Incentives and Beyond: Maximizing the Opportunities from Moving to “Meaningful Use” of EHR

A white paper exploring issues and opportunities in EHR adoption for physician practices and hospitals.

President Obama signed the American Recovery and Reinvestment Act (ARRA) into law on February 17, 2009, ushering in $787 billion in new spending and tax cuts — including billions for health information technology.

That’s right, billions.

Specifically, the Health Information Technology for Economic and Clinical Health Act (HITECH) earmarks $19 billion in grants and loans to promote adoption of Electronic Health Records (EHR). In all, the federal government will invest close to $40 billion to modernize health information technology and drive adoption of EHR by 2015.

AS GOLDEN AS IT GETS

As far as opportunities go, this may be as golden as it gets.

With incentives of $44,000 - $64,000 per physician, the payments are enough to cover the cost of a top-of-the-line EHR system — potentially at no net cost to the physician.

Hospitals are also being incentivized to adopt EHR technology, with nearly $20 billion authorized for incentive payments.

THE PROMISE OF A COMPLETE PATIENT RECORD

They’ve been called electronic medical records, computerized patient records and paperless charts. But perhaps the simplest definition of EHR is this one from the U.S. Department of Health and Human Services (HSS): “a digital collection of a patient’s medical history that could include items like diagnosed medical conditions, prescribed medications, vital signs, immunizations, lab results and personal characteristics like age and weight.”

Ideally, EHR would be a complete patient record system that seamlessly crosses the continuum of care. And that, proponents say, holds the promise of fewer adverse drug events, lower morbidity and mortality rates, enhanced continuity of care, greater efficiencies and lower costs.

“We want to make sure that every doctor’s office and hospital in this country is using cutting-edge technology and electronic medical records so that we can cut red tape, prevent medical mistakes and help save billions of dollars each year.”

President Barack Obama

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Incentives and Beyond

To drive adoption of EHR by 2015, the federal government will invest almost $40 billion in Medicare and Medicaid providers between 2010 and 2017. The remaining $2 billion will be dispersed as grants and loans to promote healthcare information technology (HIT) and improve accessibility to HIT in underprivileged areas. The grants will be available to researchers, community health centers, rural health centers and Indian health centers.

In the end, the Congressional Budget Office predicts that these incentives will increase the adoption of EHR from a current 5 percent of doctors to an estimated 90 percent within the next decade. Government spending is also expected to increase EHR adoption by hospitals to 70 percent.

THE ADVANTAGE GOES TO EARLY ADOPTERS

In this massive move toward electronic records, it appears the biggest benefits will be provided to those who act now. For example, early adopters could receive as much as an $18,000 bonus the first year of adoption if their allowed Medicare charges total $24,000 or more. In all, an “on-the-ball” provider could earn up to $44,000 in federal incentives over five years. But the incentives start getting smaller by 2015.

Beginning in 2015, the government will penalize practices that have not demonstrated meaningful use of EHR. These practices will see a 1 percent reduction in their Medicare reimbursement, and reductions of up to 5 percent by 2019. “There will be a distinct advantage to being an early adopter,” notes Dr. William F. Jessee, president and chief executive officer, Medical Group Management Association. “Decision-making in the face of uncertainty is never easy; but if you delay beyond five years, you actually start getting penalized.”

And for that, the government is willing to pay generously. The bulk of the funds (some $17 billion) will be used to incentivize physicians and hospitals that participate in Medicare and Medicaid programs to become “meaningful users” of EHR technology.

SPURRING ADOPTION

The goal is certainly a noble one: to bring efficiencies to what critics say is arguably the world’s largest and most inefficient information enterprise. As the largest payer of healthcare costs, the federal government is understandably committed to EHR adoption. “The government is focused on getting benefit through changes in behavior at the point of care,” notes Steven Van Kuiken, consultant, McKinsey & Company. “The research clearly shows a substantial benefit to creating a nationwide network of interconnected electronic health records. Quite simply, the Feds hope to tap into a wealth of otherwise unattainable information about the sickness and health of large groups of people — and what’s succeeding or failing in efforts to deliver care more effectively.”

THE MEDICAID POT

The Recovery Act also establishes financial incentives beginning in January 2011 under the Medicaid program. Eligible providers who demonstrate meaningful use of an EHR system can receive a first-year payment of up to $21,250 for adoption, implementation, upgrade, maintenance and operation of a certified EHR. Subsequent payments of $8,500 per year are available for EHR operation and maintenance.

Those eligible for Medicaid incentives include:

• Non-hospital-based professionals (physicians, dentists, certified nurse midwives, nurse practitioners and physician assistants) who have a patient volume comprised of at least 30 percent Medicaid beneficiaries.

• Non-hospital-based practitioners who have at least 20 percent of their patient volume attributable to Medicaid patients.

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PUTTING THE "MEANINGFUL" IN "MEANINGFUL USE"

In order to qualify for stimulus payments under either Medicare or Medicaid, providers must demonstrate that they use their EHR system in a meaningful way (the so-called "meaningful use" requirement). To that end, the HITECH Act specifies three general guidelines for what constitutes meaningful use:

- **E-prescribing** — The provider utilizes an EHR system for decision-support-driven medication management (eligibility, