can free up staff from administrative tasks, leaving them more time to be involved in patient care. If your plan is to add a satellite office, your EHR can keep multiple locations on one common record-keeping system.

When Should I Get Started?

The federal EHR provider incentives have created a lot of interest and excitement in the medical community. While the incentive funds are only temporary, that does not mean that you have to purchase your EHR system right away.

What you should do immediately, however, is consider how EHR adoption fits into your future plans for your practice. You should also begin assessing your future technology needs. This desk reference will provide you with tools to help you through that process.

Additional Resources

California Academy of Family Physicians' "5 Things To Do NOW"

<http://www.familydocs.org/pcmh/health-information-technology/5-things-to-do-now.php>

If you do plan to access the federal provider incentives (see section 2), then you should familiarize yourself with the timelines for those two programs. Remember that depending on practice size, a successful EHR implementation may take 12 to 18 months, so be sure to budget your time accordingly.

How to Use This Reference?

Physicians in California are in different stages of EHR implementation. There are practices that are completely paper based that will have to start the implementation process from scratch. Other practices have a fully integrated EHR and will just need a little work to help them achieve meaningful use.

This reference is intended to help you at any stage of the implementation process. It will likely be beneficial for all physicians to read chapters 1-6, which outline the rules and the structure of the federal EHR incentive program. These sections will help you understand the Medicare and Medi-Cal incentive programs, the differences between the two, and how to decide the best way to proceed with your practice.

Physicians' needs addressed in the remaining sections will vary widely. If you are just starting the process of EHR implementation, you will want to proceed to chapter 9 to begin a practice technology assessment. If you already have an EHR, you may want to skip ahead to chapter 17, which talks specifically about preparing your practice for meaningful use. ■

Section 2

Understanding the Federal EHR Provider Incentive Program

The Stimulus Act actually created two EHR incentive programs—a Medicare program and a Medicaid (Medi-Cal) program. While the basic structure of the two incentive programs is the same, there are distinct differences in some of the rules governing them (see page 20 for a summary of these differences).

You can only receive incentives through one of the programs, not both. Therefore, it is important that you consider the rules of the two programs and make a careful decision about which one to access. Once you enroll in one incentive program, you will only be allowed to switch once.

This section will help you to understand the incentive programs, so you can make a sound decision for your practice.



Chapter 1

Medicare EHR Incentive Program

In general, Medicare providers are eligible for up to \$44,000 in provider incentives, beginning as early as 2011. Physicians who have not demonstrated meaningful use by 2015 will receive Medicare payment reductions.

Maximum Incentive Payments

The maximum provider incentive that you can receive under the Medicare program is \$44,000, paid out over a five-year period. You will only receive the maximum incentive if you achieve

meaningful use in calendar year 2011 or 2012. In 2013 and 2014, you can still receive incentives, but for lower amounts. The following chart lays out the maximum amount that you will receive, based on the first year you achieve meaningful use:

Maximum Medicare Incentive Amount, by year

	2011	2012	2013	2014
2011	\$18,000	---	---	---
2012	\$12,000	\$18,000	---	---
2013	\$8,000	\$12,000	\$15,000	---
2014	\$4,000	\$8,000	\$12,000	\$12,000
2015	\$2,000	\$4,000	\$8,000	\$8,000
2016	\$0	\$2,000	\$4,000	\$4,000
Total:	\$44,000	\$44,000	\$39,000	\$24,000

In any given year, the maximum amount that you qualify for is 75 percent of your Medicare Part B (fee-for-service) allowable charges. So, in order to qualify for \$18,000 in 2011, you must bill Medicare Part B for at least \$24,000 of allowable charges ($\$24,000 \times .75 = \$18,000$).

Reductions in Payment

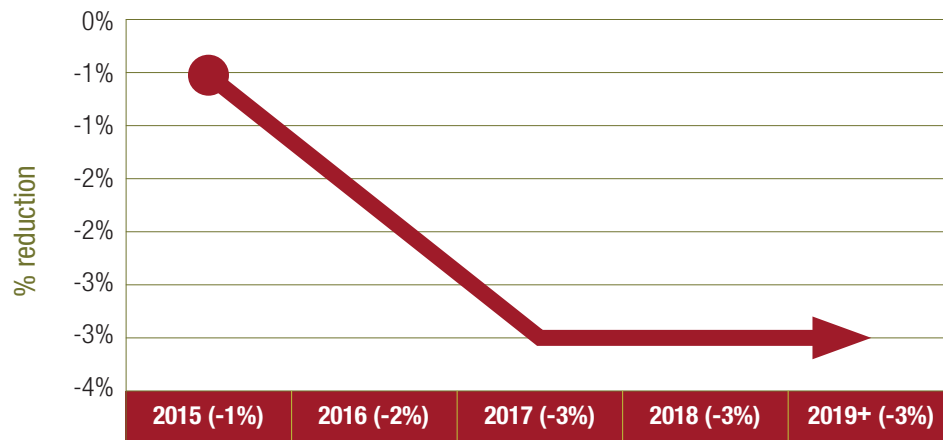
Beginning in 2015, physicians who do not demonstrate meaningful use will see reductions in payment. These reductions increase from 1 percent of total Medicare charges in 2015, to 2 percent in 2016, and 3 percent in 2017 and every year thereafter.

Additional Resources

CMA “On-Call” #1133 – Electronic Health Records

<http://www.cmanet.org/resource-library/detail?item=electronic-health-records-federal-incentive>

Reductions in Payment, by year



Bonus for Physicians in Shortage Areas

Physicians who practice in a federally designated Health Professions Shortage Area (HPSA) are eligible for 10 percent bonus payments, meaning that their maximum incentive is \$48,400. In order to qualify for this bonus, you must provide more than 50 percent of your patient encounters at a location that is in an HPSA. ■

To find out if your practice is in an HPSA, visit the website of the Health Resources and Services Administration, <http://www.hrsa.gov/index.html>.

Chapter 2

Medi-Cal EHR Incentive Program

In general, Medi-Cal providers who meet certain patient volume thresholds (outlined below) will qualify for up to \$63,750 paid out over six years, beginning as early as 2011 or as late as 2016.

Unlike the Medicare program, the Medi-Cal program will not penalize physicians who do not demonstrate meaningful use. However, physicians who accept both Medicare and Medi-Cal will still be subject to reductions in Medicare payments if they have not achieved meaningful use by 2015, even if they are getting incentive payments through the Medi-Cal program.

Physicians who accept both Medicare and Medi-Cal will still be subject to reductions in Medicare payments if they have not achieved meaningful use by 2015, even if they are getting incentive payments through the Medi-Cal program.

Eligibility Requirements

While most Medicare providers will qualify for some incentive payments, you will only qualify for Medi-Cal incentives if you fall into one of three categories:

1. Medi-Cal recipients comprise 30 percent of your patient volume.
2. If you are a pediatrician, you can qualify if Medi-Cal recipients comprise 20 percent of your patient volume. However, pediatricians who fall between 20 percent and 30 percent of patient volume will only qualify for two thirds of the total incentive (\$42,500).
3. If you practice in a Federally Qualified Health Center (FQHC), you will qualify if “needy individuals” (Medi-Cal, Healthy Families, sliding scale, or uncompensated care) comprise 30 percent of your patient volume.

Medi-Cal Incentive Eligibility

Medi-Cal recipients comprise 30% of your patient volume.

If you are a pediatrician, you can qualify if Medi-Cal recipients comprise 20% of your patient volume. However, pediatricians who fall between 20% and 30% of patient volume will only qualify for two thirds of the total incentive (\$42,500).

If you practice in a Federally Qualified Health Center (FQHC), you will qualify if “needy individuals” (Medi-Cal, Healthy Families, sliding scale or uncompensated care) comprise 30% of your patient volume.

How Medi-Cal Incentives Are Paid

Medi-Cal provider incentives are paid out over six years, beginning with the first year that you enter the incentive program. Medi-Cal physicians can begin in the EHR incentive program as late as 2016 and receive the maximum provider incentive. The following chart lays out the maximum incentive by year. The top line is the first year that the physician enters the incentive program, and the side axis is the payment by year.

	2011	2012	2013	2014	2015	2016
2011	\$21,250	---	---	---	---	---
2012	\$8,500	\$21,250	---	---	---	---
2013	\$8,500	\$8,500	\$21,250	---	---	---
2014	\$8,500	\$8,500	\$8,500	\$21,250	---	---
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	---
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	---	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	---	---	\$8,500	\$8,500	\$8,500	\$8,500
2019	---	---	---	\$8,500	\$8,500	\$8,500
2020	---	---	---	---	\$8,500	\$8,500
2021	---	---	---	---	---	\$8,500
Total:	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Contrary to the requirement of continuous demonstration of meaningful use in the Medicare program, in the Medi-Cal program you could show meaningful use one year, but not the next, with no penalty. For example, a physician could receive an incentive for adoption in 2011, but not demonstrate meaningful use in 2012. That same physician could then achieve meaningful use in 2013 and still receive the maximum incentive.

Additional Resources

California Academy of Family Physicians' Qualification Assessment Wizard

<http://www.familydocs.org/pcmh/health-information-technology/qualification-assessment-wizard.php>

Adoption, Implementation, or Upgrade

One of the key differences between the Medi-Cal and the Medicare incentive programs is that Medi-Cal providers are able to access up-front funding to help with the “adoption, implementation, or upgrade” of an EHR.

In the first year that a Medi-Cal physician expects to receive incentives, she does not need to demonstrate meaningful use. Instead, she can attest that he has adopted, implemented, or upgraded her EHR system during the previous year. ■

Adoption

Directly purchasing an EHR system from a commercial vendor demonstrates “adoption.” You can also attest that you have access to a system through an employment or contract arrangement, such as in a clinic or medical group.

Implementation

“Implementation” involves any services required for bringing the EHR into the workflow of the practice (such as staff training, workflow redesign, or any other functions that a physician needs to implement the EHR in the practice).

Upgrade

Many physicians who have existing EHR systems will need to add additional functions to their systems in order to achieve meaningful use. This qualifies as an “upgrade.”

Chapter 3

Is Your Practice Considered “Hospital Based?”

Once you have considered the basics of the incentive programs, the next thing you should determine is whether your practice is considered “hospital based” per federal rules. By the provisions of the Stimulus Act, hospital-based physicians do not qualify for incentives under either the Medicare or the Medi-Cal program. If you are hospital based, the hospital will qualify for facility incentive payments on your behalf.

Because there are a variety of arrangements that physicians have with hospitals, the federal government has attempted to strike a balance in defining hospital based for the purposes of the incentive program. The final definition was included in the definition of meaningful use and is based on patient encounters.

Definition of “Hospital Based”

The federal government considers physicians to be hospital based if they provide at least 90 percent of their patient encounters in a hospital inpatient or emergency room setting (in billing terms, any encounter that uses place of service [POS] Code 21 or 23).

Physicians who fall into this category do not qualify for incentives and will also not be subject to reductions in Medicare reimbursement that begin in 2015.

Determining Patient Volume

For purposes of determining whether 90 percent of patient encounters take place in a hospital, physicians should only consider patients covered by the program through which they expect to receive incentives. That is, physicians accessing the Medicare incentive program will be considered hospital-based if 90 percent of their Medicare Part B (fee-for-service) patient encounters take place in an inpatient or emergency room setting. Physicians in the Medi-Cal program will be considered hospital-based if 90 percent of their Medi-Cal (fee-for-service or managed care) encounters take place in an inpatient or emergency room setting.

Example: Is Dr. Jones “Hospital Based?”

Dr. Jones is a solo practice internal medicine physician based in San Francisco. One night a week, Dr. Jones takes ER call at the local hospital.

Dr. Jones does not accept Medi-Cal at his private practice, but he does treat Medi-Cal patients in the ER. Therefore, 100 percent of his Medi-Cal patient encounters fall under place-of-service code 23. For purposes of the Medi-Cal program, Dr. Jones is considered hospital-based.

Dr. Jones treats Medicare patients in both locations, and only 20 percent of his total Medicare patient encounters take place in the ER. For the Medicare program, Dr. Jones is not hospital based.

Chapter 4

Differences between the Medicare and Medi-Cal Programs

The chart below provides a quick reference summary of the Medicare and the Medi-Cal incentive programs and highlights the differences between the two. ■

Incentive Program	Medicare	Medi-Cal
Maximum Incentive	\$44,000 ¹	\$63,750 ²
Physician Eligibility	Most Medicare providers can qualify, but incentives will be based on a percentage (75%) of total Medicare Part B charges.	Physicians must meet one of the three criteria: <ul style="list-style-type: none"> - 30% of patient volume is Medi-Cal - 20% of patient volume is Medi-Cal (Pediatricians only) - 30% of patient volume is “needy individuals” (physicians who practice in an FQHC)
Penalties for Non-Adoption	Yes, beginning in 2015	No
Up-front Funding	No. Physicians can only receive funding for demonstrating meaningful use.	Yes. Funding is available for “adoption, implementation, or upgrade” of an EHR system.
Timelines	Physicians must demonstrate meaningful use in 2011 or 2012 in order to receive the maximum incentive.	Physicians can begin in the program as late as 2016 and receive the maximum incentive.
Consecutive Years of Payment	Providers must demonstrate meaningful use in five consecutive years in order to receive the maximum incentive.	Providers can fail to demonstrate meaningful use for one year, and still receive the maximum incentive (as long as all years fall before 2011).
Managed Care Patients	Medicare Advantage patients are not considered for the purposes of calculating provider incentives.	Medi-Cal Managed Care patients are counted for the purposes of meeting patient volume standards.

¹ Physicians who practice in a Health Professions Shortage Area (HPSA) can receive a 10 percent bonus payment, making their maximum incentive \$48,400.

² Pediatricians whose Medi-Cal patient volume is between 20 and 29 percent will only qualify for two thirds of the maximum incentive, or \$42,500.

Chapter 5

Medicare or Medi-Cal?



Once you have determined that your practice is not hospital based, the next step is to decide which incentive program—Medicare or Medi-Cal—you are going to access.

In general, the rules regarding the Medi-Cal incentive program are more favorable for physicians—the timelines are longer, the possible incentives are higher, and there is money available up front. Therefore, any physician who qualifies for the Medi-Cal program should strongly consider accessing incentives through this program.

As described above, eligibility for the Medi-Cal incentive program is based on patient volume. The description below will help you to decide whether your practice will qualify.

Calculating Medi-Cal Patient Volume

Physicians can demonstrate that they are eligible for Medi-Cal incentives by tracking their patient volume for a 90-day period of their choosing. In general, the patient volume requirements are calculated as a percentage of total patient encounters during that 90-day period. The formula is:

$(\text{Total Medi-Cal Patients Seen}) / (\text{Total Patients Seen}) \times 100$

Additional Resources

California Academy of Family Physicians' Qualification Assessment Wizard

<http://www.familydocs.org/pcmh/health-information-technology/qualification-assessment-wizard.php>

If the resulting percentage is more than 30 percent (or 20 percent for pediatricians), then you qualify for incentives in the Medi-Cal program.

Special Rules for Medi-Cal Managed Care

Most Medi-Cal Managed Care plans will assign patients to a physician's patient panel. The federal government will allow you to include these patients (as a percentage of your total patient panel), as well as any Medi-Cal patients you see who are not assigned to you by the plan.

Because of this, physicians who contract with Medi-Cal Managed Care plans will use a slightly different formula for calculating their patient volume. The formula physicians in this situation will use is:

$(\text{Medi-Cal Patients Assigned to the Provider} + \text{All Other Medi-Cal Patients Seen}) / (\text{Total Patients Assigned to the Practice} + \text{All Other Patients Seen}) \times 100$

Here again, if the resulting percentage is 30 percent or greater (or 20 percent for pediatricians), then you qualify for incentives.

Definition of Medi-Cal Patients

For both the fee-for-service and managed care Medi-Cal providers, the definition of “Medi-Cal patients” includes anyone covered by a state Medi-Cal waiver, such as the Family PACT program, and those covered by both Medi-Cal and Medicare (“Medi-Medi’s” or “dual eligibles”).

Physicians who are not in a federally qualified health center (FQHC) cannot count patients covered by Healthy Families, Access for Infants and Mothers (AIM), a county coverage initiative, the County Medical Services Program (CMSP), or any other state or local program.

Special Rules for Physicians in FQHCs or RHCs

As described above, physicians who practice predominantly in federally qualified health centers (FQHCs) or rural health centers (RHCs) are allowed to incorporate all “needy individuals” in their calculation of patient volume. Needy individuals include all Medi-Cal, Healthy Families, sliding scale and uncompensated care patients.

If you practice in one of these settings, you will use roughly the same calculation for determining your eligibility for Medi-Cal provider incentives. The calculation you will use is:

$$(\text{Total Needy Individuals Seen}) / (\text{Total Patients Seen}) \times 100$$

If the resulting percentage is more than 30 percent (or 20 percent for pediatricians), then you qualify for incentives in the Medi-Cal program.

Similarly, if you practice in an FQHC or RHC, and you contract with managed care plans for Medi-Cal or Healthy Families, the calculation you will use is:

$$(\text{Needy Individuals Assigned to the Provider} + \text{All Other Needy Individuals Seen}) / (\text{Total Patients Assigned to the Practice} + \text{All Other Patients Seen}) \times 100$$

If you practice in an FQHC or RHC, please be sure to read Chapter 7 of this section (Working with Clinics, Hospitals, IPAs and Others) for other considerations regarding these practice settings.

If you practice in an FQHC or RHC, please be sure to read Chapter 7 of this section (Working with Clinics, Hospitals, IPAs and Others) for other considerations regarding these practice settings.

Calculation of Medicare Incentive

If your practice does not qualify for the Medi-Cal incentive program but you are a Medicare provider, it will be important to determine the amount of incentive for which your practice will qualify.

While Medicare does not have a specific patient volume requirement, the amount of incentive you receive will be based on your allowable Medicare charges.

Maximum Incentive

In any given year, the maximum incentive that a physician can receive is 75 percent of his/her Medicare Part B (fee-for-service) allowable charges from the previous year. Therefore, in order for physicians to receive the maximum incentive in 2011, they must have at least \$24,000 in Medicare Part B allowable charges from the previous year ($\$24,000 \times .75 = \$18,000$).

Exclusion of Medicare Advantage

For the purposes of calculating their incentive, physicians cannot include any charges paid by a Medicare Advantage (Senior HMO or Medicare Part C) plan.

There is a separate incentive program specifically established for Medicare Advantage Organizations (MAOs). In order to qualify as an MAO, however, the physicians in that organization must provide 80 percent of their Medicare Advantage services to patients covered by the organization. The rules of the MAO incentive program will prohibit all but a very few very large integrated systems, such as Kaiser Permanente, from qualifying. ■

Chapter 6

What Is “Meaningful Use”?

In both the Medicare and the Medi-Cal incentive programs, you will have to demonstrate meaningful use of an EHR system in order to qualify for the full incentive payment. All physicians who contract with Medicare will have to demonstrate meaningful use in order to avoid payment reductions in 2015.

The Stimulus Act only provided a basic outline of what meaningful use would entail. From there, the Centers for Medicare & Medicaid Services (CMS) engaged in a lengthy process to define meaningful use. The definition was published in July 2010.

Meaningful Use: The Basics

Meaningful use is a set of criteria on which you as a physician will have to report. Depending on whether you are accessing the Medicare or Medi-Cal incentive program, you will either report to CMS or to the State of California. You will have to report on 20 objectives in order to achieve meaningful use. One of the objectives, reporting on clinical quality measures, will require reporting on six quality measures. Therefore, including these six quality measures, you will have to report on a total of 25 unique measures.

Objectives and Measures

The main set of items on which physicians will report are known as “objectives” and “measures.” The objectives are broad policy goals that CMS hopes to achieve through meaningful use – such as encouraging electronic prescribing. The measures are the actual criteria that physicians will have to meet to realize that objective. The objectives and measures are broken into two parts, known as “core” and “menu” objectives and measures. The core objectives and measures are a list of 15 items on which all physicians will have to report. In addition to the

Additional Resources

CMA Summary of the Final Federal Rule

<http://www.cmanet.org/files/pdf/meaningful-use-summary-071310.pdf>

CMA Physicians Guidebook for Meaningful Use

<http://www.cmanet.org/resource-library/detail.dT?item=physician-guidebook-for-meaningful-use>

15 core items, physicians will select five additional “menu” objectives from a list of the 10 menu items that are most relevant to their clinical specialty or practice. At least one of the menu set items on which a provider reports must be public health related.

Clinical Quality Measure Reporting

As described above, one of the core objectives is that physicians will report on clinical quality measures. Within the clinical quality measure objective, three of the quality measures will be “core” measures on which all physicians will have to report:

adult weight screening and follow-up

hypertension: blood pressure management

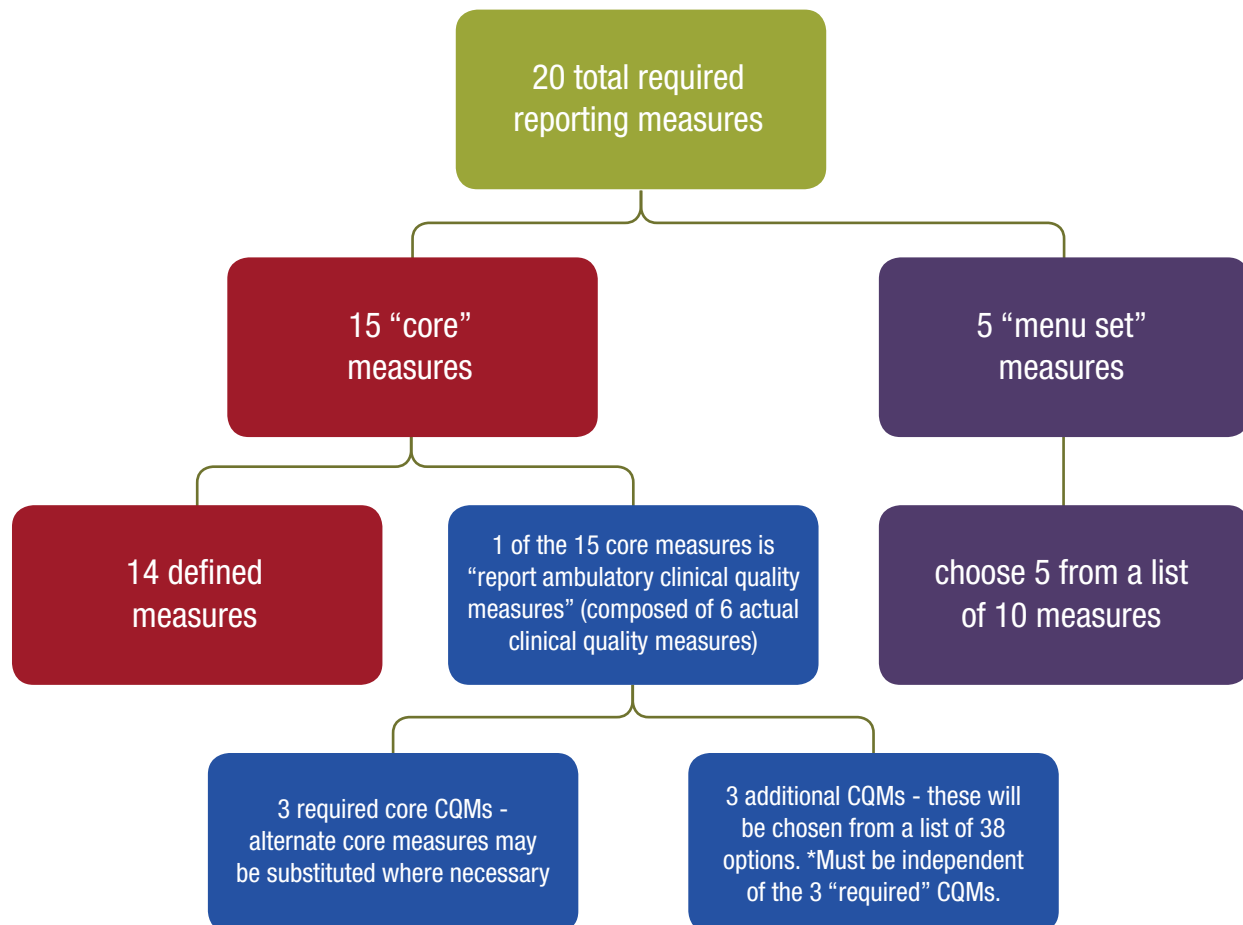
tobacco screening and cessation

If a physician demonstrates that the objective is not applicable by reporting a zero denominator for one of these core measures, then that physician may report on one of three “alternate core” quality measures:

- influenza screening for patients over the age of 50
- weight assessment and counseling for children and adolescents
- childhood immunization status

In addition, physicians will select three clinical quality measures from a list of 38 options. For example, physicians may choose to report on the percentage of their female patients who receive breast cancer screening or the percentage of their patients who receive proper asthma treatments. This will give physicians the flexibility to select measures that are most applicable to their practice specialty.

Overview of Meaningful Use Reporting Requirements



Flexibility in Reporting Meaningful Use

In the final definition of meaningful use, CMS has given physicians some flexibility in gathering and reporting the data necessary for demonstrating meaningful use. This flexibility will allow you some ability to tailor meaningful use to the realities of your clinical practice.

you can report “zero”

patient information can come from other sources

Information does not need to be entered by the physician

You can report “zero”

The final rule also gives physicians the ability to report “zero” as the denominator for percentage-based objectives, if the situation does not arise in their practice.

For example, one of the objectives on which physicians will report is “50 percent of patients who request an electronic copy of their health information receive it within three days.” If none of your patients request an electronic copy of their health information, you would simply report “zero” as the denominator for that objective.

Patient information can come from another source

You may use information received from another provider for the purposes of demonstrating meaningful use. As long as the appropriate information is entered into the EHR, it is acceptable. For example, if you are a specialist, you may not routinely record a patient’s basic information – height, weight, etc. However, you may receive that information on a referral from a primary care physician.

Information does not need to be entered into the EHR by the physician

The final rule on meaningful use clarifies that it does not need to be the physician who enters information for reporting meaningful use into the EHR in order to qualify for provider incentives.

For example, your practice may have a questionnaire that is filled out by patients while they are in the waiting room. This questionnaire is then collected and entered into an EHR by office staff, a nurse or a physician’s assistant. To the extent that the questionnaire records information that is necessary for meaningful use, it is not important who in the practice enters that information. ■

Won’t this take too much time and effort?

One of the major concerns that most physicians have regarding achieving meaningful use is that the time and effort involved with collecting and reporting data will have a deleterious effect on their practice’s productivity.

In truth, you are probably closer to meaningful use than you think. For example, most practices have a patient questionnaire that patients complete in the waiting room. This questionnaire asks patients for basic information—demographics, smoking status, etc.

By recording this information into your EHR, you can easily comply with many of the requirements of meaningful use.

Chapter 7

Working with Clinics, Hospitals, IPAs and Others

Physicians often have a professional relationship with a facility, such as a hospital or a clinic, an independent practice association (IPA), or another similar entity (such as a medical services organization, a local health plan, or a medical group). You may, for example, refer patients to a hospital in your community or work with a clinic to provide specialty care to its patients.

These entities can provide valuable resources for physicians who are beginning the process of EHR implementation. Many facilities and IPAs started the process of adopting EHR systems prior to the Stimulus Act. They may have funding and expertise that your practice can take advantage of during your implementation.

There are, however, serious considerations that physicians must understand before signing an agreement with one of these entities for the purposes of EHR implementation. This section will help you walk through some of those issues.

Reassignment of Incentives

Despite qualifying for incentives as individuals, physicians may choose to reassign their incentive payments to another entity.

When you enroll in the incentive program, you will indicate the taxpayer identification number (TIN) that will receive your incentive payments. If you wish to receive them yourself, you will enter either the TIN for your practice or, if you do not have one, your Social Security Number.

If, however, you wish to reassign your incentive to a hospital, a clinic, an IPA or another entity, you would enter that company's TIN as the one receiving your payments.



It is important for you to note that by federal rule, reassignment of EHR provider incentives must be at your discretion and should be captured in contractual language. If an eligible provider (EP) wishes to reassign his or her incentive payment to the employer or entity with which the EP has a contractual arrangement, the parties should review their existing contract(s) to determine whether the contract(s) currently provides for reassignment of the incentive payment or if the contract(s) needs to be revised. The specific contractual language will be similar to assignment language commonly included in contracts whereby a physician assigns or reassigns his or her rights to charge, bill or collect for any payments for medical services furnished. The parties should also document the basis for the assignment (e.g., the entity receiving assignment has provided the physician with the certified EHR at its sole cost and expense) for the purposes of fraud and abuse compliance.

A clinic, a hospital, or a medical group cannot make reassignment mandatory for physicians who practice there, regardless of employment or contracting status.

Physicians are only allowed to assign their incentive to one taxpayer identification number. You cannot divide your incentive payments among various practice locations. If you want your payments to go to multiple practices, that would require the entity receiving the payment to negotiate with the other entities.

Advantages of Reassignment

Reassigning the incentive means transferring both the payment and much of the responsibility for achieving meaningful use. If physicians reassign their incentive to a facility or IPA, the facility will then be responsible for ensuring that their providers achieve meaningful use. They will also be responsible for responding to compliance audits performed by the federal or state governments. In addition, reassignment allows providers to “pool” their resources to collectively implement a more robust system.

Considerations About Reassignment

There are several important issues you should consider before agreeing to reassign your incentive payment.

Federal EHR incentives are taxable income for both federal and state tax purposes. If you reassign your incentive, you may still be responsible for the tax liability on those payments. You should consult with a tax professional before signing a contract to reassign your incentive.

In addition, you may also want to consult with your attorney regarding anti-kickback (“Stark Law”) implications of reassigning your incentive. Incentive payments are treated by federal law the same as any other payments you receive under Medicare or Medi-Cal. If you assign them to an entity with which you have a contractual relationship or in which you hold an ownership interest, this could constitute a violation of federal statute.

Multiple Practice Locations

Many physicians practice at multiple sites, such as having a clinic-based practice and a private practice. Some of these physicians may have access to an EHR system at one of their practice locations, but not at another (i.e., they may use the clinic EHR system but not have one in their private practice).

Dr. Jones only has an EHR at the clinic

Dr. Jones is a physician who has 60 percent of his patient encounters at a community clinic and has 40 percent in his solo private practice. When seeing patients at the clinic Dr. Jones uses the EHR system provided, however, he has not implemented an EHR system into his private practice. In this case, Dr. Jones would be allowed to only count the patients seen in the clinic for the purposes of meaningful use.

The meaningful use rule has clarified that if a physician practices at multiple locations, and only one of them has an EHR, the physician may designate only that location to be considered for the purposes of determining meaningful use. The final rule further clarifies that meaningful use criteria and measures are applied to the patient encounters supported by an EHR. In other words, patient encounters at a practice where there is no EHR do not need to be counted in the meaningful use percentages. Further, meaningful use measures should be captured at the location where 50 percent or more of the patient encounters supported by an EHR occur.

Practice-Level Determination of Patient Volume

Clinics are allowed, under federal rules, to do a practice-level determination of patient volume. That is, if the clinic as a whole treats more than 30 percent Medi-Cal patients (or needy individuals for an FQHC/RHC), every physician practicing in that clinic qualifies as a Medi-Cal provider. Clinic corporations with multiple sites are allowed to aggregate their patients across all sites and do one patient volume calculation for all of their providers.

EHR Donations

A final consideration for working with an outside entity is EHR donations. In certain cases, hospitals have offered contracting physicians access to their EHR systems for free.

The Stimulus Act relaxed the federal fraud and abuse laws to permit hospitals, health systems and health insurers to contribute HIT to physician practices without violating the self-referral or kickback prohibitions. While, depending on the circumstances, this may make sense for some physician practices, physicians would be wise to consider these “gifts” carefully.

Up-front hardware and software costs are only a portion of the EHR implementation costs a physician practice assumes. An EHR system that does not have the functionality the practice needs, does not interface with the practice management system or lab system, costs too much to maintain, gives the donor too much access to or control of the physician’s data, or is too hard to get out of if circumstances dictate may not be in the practice’s best interest, even with a substantial subsidy of the up-front costs.

The American Medical Association has two publications to help physicians consider these issues: “Health information technology donations: what physicians should know,” a two-page primer, and a more detailed monograph entitled “Health information technology donations: A guide for physicians.” ■

Additional Resources

Health information technology donations: What physicians should know.

http://www.ama-assn.org/ama1/pub/upload/mm/362/hitdonate_physknow.pdf

Health information technology donations: A guide for physicians.

http://www.ama-assn.org/ama1/pub/upload/mm/472/hitdonate_physicians.pdf

Chapter 8

Regional Extension Centers

One more place that physicians can look for help is to the Regional Extension Centers (RECs). The RECs are federally funded nonprofit entities that provide technical assistance to physicians to assist with EHR implementation. The RECs cannot help physicians pay for the purchase of an EHR system (hardware or software). They do, however, provide services such as practice assessment, vendor recommendations based on the practice, high-level project management, group purchasing, general education, and workflow redesign.

The RECs receive federal funding for assisting Priority Primary Care Providers (PPCPs) (M.D., D.O., N.P., P.A., CNMW) certified in internal medicine, family practice, pediatrics, geriatrics, ob/gyn, and adolescent medicine focused on primary care in: individual and less than 10 group practices, community and rural health centers, public and critical access hospitals, and settings that serve the uninsured. All of the RECs in California, however, provide services to all other providers on a fee-for-service basis.

California is being served by three RECs: CalHIPSO (most of the state), HITEC-LA (Los Angeles County only), and COREC (Orange County only). CalHIPSO's actual services are provided by the 10 local extension centers (LECs), which serve geographical areas. Information on all of California's RECs/LECs is in Appendix 1. ■

Additional Resources

California Academy of Family Physicians' Guide to Working with RECs

<http://www.familydocs.org/pcmh/health-information-technology/physician-guide.php>

The RECs receive federal funding for assisting Priority Primary Care Providers (PPCPs) (M.D., D.O., N.P., P.A., CNMW) certified in internal medicine, family practice, pediatrics, geriatrics, ob/gyn, and adolescent medicine focused on primary care in: individual and less than 10 group practices, community and rural health centers, public and critical access hospitals, and settings that serve the uninsured. All of the RECs in California, however, provide services to all other providers on a fee-for-service basis.

Section 3

Selecting and Implementing an EHR in Your Practice

Once you understand the incentive programs and meaningful use, and you have made decisions about how you are going to work with hospitals, clinics, IPAs and the RECs, there are a few steps you should take before you begin choosing an EHR system.

Before you begin looking at available EHR systems, it is important that you first take some time to assess your practice and begin preparing your practice to make the transition.

This section will give you several steps to take early on to begin assessing your readiness to make the switch.



Chapter 9

Assessing Your Practice



Identify the EHR Champion in Your Practice

In every successful EHR implementation, there is an EHR “champion.” The champion is the person in the practice who acts as the project manager, overseeing the installation and workflow redesign and making sure that the implementation is proceeding as planned.

In smaller practices, the EHR champion may be the physician. In larger practices or clinics, it will often be the office manager or the chief information officer.

The purpose of the champion is to have someone in the practice that is accountable for keeping everyone on track.

Inventory Your Current Technology

Even if your practice does not currently have an EHR, it is very likely that you are using some kind of software to run your practice. This could include a scheduling program, a practice management system, revenue cycle management software, or any other software that is part of your practice.

It is likely that whatever EHR you select will need to interface with your current practice technology. It will be important that you work with the EHR vendor you eventually select to ensure that these interfaces are as seamless as possible.

Determine Your Practice's Technology Needs

As you get closer to purchasing an EHR, your decisions about system features will become much more specific—especially if seeking federal EHR incentives. Working through, in detail, exactly what the practice needs in its EHR system becomes more important. Ask yourself questions: Do you want to interface with your mobile device? Do you want simple tasks to be automated? Once you have determined your specific needs, make sure the vendor demonstrates that its product can meet your needs and in a manner that works for you.

It is important to see a demonstration of any EHR system's features necessary to the practice. The generic description

of a system's ability to, say, download to a PDA or scan files does not provide enough information for the practice to make an informed decision. Below are some examples of why this is important:

Example 1

A physician wants to download his schedule to his personal digital assistant (PDA), so he purchases a system that will sync with his PDA. When he runs the sync for the first time, his schedule for the next 30 days and the patient charts were downloaded to the PDA. However, he expected and wanted to see his schedule for the entire year, and he wanted the ability to download only selected charts, but the technology he selected does not offer these options.

Example 2

Document scanning might be particularly important to a physician because she has many patients who have records from other practices. But when a patient presents a 12-page chart for scanning, the system's scanner generated a single, 12-page image file instead of generating 12 one-page images. The EHR system she chose did support scanning, but not multipage scanning.

Perform a Complete Practice Readiness Assessment

The practice readiness assessment will help you take the next steps in the implementation process. It includes a series of questions that you and your staff should consider prior to beginning an EHR implementation. The assessment will serve as an inventory of all the important planning issues that should be properly addressed before you commit to your EHR implementation. You should take the time to perform this (or a similar) assessment prior to looking at EHR systems, to ensure more productive results. ■

In Appendix 4, there is a sample of a practice readiness assessment.

Chapter 10

Which EHR Is Right For Your Practice?

This chapter is based on information provided by the Texas Medical Association in their “EMR Implementation Guide.” The original can be downloaded at <http://www.texmed.org/HIT/>

Once you have assessed your office and considered your technology needs, it is now time to think about which EHR is right for your practice.

Before you look at specific EHR systems, it is good to know what type of system you are looking for and how you are going to access it. Start by asking yourself a few questions:

1

Are you happy with the software that you are using now (e-prescribing, practice management system, etc.)? Do you want to keep it, or would you rather buy an “all-in-one” system?

2

What kind of computer do you want to use—desktop, laptop, tablet, etc.?

3

Do you want to have all of your systems stored on site, or would you rather just log on through the Internet?

4

How many people in your practice will need to access the EHR?

The answers to these questions will influence your decision on which system to implement. The following sections will help you to answer them.

Best-Of-Breed vs. Fully Integrated Solutions

HIT solutions fall into one of two categories: best-of-breed or fully integrated. These are discussed in detail below.

Best-of-Breed Model

In a best-of-breed model, several products that each excel in a specific function are joined to work as one. A practice might choose one practice management product and combine it with a different product for EHRs, another

for document scanning/management, and yet another for electronic faxing. One aspect of best-of-breed solutions is linking the components of the legacy practice management system (billing software, for example) to the new HIT system.

One or more communication products can be added to this mix to transmit information among the different applications. For example, when a patient’s demographic information is entered into the practice management software, it automatically transfers the information to the EHR. Once the chart is complete, billable services the physician assigns at the point of care are automatically ported back into the practice management software for billing.



Pros of the Best-of-Breed Model

- Lower cost
- Option to mix preferred products from different vendors
- Option to continue using current software products



Cons of the Best-of-Breed Model

- A break in data linkages
- No single point of accountability
- Weaker integration with third party services or software
- Problems upgrading individual systems
- Interface costs may not represent actual costs

The main advantage of the best-of-breed approach has traditionally been cost. Depending on the exact combination of products, the cost of software and training (excluding hardware) is typically less than \$15,000, and often less than \$10,000 for each of the first five users in a practice.

On the other hand, this approach has its shortcomings:

1. **A break in data linkages.** The best-of-breed scenario involves multiple products built by different software developers in different languages that must communicate reliably with one another. The most common problem is that the transfer of data between programs stops. Typically, the solution is simple but disruptive. Everyone has to stop working, exit the system, restart the program or network service, and verify that data are flowing the way they should be.
2. **No single point of accountability.** Merging many software products implies many points of accountability. When one part of the system stops working, it can be difficult to determine which program is faulty and who the appropriate person is to call. The practice management vendor tells you to call your EHR vendor; the EHR vendor tells you to call your communications vendor; the communications vendor tells you to call your practice management vendor. Even if you purchased all the

products through a single reseller, getting to the root of a problem can be challenging.

3. **Weaker integration with third-party services or software.** Products in the best-of-breed model tend to lag behind the fully integrated products in terms of their ability to assimilate with productivity-enhancing services such as online insurance eligibility, lab interfaces and PDAs for hospital charge capture. Generating complex reports can also be a problem because the practice management and clinical data are separate, and data has to be captured from several sources and manually integrated into one report.
4. **Problems upgrading best-of-breed systems.** As the multiple products within a best-of-breed system need upgrading, the upgrading process can introduce incompatibilities among the different versions of each product.
5. **Interface costs are not representative of actual costs.** Interfaces are multi-sided and EHR vendors can only quote for their side. For example, a best-of-breed EHR interfaced to best-of-breed practice management system would require four interfaces: patient demographics and scheduling information out of the practice management system (interface #1) and into the EHR system (interface #2); ICD9s and CPT4s out of the EHR (interface #3) and

into the practice management system (interface #4). Interfaces require quotes, scheduling, testing and commitment from all best-of-breed vendors.

Fully Integrated Model

Generally, fully integrated products are built from the ground up on a single platform and are designed to include billing, scheduling, EHRs, document imaging, document management, electronic prescribing, and electronic faxing in a self-contained system.

Fully integrated systems tend to be more reliable. Because these systems are developed on a single platform, data flows between software functionalities seamlessly. One developer means a single point of accountability for software issues. Reporting on practice management and clinical data is easily accomplished. Finally, fully integrated products tend to integrate effortlessly with labs, PDAs and other productivity-enhancing services.



Pros of Fully Integrated Model

- Better reliability
- Seamless data flow
- Single point of accountability
- Better integration with external facilities and devices



Cons of Fully Integrated Model

- Higher cost
- Misrepresentation of integrated modules as single integrated product
- Lapses in integration

There are downsides to fully integrated systems as well:

1. **Higher cost.** Software and training for some fully integrated products can be more expensive than for best-of-breed solutions.
2. **Single vendor misrepresented as an integrated solution.** Although physicians may purchase an EHR solution from a single vendor, vendors historically have purchased best-of-breed systems from smaller vendors and interfaced practice management systems to the EHR system, often using separate databases. A physician should always question the vendor as to who initially wrote the applications, not who owns them, and clarify if there is a single database for the entire integrated solution.
3. **Lapses in integration.** Many times, fully integrated products are portrayed as being more fully integrated than they actually are. The classic example is faxing. Many products use simple faxing software to fax prescriptions from the practice to the pharmacy. In some cases, however, this does not include the ability to easily receive and share all faxes electronically, which is how the functionality is portrayed.

In summary, costs of fully integrated systems have dropped significantly in recent years, making it difficult to justify best-of-breed solutions on a cost basis alone. A fully integrated system can be more expensive initially, but offers a large productivity advantage due to its lack of redundant data entry, interface synchronization upgrade requirements, single-platform nature and ability to integrate with outside services and technology.

The advantage for some practices in using a best-of-breed approach is that it may allow you to work with software that your practice is already using and could present immediate cost savings as you will not be replacing existing software. For example, if you are happy with the practice management system that you are currently using, you may wish to select an EHR that can work with that system, even if it is made by a different company. This will also save you from having to move data to the practice management system that is incorporated into the EHR system, but you will be required to transfer the patient demographics and scheduling into your new EHR from your legacy Practice Management System.

That Old Practice Management System

Practice management systems and EHR systems share patient demographic data. Linking a legacy practice management system to a new HIT system requires the development of multiple custom interfaces. The vendor who provided the practice management system will very likely know or be able to find out whether a custom interface has been developed and you will need to obtain the costs of this interface and coordinate the scheduling of work with your practice management vendor as you migrate to your EHR.

However, custom interfaces are notoriously finicky, and a practice using one to link two data systems essential to its daily operations assumes two risks:

- 1) When either the practice management software or the HIT software is updated, the update may disrupt the functioning of the interface.
- 2) If a disruption does occur, it may be unclear who is responsible for fixing it, because the HIT vendor is unlikely to provide support for the interface. The provider of the interface may not be willing or able to correct a problem due to the updating of the HIT software. This is a situation no practice wants to have to resolve, because it disrupts the efficient operation of the practice.

You should consider the initial and ongoing direct and indirect costs when assessing whether to keep your practice management system.

Input Devices

Along with deciding what type of EHR you want to purchase, you will also want to consider what type of device you will use to access your system. There are five main types of input devices to choose from:

1. Desktop Computer
2. Workstation on Wheels
3. Laptop Computer
4. Tablet Computer
5. Smart Phone

Many practices will use more than one of these devices, such as having a desktop computer for use in the office, and laptops or smart phones for remote access.

The right input device for your practice is entirely dependent upon your wants and needs. In general, desktop computers are the most secure devices and usually do not rely on wireless technology. Portable devices, such as tablets and smart phones, are easier to take with you inside or outside the office, but they are more easily lost or stolen.

The following chart, which was developed by the Intel Corporation, will help you walk through some of the considerations when choosing an input device.

	In the Clinic			Outside the Clinic	
	Stationary	Mobile	Mobile	Ultra-Mobile	Ultra-Mobile
	Desktop	Workstation on Wheels (WOW)	Laptop	Tablet / Mobile Clinical Assistant	Smart Phone
Portability	- None	- Rolls easily	- Easy “walk-and-dock”	- Easy to carry	- Easiest to carry
Input / Output Support	- Easy access to many output devices	- Keyboard support - Easy access to many output devices	- Keyboard support - Easy access to many output devices	- Touch and stylus support	- Limited input capabilities by device - Limited access to output devices
Delay in Capturing Information	- Yes	- No	- No	- No	- No
Pros	- Handles large volume of data and graphical data review - High security	- Easy to attach keyboard and other peripheral devices	- Extended battery life - Easy to carry - Versatile - Extended battery life	- Extended battery life - Easy cleaning for better cross-contamination control	- Best review snapshot - Ultra-mobile
Cons	- Difficult to share among users	- Largest mobile device	- Needs to be physically secured	- Needs to be physically secured	- Limited screen size - Limited keyboard - Limited application support - Needs to be physically secured

Accessing the Software: Client Server vs. Application Service Provider Models

Physicians can access HIT software through two different models: client-server and application service provider (ASP).

Client-Server Model

In the client-server model, EHR software is installed on a server located in the physician's office and is accessed through the practice's input devices.

Let's take a look at some of the pros and cons of the client-server model.

Pros: Client-Server Model

Your EHR is in your office. Therefore, the EHR can still function even if the Internet connection goes down.

Data security. In this model you will house all of your data onsite. Therefore, you will still have control over it if you have a contract dispute with your vendor, or if your vendor goes out of business.

Cons: Client-Server Model

The necessity of having a server on site.

Depending on whether you already have a server, this could require you to invest additional money into purchasing a server and paying someone to connect it to the computers in your office, as well as the annual costs associated with maintenance of the server and operating system.

Physical security. Servers also need to be physically secured in a locked room that is kept at a moderate temperature. This could cause you to have to rearrange your office to accommodate the server.

Backing up your data. The server in your office will have all of your practice data on it. If it should fail for any reason, you will need to have backup to keep your practice functional.

Application Service Provider (ASP) Model

Alternatively, in the ASP model, the software is on a server at a remote location and accessed most commonly via the Internet. The advantages of the ASP model are lower initial costs, the reduced need for ongoing network monitoring and support, and less responsibility for data backup and security. The medical practice pays a monthly per-physician fee for access to the software, the storage of the practice's medical records on the software company's server, and the costs of the high-speed Internet connection. It is imperative that the practice has reliable high-speed internet service (such as DSL, cable, or T1). If you choose an ASP model system you should consider having a backup Internet connection available on site.

ASP solutions are highly attractive to small offices with fewer than 10 users. HIT software can provide the following transactions using an ASP:

1. EHRs, including voice recognition and transcription;
2. If the practice is also purchasing the practice management solution from the same ASP vendor.
 - Patient scheduling and registration
 - Claims submission, eligibility inquiries, referrals, and, depending on the health plan, prior authorizations.
 - Clinical/financial reporting and collections management

Pros: ASP Model

Up-front cost savings. Practices generally pay \$100 to \$500 per physician per month, as long as they are using the vendor's server, for ASP-based software vs. a multi-thousand-dollar per physician initial investment plus annual maintenance costs as in the client-server model. Practices with ASPs will still incur costs to set up a wired network in their office, which is required for this model.

Easy upgrades. An ASP can install software improvements at its central server overnight, and the office can take advantage of them the next day.

Less responsibility for data backup and security.

Staff or contract savings. Most ASPs manage all of the software maintenance so that the practice will have less need to hire any IT staff or outside contractors other than those required to maintain the infrastructure, firewall, and coordination with your ISP (internet service provider) carrier.

Practice relocation. Since you will access an ASP-model EHR through the Internet, you will not have to move a server if you move to a new office, only the firewall and ISP connection.

Cons: ASP Model

Complete dependency on Internet access.

Without Internet access, the practice cannot function. It is best to pay more for T1-type technologies that provide very reliable Internet connectivity at high speeds and it is highly recommended you have redundancy in your ISP connection.

Be careful of contractual or payment disputes with the ASP provider since the data resides outside your office.

There is potential for the provider to lock the system and prevent access. These issues should be specifically addressed in your contract.

Limited capability to customize the EHR system as the EHR vendor's cost savings are realized through product standardization, which minimizes their support costs.

Market Penetration Considerations

Purchasing a system or products whose developer is committed to your home state and/or has a large local client base increases the likelihood of responsive customer service whenever a problem arises. With rapid industry consolidation and increasingly difficult certification standards, physicians should be concerned that the software developer may go out of business or be acquired. This is generally more likely with small, less capitalized developers with specialty-specific products, although industry consolidation often also occurs with midsize established vendors. Larger vendors commonly purchase the midsize established EHRs to incorporate the new product into their product line. Often this type of consolidation is done to capture the recurring revenue stream (EHR annual maintenance fees). Physicians should discuss with their potential EHR vendors the company's future business plans prior to contract signing.

Another likely scenario is that developers who are less successful in penetrating the local market will concentrate on other areas of the country where they have an existing customer base. While customers in your market will still be able to get support from providers out of state, the incentives for those providers to offer excellent service are reduced, and the community of users—which also is a

great resource for product support — will diminish steadily. Also, prior to contract signing, clarify hours of support in your time zone. Support of 8 a.m. to 5 p.m. EST translates to 5 a.m. to 2 p.m. PST. Often key individuals in your group with clinical duties cannot “drop everything” and call about a problem prior to 2 p.m.

Practice Size

Some HIT systems are designed for small practices with no more than two physicians, and others are designed for practices with 100 or more physicians in multiple specialties at multiple sites. The key concept is scalability (i.e., the ability of the software to accommodate the number of users who can work on the system simultaneously without it crashing or running at an unacceptably slow speed). Now is the time to think about whether your practice will be expanding during the next three years. Are there plans to add physicians, nurse practitioners, or physician assistants? Are there plans to add a satellite office? While there is no need to purchase the capacity necessary for future expansions in the initial system acquisition, it is necessary to determine whether the system your practice purchases can accommodate an expansion and what the estimated costs would be if you add users. ■

Chapter 11

Help With Making Your Selection



After you have assessed your practice and your current technology and considered your options regarding the type of EHR system you need, you will likely find that there are still many options for you to consider. This section will give you tips on places you can look for help in further narrowing your selection.

Federal EHR Certification

In order to qualify for federal EHR provider incentives, physicians will have to demonstrate meaningful use of a “certified” EHR system. The federal Office of the National Coordinator for Health Information Technology (ONCHIT) will be the lead agency certifying products that will enable physicians to achieve meaningful use.

The ONCHIT has actually established two certification programs. The initial temporary program runs from the fall of

A complete list of federally certified EHR systems is available at <http://onc-chpl.force.com/ehrcert>

2010 until the end of 2011. The certifications performed in this temporary process will only last until the end of 2011.

Beginning in 2012, a permanent testing and certification process will begin. All products that were previously certified will continue to be certified. However, products certified under the temporary program may not include all of the capabilities needed for later stages of meaningful use.

In general, physicians should not select an EHR system that is not federally certified. Doing so would prevent you from accessing federal provider incentives and may not prevent Medicare payment reductions.

This list is updated daily by the three federally designated organizations that certify EHRs, so if the vendor is not listed today, ask when it will be certified and verify the certification. Also check to see if the entire EHR application is certified, not just a module such as Electronic Pharmacy within the EHR.

Medical Societies and Specialty Societies

Another source where you can look for help in narrowing your choices is the lists of vendors approved by the state medical and specialty societies.

Here in California, the California Medical Association (CMA) has reviewed and vetted EHR systems from multiple vendors in an effort to assist physicians in locating the most functional and cost-efficient options. A list of vendor

solutions can be found on the CMA HITLIST website, which is part of the CMA HIT Resource Center website.

Your county medical societies and specialty societies may also be able to get help finding consultants or others who can assist you with your implementation.

Regional Extension Centers

The regional extension centers (RECs) are federally funded to help physicians assess their practice and assist in the selection of an appropriate EHR system for their practice, as well as assisting with high-level EHR project management. They are also required to develop group purchasing programs, wherein they negotiate the best price for physicians on a limited number of products.

It's also important to note that the RECs' sole focus is helping you to achieve meaningful use. They will therefore be developing pre-configured systems that include data templates necessary for incentive program reporting.

Whether or not you are ultimately planning to work with a REC, you may want to consider their approved products. In fact, many physicians may find that the group purchasing discounts and pre-configured systems are the most powerful reason to work with a REC.

Hospitals, Clinics, and IPAs

A final consideration in narrowing your list of EHR products is whom your practice contracts with or refers patients to, and what those contacts are currently using. For example, if you refer patients to a certain hospital that is using NextGen, it may be beneficial for you to use NextGen as well.

That way, you will be able to more easily transfer patient information to the hospital without worrying about whether your system will interface.

In addition, many hospitals, clinics and IPAs currently have EHR adoption programs, wherein they are assisting their contracted physicians with implementation of an EHR system. Much like the RECs, these programs may offer physicians pre-configured systems at deep discounts. ■

California is being served by three RECs: CalHIPSO (most of the state), HITEC-LA (Los Angeles County only), and COREC (Orange County only). CalHIPSO's actual services are provided by the 10 local extension centers (LECs), which serve specific geographical areas. Information on all of California's RECs/LECs is in Appendix 1.

Chapter 12

Budgeting For Your EHR System

This chapter is based on information provided by the Texas Medical Association in their “EMR Implementation Guide.” The original can be downloaded at <http://www.texmed.org/HIT/>

Once you have narrowed your options for EHR vendors, there is one more thing to do before you begin talking to vendors: develop a budget for your EHR implementation. This section will walk you through some things to consider as you develop your practice's EHR implementation budget.

Return-On-Investment

Physician practices, when constructing an EHR budget, may find it helpful to use a return-on-investment (ROI) model. An ROI model can help you to consider all the added costs besides the software (staff training, temporary loss of productivity, interfaces, etc.) and offset that with expected benefits (increased efficiencies, federal incentive payments, practice quality improvement, etc.).

There are ready-made ROI tools available to help walk you through the process of calculating your expected ROI.

Getting the Most Return on Your Investment

In small and medium-size practices, calculating a precise return on investment is difficult because indirect costs are difficult to track and allocate to particular projects. The widely quoted rule of thumb is that practices recover their acquisition costs in approximately 18 to 24 months. The cost recovery and subsequent improvement in practice profitability result from a series of process improvements that EHR capabilities facilitate.

Correlations between Product Cost and Satisfaction

Neither paying the most for a system full of bells and whistles nor skimping with a bare bones system will ensure you a high degree of satisfaction with your EHR purchase. The most important factor in success and satisfaction is not simply price, but matching the product's capabilities with your practice's needs. Successful implementation will require team commitment and effective project management.

Additional Resources

CMA's Best Practices: Statewide and Regional Webinars

http://www.ehrbestpractice.com/register/regWebinar_CMA.php

CMA's Best Practices: Successful Preparation and Implementation of an EHR System

<http://www.cmanet.org/files/pdf/ehr/best-practices-7.pdf>

System Pricing Methods

Although the cost of an EHR is generally stated as cost per physician, practices in the market for a new system will find that EHRs are not actually priced that way. When a practice acquires HIT software, it is actually acquiring licenses to use that software.

The most common metric for pricing is the number of licensed professionals in the practice whose services can be billed. Those professionals include not only physicians, but also, for example, advanced practice nurses, physician assistants and physical therapists who are employed by the practice.

Be aware that some expected costs are merely estimates. Implementation costs have been reported to be 5, 10, and sometimes 50 percent over vendor estimates. Include some cushion room in your budget. Be sure to check the vendor's history in working with other practices before accepting the proposal. HIT is a highly competitive industry, and in some cases, vendors may attempt to close sales by using estimates that are unrealistically low.

The elimination of paper records may lead to numerous efficiencies, such as:

- The time spent pulling paper records for every patient visit, telephone call, or request for a prescription renewal is virtually eliminated.
- There are no more lost records.
- Medical record supply costs also are eliminated. The office space used to store medical records can be eliminated or put to profitable use.
- The number of nonclinical employees can be reduced, or alternatively, each staff person's responsibilities can be shifted to support a practice's ability to handle an increased patient load. For example, an EHR would enable faster delivery of lab results into a patient's chart.
- The ability to run a profitable satellite office is greatly increased through the availability of EHRs over a practice's network, which eliminates the need for faxing records back and forth.
- A combination of template-based documentation and expert coding advice increases the use of higher-level codes because physicians and coders are more confident of their ability to demonstrate the appropriateness of their code selections.

There are several pertinent questions to ask when researching EHR system costs. These include:

- Will your practice require interfaces with e-prescribing, a practice management system, lab, or radiology? If so, what are the interface costs from the legacy systems? Who is ultimately responsible for the success of these interfaces? Be aware that there is frequent finger pointing when these interfaces fail.
- What are the ongoing price considerations like annual fees, upgrades or technical support?
- Are there charges for additional features like reporting tools, voice recognition, scanning software or a Web-based patient portal?
- What are the costs associated with having current records converted into the new system?
- What are the hardware needs?
- What are the costs for cabling or building infrastructure?
- What are the ongoing costs for bandwidth to your carrier?

Costs Associated With Implementation

In addition to the cost of software, hardware and services provided by the vendor, the acquisition of HIT generates other costs for which your practice should budget.

The cost of the EHR champion's time.

Inevitably, the EHR champion's commitment to the project reduces the amount of time spent on daily office responsibilities and this has a negative impact on practice productivity that can be larger or smaller depending on the practice's compensation arrangements.

The cost of closing the practice for installation and training.

Practices will close for about a week while installing the system and training staff; in a fee-for-service practice these activities will reduce revenue but not expenses.

The cost of ramping up the practice after installation.

Immediately after the installation, practices will frequently begin operation at a reduced pace for a limited time, generally two to three months, as the practice works to integrate the new technology and the new workflows. This process will commonly reduce the number of patients seen by about 25 percent.

Considering the Federal Incentives

In determining your ROI, you should include incentive payments that you expect to receive from the federal government. For most physicians, the incentive payments will not completely cover the cost of purchasing and implementing an EHR. They should, however, be part of your expected return.

For physicians who expect to receive incentive payments through the Medicare program, remember that your total incentive will be affected by how soon you achieve meaningful use. See the chart on page 14 for reference. Also, physicians in the Medicare incentive program will need to consider that starting in 2015, there will be payment reductions for physicians who have not achieved meaningful use. Not losing those payments should be considered as part of your ROI. ■

Things to consider for Medicare:

- Delaying meaningful use can affect your total incentives
- Payment reductions begin in 2015

Chapter 13

Approaching EHR Vendors

This chapter is based on information provided by the Texas Medical Association in their “EMR Implementation Guide.” The original can be downloaded at <http://www.texmed.org/HIT/>

Once you have finished assessing your practice and preparing your budget, it is time to begin approaching EHR vendors.

The vast majority of EHR vendors in the marketplace right now have multiple products available that are made to service different types and sizes of practice. If the vendor knows some of the specifics of your practice—number of physicians, specialty, etc.—ahead of time, it can tailor its product demonstrations to your needs.

One approach that many physicians use is to construct a formal request for proposal (RFP) and distribute it to vendors.

Should You Use A Request For Proposal (RFP)?

One approach for getting the maximum value out of the vendor meetings is by submitting a formal request for proposal (RFP). An RFP is a carefully structured, detailed outline that includes all of the decisions your practice has made so far about its HIT needs plus information about your practice—number of physicians, specialty, location or locations, current IT hardware and software, and so on.

Benefits of an RFP

An RFP enables vendors to focus on the issues that you have identified as important and tailor their offering to your practice's needs. Because all vendor presentations will be built on the same specifications, you can compare them fairly. As an added benefit, after a proposal has been accepted, the RFP can serve as the basis for building a project timeline and minimizing misunderstandings between the vendor and the practice regarding costs.

Additionally, an RFP is a document that provides a consolidated overview of all the decisions the practice has made throughout the planning process. Particularly in a practice with more than three partners, the RFP closes any gaps in communication that may have occurred during a long planning process. Circulating the RFP to staff also is an

Additional Resources

CMA Sample RFP

<http://www.cmanet.org/resource-library/detail/?item=sample-ehr-rfp>

important opportunity for additional input. In the process of change management, the RFP is a major keystone for both physician and staff buy-in.

Determine the Necessity of an RFP

If the vendors invited to make presentations have performed several installations in practices similar to yours in size and specialty, and if the consensus within the practice is strong, the detailed RFP process may not be necessary. However, if you need the structure and clarification that an RFP provides, a vendor presentation tailored to your practice's self-defined needs is well worth the time and energy. If you are working with a consultant, he or she can help you prepare your RFPs.

Why use an RFP?

1. **It saves time.** An RFP will save you and your staff from having to inform every vendor about the specifics of your practice. You write it down once and send it to every vendor.
2. **It makes in-office demonstrations more meaningful.** If a vendor has an RFP from you before your in-office demonstration, it can show you products and features that fit your practice's needs.
3. **It helps to focus your thinking.** You may find that the process of creating an RFP helps you and your staff to think through your EHR needs. In that sense, it can be a helpful exercise. ■

Chapter 14

Product Demonstrations

Once you have received responses to your RFPs, it is important that you schedule product demonstrations. Ideally, a demonstration will take place in your office; however, many vendors are now offering web-based demonstrations that may be more convenient for your schedule.

Involvement of Your Whole Staff in the Demonstration

Ultimately, everyone in your practice will interact with the EHR at some point—physicians, mid-level practitioners and administrative staff. Everyone will need to be involved in the EHR implementation. Therefore, it is always beneficial to receive input from everyone in the office up front.

In some larger practices, this may mean scheduling several demonstrations, so that different staff members can view the product at different times and the demonstration can focus on different areas of your practice. For example, a medical assistant charting vitals or entering the chief complaint would have a different focus than a physician documenting an encounter.

Use Real Scenarios from Your Practice

The right EHR system is the one that works for your practice. In an EHR demonstration, you need to see how the system will work for a practice that is your size, specialty, and patient mix.

One way to do this is to prepare typical patient scenarios for your practice and test data based on real patients you treat. During the presentation, ask the vendor to demonstrate how its system works with your test scenarios and test patients. Finally, it is highly recommended that you ask the demonstrator to input your “test scenario” without explaining what he is doing step by step. Your objective is to see, on the vendor’s software, how long it will take you

Additional Resources

CMA Standard EHR Evaluation Form

<http://www.cmanet.org/resource-library/detail/?item=ehr-demonstration-form>



to input the clinical data. The test workflow must be timed and documented so you can compare the timed workflow on competitive EHR software. For example, a test scenario might be that a patient arrives with four chronic conditions, which, you document; a new problem; review of existing prescriptions; modification of existing prescriptions; and

then finally, after everything is done and the patient is on the way out the door, an “Oh by the way” scenario. If the vendor is allowed to explain what he is doing during this timed scenario you will not have a true understanding of how the software will impact your patient flow.

Evaluating EHR Products

You will probably see product demonstrations of at least three to five EHR products. It is important that after you have seen them all, you have detailed notes that remind you what you liked and didn't like about each one. You also want to make sure that you can make an “apples to apples” comparison of what will be very different products. One way to do this is to develop a standard set of criteria on which you want to evaluate EHR systems, and then ask everyone who will be attending the demonstration to grade the products based on that criteria.

The California Medical Association has developed a standard evaluation form that you can use. You may, however, want to tailor this form for the specific needs of your practice. For example, radiologists or ophthalmologists may need an EHR system with very specific imaging capabilities. Those physicians would probably want to give more weight to those specific functions.

The Importance of Meaningful Use

If you are planning to access the federal EHR provider incentives, it is essential that you know how your EHR will enable you to achieve meaningful use. If the product you are researching has been federally certified, then it has been tested to guarantee that it includes the functionality to demonstrate meaningful use.

It is up to you, however, to ask the vendor to demonstrate exactly how the system will do that. Where are the reporting templates that will be used to extract the data from your EHR and report it? Will you have to pay extra for templates and interfaces required for meaningful use?

Make sure that you and your staff know exactly how you will get to meaningful use using this system in your practice. For more information, see Chapter 17: Achieving Meaningful Use. ■

Chapter 15

Contracting Tips

After taking the time to research vendors and set up demonstrations, you will want to ensure that the selected vendor delivers its promised services. For this reason, a written contract that clearly meets the practice's needs, goals and security expectations is crucial.

Determinants of Contract Details

The specificity of vendor contracts varies, in part, with respect to the size and technical capabilities of a practice. For example, many larger practices and clinics hire IT personnel to oversee the security of data and create individualized software interfaces unique to their practice. In these situations, it may be necessary to ensure that the EHR system will interact with these existing interfaces.

On the other hand, a smaller practice may completely rely on the contracted vendor for all of its security, software, and integrity needs. In such a case, the vendor's capabilities become particularly relevant, and the practice will want to ensure that the vendor's program not only meets its specific needs, but also facilitates compliance with federal and state law.

In developing a contract, payment terms are critical and must be negotiated. Remember, you are the customer. In most cases "canned" contracts are written to the advantage



of the vendor. Optimal payment terms should include a small percentage at signing, a small percentage at delivery of the system, a percentage at completion of successful training, a percentage at go-live and the greater majority to be paid based on your "system acceptance." The practice's "system acceptance" definition must be included in the payment terms and thoughtful consideration must be given to this prior to contract signing. ■

A complete checklist of items you should ask about and look for when negotiating a contract with a vendor is included in Appendix 5.

Section 4

After Implementation

There is probably no issue that more concerns you or your patients than the privacy and security of very sensitive information, and how you will continue to protect it in the transition to EHR. As a physician, you probably have two related concerns: you want to protect yourself and your patients, and you want to make sure that you are complying with federal and state laws so you are not exposed to civil penalties.



Chapter 16

Privacy and Security - HIPAA

HIPAA Compliance

The main federal law governing the privacy and security of patient information is the Health Insurance Portability and Accountability Act (HIPAA). While HIPAA has been in law since the 1990s, the Stimulus Act added to it in some very important ways.

Right now, you have business associate agreements (commonly referred to as BAAs) with anyone who handles your patient data – billing consultants, health plans, etc. Under new federal law, these business associates will now be subject to the same requirements for handling patient information that you are. This means that they will have to have written security policies, train their staffs on handling personal health information (PHI), and develop sanction policies for violations.

Possibly of more interest to physicians, you will now be required to notify anyone whose patient information was potentially compromised, known as a “breach notification.” You will be required to provide a breach notification to patients within 60 days of the date of the discovery of the breach.

State attorneys general will now be allowed to enforce HIPAA, so this should provide for more stringent enforcement.

Steps to Take

In order to protect yourself and your patients, there are certain steps you should take immediately:

1. **Perform a security risk assessment of your practice.** Performing a security risk assessment is a requirement of meaningful use, but it is also just a good idea. Look at issues such as who has access to your EHR, where servers and workstations are located, and where there are weak points in your office’s physical security.

Additional Resources

HIPAA Compliance Kit

<http://www.cmanet.org/resource-library/detail/?item=hipaa-compliance-toolkit-cdrom>

CMA “On-Call” #1600 – “HIPAA Overview”

<http://www.cmanet.org/resource-library/detail.dT?item=hipaa-overview>

CMA “On-Call” #1607 – “HIPAA Security Rule”

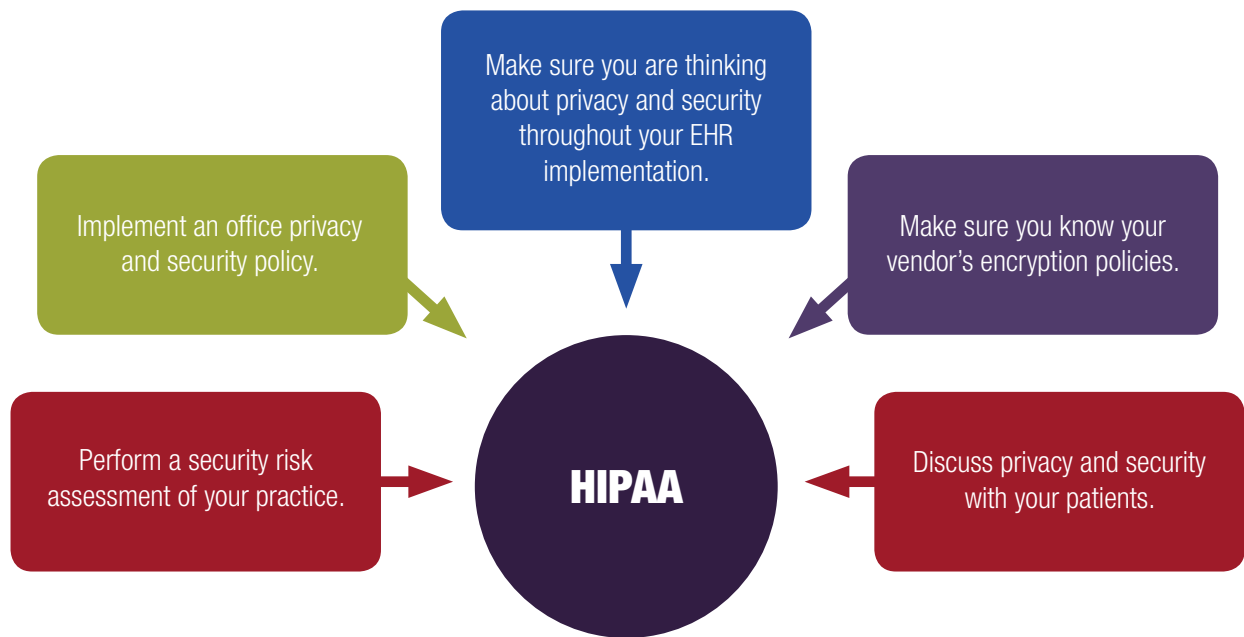
<http://www.cmanet.org/resource-library/detail.dT?item=hipaa-security-rule>

2. **Implement an office privacy and security policy.** This is very important! Even before the Stimulus Act, physicians were required, under HIPAA, to have an office privacy policy. Hopefully your practice already does. Even so, you will need to rethink what else should be in your policy to reflect the new structure of your practice. You need to have very strict and very clear rules about taking laptops out of the office, accessing the system from home, the use of cell phones, and other issues that are raised by the digital nature of your system.
3. **Make sure you are thinking about privacy and security throughout your EHR implementation.** Privacy and security can govern many of your decisions during implementation. For example, you may choose to go with an ASP-model EHR, since it means that your servers will be off-site, and thus less likely to be compromised

if someone breaks into your office. Do not leave devices powered up in patient areas where security could be compromised. Even if your data is hosted off site, do not leave devices powered up when you close the office. If you do have a server on site, you will want to make sure it is set up away from the public in a locked room.

- 4. **Make sure you know your vendor's encryption policies.** Your EHR vendor will have procedures and policies in place to encrypt your data when it is stored or exchanged. It is important for you to understand that process.
- 5. **Discuss privacy and security with your patients.** Many of your patients may be uncomfortable about the idea of their information being stored in a computer, much less exchanged over the Internet. Therefore, it is important that you as the physician help your patients to understand why you are moving to EHR, and the steps you are taking to protect their information. ■

Steps to Take



Chapter 17

Achieving Meaningful Use

Even if you are still in the process of implementing your EHR system, you can begin the process of determining how you will achieve meaningful use. In fact, it may be easier to build toward meaningful use if you start planning before you implement your EHR system, so you can plan your implementation around it.

How Close Are You Right Now?

The main thrust of meaningful use is collecting and reporting on clinical data. Although meaningful use may seem quite daunting, you will likely find that much of the data needed for reporting you already collect in some form. You may just not be currently sorting it into a reportable format.

A good place to start would be to catalog, of the needed data, what you are already collecting. For any data you are not currently collecting or steps you are not taking; begin planning for how you are going to work it into your practice workflow.

For example, many specialists do not regularly record a patient's height, weight, or other vital signs. If you are a specialist are you going to start collecting that data? Can you work with primary care physicians to send that information along with patient referrals?

Deciding On “Menu Set” Items

After you have cataloged your current capabilities, it is time to begin tailoring your meaningful use reporting to your practice.

Meaningful use allows physicians some flexibility in their reporting. Although all physicians will report on the 15 Core Objectives and Measures, they will be allowed to select the other five reporting objectives from a menu set of 10 measures.

Additional Resources

CMA Summary of the Final Federal Rule

<http://www.cmanet.org/files/pdf/meaningful-use-summary-071310.pdf>

CMA Physicians Guidebook for Meaningful Use

<http://www.cmanet.org/resource-library/detail.dT?item=physician-guidebook-for-meaningful-use>

You and your practice will want to take a look at the menu set items and select which of the five are most applicable to you. You will want to consider what objectives you already comply with, such as if you already electronically report to a local immunization registry, to ease the transition. You may also want to consider what measures are more applicable to your practice and/or specialty.

Selecting Your Clinical Quality Measures

Another decision that practices will have to make is which clinical quality measures to select. All physicians will have to report on three core clinical quality measures, or three “alternate core” measures.

After those three, however, physicians will be required to report on three additional measures from a list of 38. This will give physicians the opportunity to select measures that are most applicable to their specialty. For example, a gynecologist could choose to report on the percentage of women ages 21 to 64 who received cervical cancer screening.

In clinic or medical group settings, different physicians may select different clinical quality measures, depending on their patient mix or specialty. In that case, you will need to ensure that your EHR system is built to collect relevant data for the entire list of clinical quality measures.

Working With the Whole Practice On Data Collection

Achieving meaningful use will require your entire practice to collect the proper data. So it is important to ensure that your entire practice understands what needs to be done.

For example, basic patient information (demographics, height and weight) is usually not collected by a physician. It is taken either on a patient questionnaire or collected by the office staff. It will be important that the office staff understand that this data needs to be entered into the EHR as structured data so that it can be reported.

Always Keep an Eye on the Future

One final thing to remember: meaningful use is going to change. What is available as of right now is considered “Stage 1” of meaningful use. There will be at least a Stage 2 and maybe more stages in the future.

You may be tempted to achieve the letter of Stage 1 and then stop there. While this may be fine for 2011 and 2012, it could leave you scrambling to update your practice in 2013.

Instead, you should think of meaningful use as the first step in a more continual process. As soon as your practice achieves Stage 1, begin thinking about building toward Stage 2. The future of meaningful use will require your EHR to be connected to a health information exchange, and to report to public health agencies and immunization registries. Therefore, you may want to start researching what capacity already exists in your community for all of the above. ■

Chapter 18

Health Information Exchanges

The true promise of EHRs lies in their ability to improve coordination of care among providers. They cannot, however, accomplish this on their own. To truly improve coordination of care, EHR systems have to be connected through a health information exchange (HIE).

What Is A Health Information Exchange (HIE)?

A health information exchange is a secure Internet portal that allows health care providers to send patient information from one treatment site to another. The most important element of an HIE is its ability to protect the data being exchanged. Sensitive patient health information should never be sent over a commercial Internet or e-mail service, since there is too great a chance that it would be compromised.

There are several forms of HIE on the market right now. Many medical groups, IPAs and hospitals set up small, proprietary HIEs. These private HIEs are only accessible by providers who are employed by or who contract with the entity. They generally only include information about patients to the extent that it was provided in that hospital, group, or IPA. For example, integrated systems like Kaiser Permanente or Sutter have internal exchanges that allow data to move within their systems, but have limited ability to move data outside of their networks.

There are also larger, public HIEs that are operated by nonprofit entities. These HIEs are usually accessible to any provider in a given geographic region. Their funding comes from a variety of sources, including subscription models or user fees.

You should check in your local community for HIEs that are currently being formed. For example, in Southern California in the Inland Empire, 52 healthcare organizations, including hospitals, Medical Groups, MSOs, IPAs and affiliated

Public Health Information Exchanges in California

HIE	Geographic Region
Eastern Kern Intergrated Technology	Kern County
OCPRIO	Orange County
Redwood MedNet	Mendocino and Lake counties
Santa Cruz Health Improvement Partnership	Santa Cruz

(Since many projects are in the planning stages, this list may not be comprehensive)

medical organizations, are currently working together on the formation of an HIE.

Cal eConnect

Concurrent with the EHR incentive programs, the federal government is also using stimulus funding to promote the development of HIEs across the country. The HIE funding goes to the states or to nonprofit entities designated by the states to support HIE.

The State of California has designated Cal eConnect, a 501(c) (3) formed for the sole purpose of developing HIEs, as the entity to coordinate this effort. Cal eConnect is governed by a stakeholder board, which includes representatives from various stakeholder groups.

Cal eConnect has received over \$38 million in federal funding to coordinate the efforts to develop HIE in California. This funding will be used to support HIEs where they currently exist and to build capacity in areas where HIEs are not currently functioning.

Why Would You Work With an HIE?

Your patients very likely receive care in many places beyond your office. Even if they come to your practice for all of their medical treatments, they may still have home health support, a behavioral or substance abuse provider, an acute care stay, or others involved in their total health.

In order for you to be able to provide the best treatment to your patients, you need to know the whole picture of their health care. That is the promise of an HIE.

Once they are fully functioning, HIEs will funnel all of the available information about a patient into your EHR or you will be able to access the information via the HIE. For new patients, you will have access to information about who else has treated them, what medications they are currently taking, and their current diagnoses. For existing patients, you can find out more about what is happening with their health between visits to your office. Whether the information is “pushed” into your EHR about a specific patient or if you access the information via the HIE will be dependent on the structure of your EHR and HIE.

One of the most important qualities of an HIE is that it allows different EHR systems to communicate with each other. If, for example, Doctor A is using NextGen, and Doctor B is

For the most current information on Cal eConnect, please visit their website, <http://www.caleconnect.org/>

using eClinical Works, the HIE will facilitate the exchange of information between the two. This eliminates the need for specific interfaces to be built between EHR systems.

The Connection to Meaningful Use

Stage 1 of meaningful use requires you to conduct one test of your EHR’s ability to transmit information to other providers. In addition, you will have to choose between sending information electronically to an immunization registry or to a public health agency. All of the above will require some level of HIE capability.

It’s also important to note that meaningful use is going to change. The federal Centers for Medicare & Medicaid Services have already indicated that Stage 2 of meaningful use will require physicians to be connected to an HIE, and to be actively exchanging data. Therefore, you will have to be connected to an HIE in order to continue receiving incentive payments. ■

Chapter 19

EHRs and Your Patients

If your EHR implementation is going to be successful for your practice, it is essential that your patients understand the transition you are making, and why you are doing it.

It is best to start the process of talking to your existing patients about your EHR before you implement. This will obviously be necessary if you are planning to shut down your practice for several days during the installation. Even if you do not shut down, your patients will notice that there are more computers and servers in your office than before.

How patients react to your new technology will in some ways depend on your patient population. For example, older patients may be more cautious about technology, and may wonder why all of their health information needs to be in a computer. Younger patients, who are more used to technology, may have more questions about their privacy and the security of their data.

Steps To Take Before, During and After Implementation

There are steps that you can take to make sure that all of your patients are comfortable with their EHRs. Here are some good places to start:

1. **Talk to your patients early and often.** If you have a patient newsletter or e-mail list, include an article about your EHR before you make the switch. Keep your patients updated throughout the process. If you do not have either one, consider sending a letter to your patient's about your EHR or have flyers available at check-in.
2. **Explain the benefits to your patients of the EHR.** In writing or talking to your patients about the EHR, stress how it will benefit them. You can point to timesavers such as electronic prescriptions, and talk about how better coordination of care will help you to provide them with better treatment recommendations.

Additional Resources

CMA's Best Practices: Successful Preparation and Implementation of an EHR System

<http://www.cmanet.org/files/pdf/ehr/best-practices-7.pdf>

CMA "On-Call" Document #1132 – Electronic Health Records

<http://www.cmanet.org/resource-library/detail?item=electronic-medical-records>

3. **Create a patient notification of your security practices.** This is essential. You should have a written notice that explains to your patients how their data will be handled and who will have access to it. Tell them of any steps you take to maintain their privacy (keeping servers in a locked room, changing passwords frequently, etc.).
4. **Show your patients their record.** Especially in the first office visit after your implementation, turn the screen around and show your patients their own record. Once they see that the information in it is essentially the same thing you had in their paper record (only more complete), they may feel even more comfortable with it.
5. **Don't let the EHR come between you and your patients.** One of the main complaints that patients make when a practice moves to EHR is that the physician is always looking at the screen, and not at them. Make a point of looking at your patients when they are talking. When you have to type something into the EHR, explain to your patients that you are simply making your notes. It also

sometimes helps to read back what you wrote, to let the patient know you are still paying attention.

Personal Health Records

A personal health record (PHR) is the patient end of an EHR. It is also sometimes known as a “patient portal.”

Through a PHR, patients can receive information such as lab results through a secure website, without ever having to come into your office. Most PHRs also include a secure email system, where patients can send you email about sensitive topics that they would otherwise not send electronically.

There are two basic types of PHRs:

Tethered PHR

- connected directly to your EHR system
- they are generally only used for communication between you and your patients, not third parties (i.e. labs, hospitals, etc.)

Untethered PHR

- not directly connected to your EHR
 - maintained by the patient
 - often include information from many different sources
 - well-known examples of untethered PHRs are Microsoft HealthVault and Google Health
-

A robust PHR can be a big selling point for your practice, as it creates convenience for patients. However, patients do need to be careful about how they use their PHRs. It is important that when the vendor demonstrates this aspect of an EHR you consider your patient population and how they will interact with the PHR. Please see the box below for a list of tips you can give your patients about accessing their information on a PHR.

Your Patients Can Be Supportive!

There is no reason that an EHR needs to make the patient experience less personal. And once your patients get used to it, they will probably be supportive of it. Electronic health records have the potential to save your patients a lot of time and hassle and to improve the patient experience overall.

Many practices with EHRs find that they are a selling point for bringing in new patients and re-engaging existing ones. They help patients to be more involved in their own care and to communicate better with you.

An EHR will potentially give you a competitive advantage by enabling you to report on the services you provide. Patients may be impressed with your new ability to give them a print out of their existing medications and, with access to your HIE, the ability to access all pertinent clinical information across the continuum of care. ■

Patient Tips for Using a PHR

Patients need to be aware that PHRs contain very sensitive information about their health. Here are some tips to give your patients:

1. Do not access your PHR from a shared computer.
2. You should also not access your PHR from a shared network, such as a public wireless network.
3. Make sure you log off as soon as you are done.
4. Change your password often, and do not share it with anyone.
5. Be very careful about accessing it from a device that can be easily stolen, such as a smart phone or a laptop.
6. Immediately notify your physician if you believe your record has been compromised.

Appendix

Appendix 1

California's Regional Extension Centers

The California Health Information Partnership and Services Organization (CalHIPSO)

Regional extension centers (RECs) are federally funded programs to help physicians implement electronic health records (EHRs) in their practices and achieve meaningful use.

The California Medical Association (CMA) is a founding partner of the California Health Information Partnership and Services Organization (CalHIPSO), the REC for much of California. CMA is working with CalHIPSO to provide education, outreach and technical assistance to help physicians select, implement and achieve meaningful use of certified EHR technology.

To ensure that the voice of physicians in all modes of practice was considered, CMA partnered with the California Primary Care Association (CPCA) and the California Association of Public Hospitals and Health Systems (CAPH) to be the REC for all of California, except for Los Angeles and Orange counties, which will be served by HITEC-LA and COREC, respectively. CalHIPSO is a 501(c) (3), independent of any of the founding organizations.

Services Offered by CalHIPSO

CalHIPSO offers participating practices a wide range of services, including:

- Assistance with EHR vendor selection and access to group purchasing discounts
- Readiness and workflow assessment leading to a Practice Service Plan
- High-level project management
- Education and training

- Assistance meeting meaningful use requirements and accessing incentive payments through Medicare or Medi-Cal

Who is Eligible?

Priority Primary Care Providers (PPCPs) are eligible for funded LEC assistance. A PPCP is defined as a M.D., D.O., N.P., P.A., CNMW certified in internal medicine, family practice, pediatrics, geriatrics, ob/gyn, and adolescent medicine focused on primary care in:

- Individuals and fewer-than-10 group practices
- Community and rural health centers
- Public and critical access hospitals
- Settings that serve the uninsured

Any physician (M.D. or D.O.) who works in an ambulatory care setting is eligible to work with CalHIPSO. Non-PPCPs can access CalHIPSO services on a fee-for-service basis.

CalHIPSO is waiving membership fees for all PPCPs until 2012. All non-PPCPs can join CalHIPSO for the reduced rate of \$150 per year.

Practices of 10 or fewer:

- Annual fee \$150 per provider up to a maximum of \$750/practice

Practice of 11 or more:

- \$1,500 annual fee cap per site
- \$3,000 annual fee cap per organization

For more information on CalHIPSO, visit <http://www.calhipso.org>

Health Information Technology Extension Center for Los Angeles (HITEC-LA)

HITEC-LA is the exclusive federally designated Health Information Technology Regional Extension Center (REC) for Los Angeles County, charged with helping doctors and primary care providers purchase, implement and use electronic health records in a meaningful way. HITEC-LA is a project of LA Care.

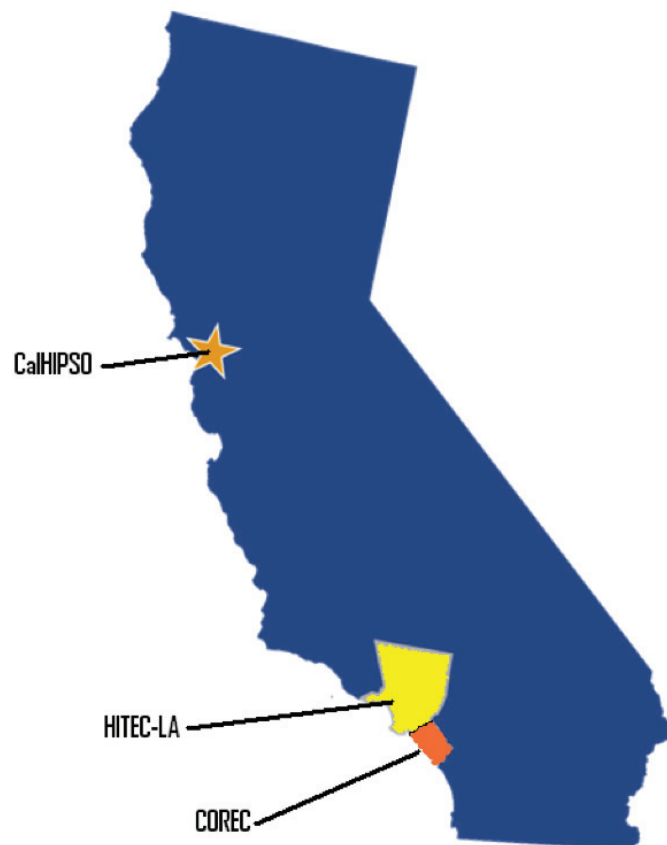
For more information about HITEC-LA, visit <https://www.lacare.org/aboutlacare/hitec-la>

CalOptima Regional Extension Center (COREC)

CalOptima is the Regional Extension Center (REC) for Orange County, California. Through the CalOptima Foundation, a nonprofit organization created by CalOptima, the CalOptima Regional Extension Center (COREC) will collaboratively work with physicians and other eligible providers to integrate health information technology (HIT) into their offices and bring them to meaningful use. COREC is a project of CalOptima.

For more information about COREC, visit <http://caloptima.org/en/Providers/RegionalExtensionCenter.aspx> ■

California's Regional Extension Centers



Appendix 2

Definitions

ARRA - The American Recovery and Reinvestment Act, also known as the “Stimulus Act,” is the federal legislation approved in February 2009 that created the EHR incentive program.

ASP - Application service provider is a model of EHR in which the system is accessed through an Internet portal and is not stored locally on a server in the provider’s office.

Cal eConnect - The nonprofit entity designated by the State of California to develop health information exchanges in the state.

CalHIPSO - The California Health Information Partnership and Services Organization is the federally designated regional extension center for the vast majority of California.

CMS - Centers for Medicare & Medicaid Services is the federal agency which oversees the Medicare and Medicaid EHR incentive programs.

COREC - The CalOptima Regional Extension Center is the federally designated regional extension center for Orange County.

EHR - Electronic health record. An EHR is similar to an EMR (the two are often used interchangeably). However, EHR is considered the more comprehensive term, since EHRs usually contain more functionality, such as patient portals and clinical decision support tools.

EMR - Electronic medical record. It is a digital version of the traditional paper-based patient record.

FQHC - Federally qualified health center is a clinic that receives a grant from the federal government for the purposes of providing health care to underserved populations.

HIE - Health information exchange is an Internet-based system that allows physicians to exchange clinical information using a secure portal.

HIPAA - The Health Insurance Portability and Accountability Act is the federal law that governs the privacy and security of patient data.

HIT - Health information technology is a comprehensive term that encompasses all technology used to store or transmit clinical information, including EHRs and HIEs.

HITEC-LA - Organized by L.A. Care Health Plan, HITEC-LA is the federally designated regional extension center for Los Angeles County.

HPSA - Health professions shortage area is a geographic region designated by the federal Health Resources Services Agency (HRSA) as having a shortage of health care providers.

HRSA - The Health Resources Services Agency is the federal agency that tracks the supply of practicing physicians.

IPA - An independent practice association is an entity that contracts with small practice physicians and provides shared services. Many IPAs have programs to assist small practice providers in adopting and implementing EHRs.

ONC or ONCHIT - The Office of the National Coordinator for Health IT is the federal agency that coordinates all of the government’s efforts to promote the adoption and use of HIT.

PHR - A personal health record is the patient’s portion of an EHR (see above). A PHR is a secure Internet-based portal where patients can review their own personal health information and interact with their physicians. It is also sometimes known as a “patient portal.”

REC - A regional extension center is a federally funded nonprofit entity that provides assistance to providers in achieving meaningful use of an EHR system. See: CalHIPSO, COREC and HITEC-LA.

RHC - Rural health clinic. Similar to an FQHC, an RHC received federal funding to provide treatment to underserved rural populations.

Appendix 3

Frequently Asked Questions (FAQ)

1. What is the difference between an electronic medical record (EMR) and an electronic health record (EHR)? (Introduction)

An EMR is simply the digital version of the paper-based medical record. It is a computer database that records data about patients. An EHR is a more comprehensive system, in that it includes clinical decision support tools and often includes a patient “portal” as well.

2. Can I receive incentives from both Medi-Cal and Medicare? (Section 2)

No. You must select one or the other. Once you select, you will be able to change once during the incentive program.

3. How will the EHR incentives affect the e-prescribing and Physician Quality Reporting Incentive(PQRI) incentive programs? (Chapter 1)

Once you receive an EHR incentive payment, you will not be able to receive incentives for e-prescribing or PQRI.

4. How do I know if I’m hospital based? (Chapter 3)

If you see 90 percent or more of your Medicare or Medi-Cal (depending on the program you access) patients in hospital inpatient or emergency room settings, you are considered hospital based and do not qualify for incentives.

5. Do I have to see a lot of Medicare patients in order to receive incentives? (Chapter 5)

No. Almost all Medicare providers will qualify for some incentives. However, the maximum Medicare incentive you can receive in any one year is 75 percent of your Medicare

Part B charges. For example, in order to receive \$18,000 in 2011, you must have \$24,000 in Medicare Part B charges.

6. I only see Medicare Advantage patients. Can I still receive Medicare incentives? (Chapter 5)

Your incentives are only based on the amount of your Medicare Part B (fee-for-service) charges. You will not count Medicare Advantage charges. There is a separate incentive program specifically for Medicare Advantage Organizations (MAOs).

7. Are the EHR incentive payments taxable income? (Chapter 7)

Yes, they are taxable like any other Medicare or Medi-Cal payment. If you reassign your incentive to another entity, such as a clinic or an IPA, you may also transfer the tax liability for those payments. You should consult a tax professional for more complete advice on the tax implications of the incentives.

8. How do I sign up for my incentive payments? (Section 2)

If you are accessing the Medicare incentive payments, you will sign up on a website established by CMS:
http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp#TopOfPage

If you are accessing Medi-Cal incentives, you will sign up both on the CMS website, and one established by the State Department of Health Care Services (here in California, registration is tentatively scheduled for Summer 2011). For more information on the Medi-Cal registration process, visit the Medi-Cal website: <http://medi-cal.ehr.ca.gov/>

9. How will I report on meaningful use? (Chapter 8)

For 2011 only, you will report both the numerator and the denominator for every measure through an attestation. After that, CMS will transition to an online reporting system.

Example: In 2011, you could report that you wrote 1,000 prescriptions (denominator) and that you transmitted 500 of them electronically (numerator). Since this is more than 40 percent ($500/1,000 = 50\%$), you would have met this objective.

10. When is the earliest I can receive incentive payments? Or: When is the latest I can get started and not get penalized? (Chapter 1 and 2)

Under either program, the earliest you can receive incentive payments is late Spring 2011. If you are a Medicare provider, you must meet meaningful use by 2015 in order to avoid penalties.

11. Will I get penalized under Medi-Cal if I don't meet meaningful use? (Chapter 2)

No. But if you are both a Medicare and a Medi-Cal provider, you will still be subject to Medicare penalties if you do not achieve meaningful use by 2015, regardless of the incentive program for which you have signed up.

12. My hospital/clinic/IPA says I can send my incentive payment to them, and they'll deal with my EHR. Is that true? (Chapter 7)

Yes. You are allowed to reassign your incentive payments to another entity, and they are then responsible for getting you to meaningful use.

13. I work at a hospital two days a week. Can I just use their EHR system and receive incentive payments? (Chapter 7)

In certain circumstances, yes. If you work at multiple locations, and only one of those locations has an EHR, and you see at least 51 percent of your patients in the location with an EHR, you can choose to only be assessed on your work at that location.

14. Do I get to count Medi-Cal Managed Care patients toward my 30 percent patient volume? (Chapter 5)

Yes. In fact you are allowed to count MCMC patients assigned to your patient panel, even if you do not see them during the representative 90-day timeframe.

15. Do I get to count Healthy Families patients toward my 30 percent patient volume for Medi-Cal? (Chapter 3)

Only if your practice is based in an FQHC or RHC, otherwise, "no."

16. Do I get to count Family Planning Access, Care and Treatment (FPACT) program patients toward my 30 percent patient volume for Medi-Cal? (Chapter 5)

Yes, patients covered by FPACT or any other program organized under the auspices of Medi-Cal do count toward your 30 percent patient volume.

17. How do I know if my practice is in a health professions shortage area (HPSA)? (Section 2)

Visit the website of the federal Health Resources and Services Administration (HRSA) at <http://www.hrsa.gov/index.html>. Enter your practice address and the site will tell you whether you are in a shortage area.

18. Do psychiatrists qualify for incentives? (Section 2)

Yes. Psychiatrists, since they are M.D.s, can qualify under either Medicare or Medi-Cal. Psychologists, on the other hand, cannot qualify under either program.

19. Do "dual eligibles" count as Medi-Cal patients? (Chapter 6)

Yes. So-called "dual eligibles," those who are on both Medicare and Medi-Cal, can count as Medi-Cal patients for the purposes of establishing 30 percent patient volume. If the Medicare portion of their coverage is fee-for-service, their charges can also be used for establishing your maximum incentive under the Medicare incentive program.

20. In my practice, the patient's basic information is entered by a medical assistant. Does that data still count for meaningful use? (Chapter 6)

Yes. As long as the information is entered into the EHR as structured data, the physician does not need to be the one who enters it.

21. I work in a five-physician medical group. Do we have to assess the patient volume of each physician for the purposes of the Medi-Cal incentive program? (Chapter 7)

No. The Medi-Cal EHR program allows multi-provider practices to do practice-level determination of patient volume. That is, if all of the physicians collectively treat 30 percent Medi-Cal patients, all of the physicians qualify for Medi-Cal incentives even if one physician does not meet the patient volume standard.

22. I'm about to retire. Is this even worth it? (Section 2)

Maybe. Even if you are planning to retire before the Medicare penalties begin, it may still be worth it to you to implement an EHR. If you are planning to either sell your practice or recruit a younger physician to take it over, your practice will be much more attractive if it has an EHR.

23. Should I just go with the same company that made my practice management system? (Chapter 10)

For many physicians, this may be a sensible choice. If you want to keep your practice management system, your EHR will need to interact with it. If your EHR is from the same company, you should not have problems with the two communicating. Make sure, however, that the company's EHR works for your practice.

24. I have an EHR, but it is not currently certified. What should I do? (Chapter 11)

Don't panic. The temporary EHR certification process will run throughout 2011, so your system may be certified eventually. That being said, you may need to have your EHR vendor make modifications if you have had your system for some time. Contact your vendor for more information. ■

Appendix 4

Practice Readiness Assessment Questionnaire

Readiness Assessment Questions

Name (please print): _____

Date: _____ Role: _____

Practice Location: _____

Directions: In order to effectively assess the readiness of the practice to adopt electronic health records (EHR) the following questions should be utilized.

Organizational Alignment

Culture

- What is the perception of the purpose of implementing an EHR in your office?
- How are decisions made around the EHR planning? Who is involved? Is there physician involvement and to what degree?
- Has the practice defined efficiency and quality goals?

Leadership

- Do the primary stakeholders understand the need for an EHR? Have the pros and cons been investigated? Are the benefits understood and are they communicated?
- How is project planning allocated among the practice?

Strategy

- Has there been any strategic planning completed for the EHR process to date?
- Is there a defined strategy for quality and efficiency?

Organizational Capacity

Information Management

- To what degree has your practice management system been utilized?
- Have EHR reports been considered for population management, health and quality improvement?

Clinical & Administrative Staff

- Who is involved/dedicated to the EHR vendor contracting? Physicians, staff, etc...
- Has the practice identified/documented/planned for staffing needs during the implementation of the EHR?
- Has the practice identified and assigned a dedicated project manager?

Training

- How does the practice view training (for general skills as well as for EHR functionality)?

Workflow Processes

- Are current/future processes understood and documented?
- Have policies and procedures for EHR-enabled processes been analyzed and documented?

Accountability

- Have roles and responsibilities for analyzing products, options and contracting been established and assigned?

Finance and Budget

- How is the cost of an EHR justified? Is it seen as an expense or as an investment? How is the project being funded?

Patient Involvement

- Has there been discussion around patient interaction with the EHR, i.e., a web portal?
- Have policies and procedures been evaluated/documented for corrections and/or amendments to the electronic medical record?
- Have EHR-enabled referral processing, e-prescribing and educational materials been discussed and evaluated?

IT Management and Support and Infrastructure

- Do you have IT support on staff? What is the level of experience?
- Has the IT staffing been analyzed/planned for the implementation process and subsequent ongoing maintenance.
- Is the IT staff involved in the EHR planning process and to what degree?
- Has a needs assessment for hardware been evaluated and planned for?
- Is there a plan established for the technical infrastructure? Has it been documented and is it in place?

Appendix 5

Contract Review Checklist

This chapter is reprinted from the Texas Medical Association's "EMR Implementation Guide."

The original can be downloaded at <http://www.texmed.org/HIT/>

New contract or renegotiation

Is the proposed contract arrangement a renegotiation with an existing vendor or a new relationship? While everything discussed below applies equally to both situations, physicians should view renegotiations as an opportunity to evaluate the vendor's performance and make needed changes.

Contract term

The contract should clearly state (1) the beginning or effective date and (2) the ending or expiration date.

Contract parties

The contract should include the full name, address, legal status (e.g., corporation, partnership), and contact person of the other party. Verify that the vendor identified in the contract is the party that you have been dealing with, and not a less solvent subsidiary or affiliate. Finally, pay close attention to the definition of a "licensee." You may want to widen the scope of the term "licensed parties" to include use by affiliates or related parties.

Duties and obligations

The contract should clearly state all duties and obligations of the practice and the other parties to the contract so that all know (1) what the duties and obligations of each party are, (2) how each party is to perform them, and (3) when they will perform them. The contract should be evenhanded so that both parties are subject to similar obligations.

What is being licensed and its purpose

Contracts frequently fail to identify exactly what is licensed and the functions the software performs. An exhibit outlining software functions is an ideal way to include this information - the more detailed, the better for the practice. You also might consider creating an exhibit with an understanding of

what the licensed program will do (e.g., the specifications). If nothing else, consider attaching brochures, presentations or any other document the vendor provided.

Review your contract carefully to determine the exact deliverables:

- If you use an outside lab or other vendor for your practice management system, the application interfaces must be included. Do not assume your lab vendor will pay for this.
- Is the hardware included in the purchase price? Are the costs for field engineers to install your hardware included?
- Implementation and training services. It is preferable for this to be done at your practice rather than remotely. Project management should be on site with regular scheduled vendor meetings, how many hours are included in the quote for this service? How many hours are included for on-site training? Most systems require modifications; how many hours are included in the contract for clinical content modifications? Workflow redesign? The single most frequent complaint of physicians is the lack of on-site support and training and it is a wise investment to pay additional fees for these services.

Scope of license

The contract should specify the scope of the purchased service. For example, a contract may be "exclusive" or "nonexclusive." The issue of exclusivity may not be important if the practice uses mass-produced or retail software; however, it becomes very important if the practice pays a programmer to develop custom software. In addition, a vendor contract may refer to the "use" of the software. As a licensee, the practice should seek a broad license that will not limit future use if the practice later expands.

In addition to limiting the scope of the license to internal use only, vendors commonly attempt to limit:

- Number of users;
- Right to create derivative works;
- Territory and industries covered;
- Who can perform repairs (i.e., only the licensor);
- Use as a service bureau;
- Right to sublicense; and
- Location (if the practice has facilities in nearby towns or cities that will need use of the software, you don't want a license that is limited to a particular location or facility).

Questions to Ask Your Vendor about Your Software

- In which format is the software delivered?
- What type of user documentation is provided?
- Will use of the software require purchase of hardware owned by a third party? If so, how much will it cost?
- Are updates included in the license agreement or will they incur additional cost?
- Will the version that the practice is licensing be phased out over the next two years and no longer be supported?
- Is the vendor in discussions with another company for a possible merger or sale?

Finally, the contract should stipulate whether the license is transferable or nontransferable. A physician who sells his or her practice will want the license to be transferable to the buyer, or else the buyer will have to get a new license to use the software (and the buyer may seek to lower the purchase price for the practice in this case).

Compliance with laws and standards

The vendor should agree to comply with applicable laws and any applicable accreditation standards, including adherence to American Recovery and Reinvestment Act (ARRA) criteria.

Payment and fees

The contract should clearly and accurately state the amounts the practice is obligated to pay under the contract, and clearly establish place, time and method of payment expected following receipt of an agreed-upon invoice. The contract should state what detail will be included in the invoice.

Payment methods vary greatly and may include flat monthly or project rates, amounts based on usage time and materials, or fee schedules based on the number of system users or the quantity of data hosted.

Consider the following when evaluating the contract for payment information:

- If the payment schedule calls for a down payment, the contract should make clear as to whether there also are additional annual payments.
- If the payment schedule calls for a down payment plus royalty, the contract should clearly outline how the royalty is calculated and what is deducted.
- Consider incorporating provisions that allow for a right to change or modify pricing within a certain range after one or two years. Alternatively, the practice may prefer a right to change pricing after the initial term.
- The contract should outline whether support services are provided as part of the fee or whether the fee includes any customization services.
- The contract should outline whether training services and documentation are included in the initial payment fee. If so, the contract should clarify who will provide the training and to what extent and whether the training will be "live" or through "remote services." Ideally, the physician and vendor should anticipate changes in the volume of system users and data requirements when agreeing to initial terms.
- The contract should define annual maintenance fees, and the duration of maintenance cost should be tied to the contract length and not increase annually. If maintenance fees do increase, they should not exceed consumer price index (CPI) increase.

Privacy and security

The contract should require the vendor to maintain and document a comprehensive privacy and security program that includes administrative, technical and physical safeguards to reasonably and appropriately protect the confidentiality, integrity and availability of electronic health information as required by HIPAA. The contract should require the vendor to provide documentation upon the practice's request.

Disclosure protocol

The vendor should have an established protocol for reporting to the practice any inappropriate disclosures of information that may occur.

Termination

A contract may set forth various types of termination provisions, including:

- A fixed, initial term of multiple years with automatic renewal, unless a certain amount of notice is provided;
- A fixed term with annual renewal unless terminated with prior notice;
- Termination without cause (this gives the practice the most flexibility to get out of the license, but also offers the vendor the same flexibility); or
- A provision allowing either party to terminate only in the event of material breach.

At a minimum, the physician should be permitted to terminate for the following events:

- Vendor's failure to maintain state licensure or comply with legal requirements imposed upon the practice;
- An increased number of patient complaints or the practice's perception that serious problems in care quality have occurred as a result of the vendor's failure to comply with the agreement;
- Vendor's failure to maintain system performance resulting in system downtime (resulting in less than 98 percent

performance), compromise of data integrity and/or security or a physician's ability to render services; or

- Vendor's failure to mitigate consequences or implement appropriate safeguards in the event the vendor makes inappropriate disclosures.

Wind-down provision

The practice should attempt to include a wind-down provision to protect it from the effects of termination by a vendor or if the practice elects to migrate to another EHR vendor. Termination by vendor is typically coordinated with the termination section so that there is a reasonable period of time to transition services. In addition, the vendor should be obligated to remedy any material breaches prior to ending the relationship, to cooperate with new service providers or vendors, and especially to migrate or transfer electronic information in a mutually agreed upon format at no additional cost to the physician. Termination by practice must include verbiage regarding data ownership and data migration costs.

Data ownership

The contract should acknowledge the ownership of data contained in or generated by the system and designate the practice as the owner of all patient information, confidential information, or any derivative thereof. The contract also should clarify the format in which information is to be returned, the method for returning the information, and the time frame. This provision should apply equally to subcontractors.

Software ownership

The contract should address who has ownership rights to licensed software, set forth who owns derivative works to the software, determine whether the practice has the right to modify software, and agree on ownership rights in any modifications. Ownership rights become especially important if the practice initiates and makes modifications to the software. This can also be addressed when determining who will have rights to the source code; the practice should inquire as to whether the software is placed in an escrow account.

System updates and changes

The practice should require the vendor to provide prior notification of any new versions or updates to the software, especially for compliance with federal or state regulations, and improvements in security and operability functions and coordinate with the practice prior to implementation and upgrades. The practice must receive documentation for any upgrade that modifies end user screens or workflow, prior to the scheduled upgrade.

Testing and quality assurance

If the vendor is providing solutions or modifications unique to the practice, the contract should ensure that the vendor tests systems to verify that they will meet the contract requirements.

You may request that the vendor provide evidence of having tested systems or system components under simulated conditions similar to those you expect in your practice. This will ensure that the vendor is able to address all of your needs. Because such quality assurance requires a high degree of expertise, the practice and vendor may contract with a third party to review the systems for contractual compliance and to identify potential issues.

Support services

The contract should specify whether support is provided by a third party or the vendor. Issues to address:

- Is there a 24-hour help desk? If not, what are the help desk hours of operation and in which time zone do they operate?
- If support is needed at the practice's site, who pays for the travel time and expenses?
- How quickly will the vendor respond to requests for support services? What is the contracted rate of turnaround time for calls to the help desk? System downtime? Workaround provided? Request for customization?

Representation and warranties

Warranties obtained from a vendor will vary greatly depending on services provided. Evaluate the following:

- Whether the contract includes a "performance warranty" stating that the software will actually perform the functions the seller claims it will. These functions usually are outlined in a specification sheet, preferably attached to the license agreement.
- Vendors typically try to avoid a performance warranty, or they include language that leaves them wiggle room, such as "substantially comply with specifications"; "no known major bugs"; or "free from defects as delivered." Instead, the practice should try to insert contract language that states the software will "operate in accordance with the specifications" or "conform to specifications."
- Whether the support services will be performed in a professional and quality manner, as well as the inclusion of an escalation and remediation process.
- Whether the provided hardware and computer programs constitute all applications, systems software, or interfaces required to operate computer programs.
- Whether computer programs are compatible with the practice's existing data files, business information and systems, so that significant additional applications, software, or interfaces are not required.
- The amount of time for which the vendor agrees to maintain up-time of services during a calendar month. (Typical usage time is near 98 percent.)
- The vendor's agreement to repair or replace a defect, or alternatively, to provide a refund.
- The vendor's representation that the media in which the computer programs are delivered shall be free of any defect, virus or other program designed to erase or otherwise harm or collect unauthorized information from the physician's hardware, data or other programs.
- Whether the vendor ensures that services for which it is responsible are free of defect or malfunction.
- Whether each party has the power and authority to execute, deliver and perform the obligations under the contract and that the person signing the contract is authorized to perform these functions.

Language to look for in a warranty (in order of preference)

The physician should look to include these phrases in a warranty dealing with the expected performance of the vendor:

- “Good and workmanlike manner,”
- “Timely and professional manner,”
- “In a commercially reasonable manner,” or
- “In accordance with standards generally observed in this industry for similar software.”

The physician should be leery of negation of warranties.

Vendors sometimes seek these disclaimers:

- “As is,” which means all warranties are excluded;
- “Software contains no known viruses”; or
- Disclaimer of implied warranties under a statute commonly referred to as the Uniform Commercial Code or UCC.

Liability

Licensors typically insist on disclaimers for particular damage remedies. Try to limit the contract so that the vendor is still liable for actual damages caused by the software. The vendor should be liable for any claims directly attributable to product malfunction or failure to protect integrity of information. Also look out for provisions capping any liability at a certain amount (e.g., license fees paid) and whether such provisions apply to indemnificatory obligations. Also request and include in your contract the “EHR” Vendor’s project plan for your practice. In the event that the “live date” is documented on the attached project plan for six months in the future and, in today’s EHR incentive market, the vendor “over sells” his product and does not have sufficient implementation staff, vendor penalties should be agreed on prior to contract signing. For example, for every week the vendor is responsible for delay in your implementation, your EHR or maintenance fees are discounted by a given percent. This type of language in your contract will assure timely service.

Downtime provisions

In any data-hosting arrangement, there will be times when access is impossible because of periodic maintenance procedures or repairs. The vendor should agree that any controlled downtime will occur only on an “as-needed basis,” not exceed three hours per week, and be scheduled after practice business hours. The vendor should give the practice at least 48 hours’ prior written notice of controlled downtime and use its best efforts to schedule the downtime during non-business hours.

Subcontractors

The vendor should identify any expected outsourcing or subcontracting of the services provided to the practice. If a vendor subcontracts work, the subcontractor or agent must be held to the terms of the contract, including the same standards for protecting the confidentiality and integrity of patient information as the original vendor. Each subcontractor or agent must be subject to your state’s jurisdiction and venue—especially given today’s environment where a large percentage of work is subcontracted to other countries such as India.

Personal services

If the contract is for personal services (as in many consulting agreements), it must clarify the independent contractor status of the vendor.

Insurance

The contract should specify the amounts and types of insurance that the vendor is required to carry.

Arbitration

Almost all agreements contain a process for arbitrating disputes. Be sure to review these provisions carefully. At a minimum, the arbitration section should stipulate that the arbitrator(s) have expertise in the arbitration matter and that the process be conducted in accordance with the Arbitration Rules of the American Arbitration Association. The contract also should require that any arbitration take place in the county in which you practice.

In addition, decide if your arbitration clause should:

- Designate particular people or positions to be involved in early resolution of disputes;
- Require parties to negotiate in good faith to resolve disputes informally;
- Establish if it is possible to withhold payments over disputed invoices;
- Specify whether all disputes should be resolved by arbitration (you may want use of a courthouse for certain types of claims, such as breach of confidentiality or violation of intellectual property rights);
- Set limits on the authority of arbitrators or scope of relief; or
- Stipulate recovery of attorney's fees and court costs.

Venue

Make sure the contract contains no clauses that make it subject to either the substantive law or the jurisdiction (also referred to as "forum" or "venue") of another state; the contract should reference only your state.

Assignment

An assignment clause sets forth whether or not you will be allowed to transfer your rights or obligations under a contract to a third party. There are many different types of assignment clauses, such as those under which:

- Either party has assignment rights;
- The vendor may assign but not the physician;
- Neither party may assign without consent of the other party, but consent shall not be unreasonably withheld;
- Neither party may assign, unless the assignment is in connection with transfer of all or substantially all assets of the party; and
- The vendor may retain right to renegotiate terms if assigned by the physician.

Ideally, neither party should be allowed to assign the contract without the prior written approval of the other party.

Source code escrow

It is in your interest as a licensee to seek a source code escrow under the contract. This ensures that if the vendor goes out of business, a copy of the source code is available so that the practice can continue to use it and have repairs made to it. Items to consider:

- Escrow location,
- Access terms,
- Payment for upkeep of escrow, and
- Duty to keep updated version of source code in escrow.

Promised items

The contract should expressly incorporate all representations, promises, inducements, and warranties that are made to the practice (i.e., verbal assurances and representations that have material influence in convincing the practice to enter into the contract).

Integration

The practice should obtain and review all documents that relate to the contract or are referred to in the contract, as well as any policies and procedures referenced in the contract.

Meaningful use (all stages)

Many vendors are guaranteeing that their EHR systems will enable physicians to achieve meaningful use. While this is good, it is important to remember that meaningful use will change in the future. The meaningful use rule released in July 2010 is stage 1. There will be a stage 2 in 2012 and possibly future stages in 2014 or later. The contract should stipulate in writing how future stages of meaningful use will be handled. Otherwise, physicians may find themselves in several years having to purchase new reporting templates or interfaces, which could be very expensive.

Useful Resources

California Medical Association (CMA)

CMA's HIT Resource Center

Description: A collection of useful resources developed by CMA to assist physicians with all aspects of HIT - EHR adoption, federal incentive programs, HIPAA, telemedicine, and many others.

<http://www.cmanet.org/issues-and-advocacy/cmas-top-issues/health-information-technology/>

California Academy of Family Physicians (CAFP)

CAFP's HIT Toolkit Webpage

Description: A collection of interactive tools designed to assist with the process of EHR implementation.

<http://www.familydocs.org/pcmh/health-information-technology.php>

AmericanEHR Partners

Description: This website includes extensive resources for physicians, office managers and others. This resource was developed by the American College of Physicians (ACP) in conjunction with Cientis technologies and other partner organizations.

<http://www.americanehr.com/Home.aspx>

Centers for Medicare & Medicaid Services (CMS)

Medicare & Medicaid EHR Incentive Program Registration and Attestation System

Description: All physicians planning to participate in either the Medicare or the Medi-Cal EHR incentive programs will need to register and attest via this system.

<https://ehrincentives.cms.gov/hitech/login.action>

EHR Incentive Programs Webpage

Description: This is the official web site for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs; all official details and updates can be found here.

http://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage

Department of Health Care Services: Medi-Cal

Medi-Cal EHR State Level Registry (SLR) for Provider Incentive Payments

Description: The official Medi-Cal Incentive program registration webpage. Physicians planning to participate in the Medi-Cal incentive program must register via this system in addition to the CMS system.

<http://medi-cal.ehr.ca.gov/>

Office of the National Coordinator for Health Information Technology (ONCHIT)

Description: ONC is the principal Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.

http://healthit.hhs.gov/portal/server.pt?CommunityID=2998&spaceID=42&parentname=&control=SetCommunity&parentid=&in_hi_userid=12059&PageID=0&space=CommunityPage

Regional Extension Centers

Description: Regional extension centers (RECs) are federal-funded non-profit organizations who are available to help physicians select and implement EHRs, and to achieve meaningful use. There are three in California:

California Health Information Partnership and Services Organization (CalHIPSO) is the federally funded regional extension center responsible for serving the majority of California providers. <http://www.calhipso.org/>

To contact CalHIPSO and apply for EHR implementation support services, please complete their Provider interest Form http://www.calhipso.org/forms/interest_form.html

CalOptima (COREC) is the federally funded regional extension center serving Orange County.

<http://www.caloptima.org/en/Providers/RegionalExtensionCenter.aspx>

To contact COREC and apply for EHR implementation support services, please complete their Provider interest Form <http://www2.caloptima.org/recform/>

L.A. Care (HITEC-LA) is the federally funded regional extension center serving Los Angeles County.

<https://www.lacare.org/aboutlacare/hitec-la>

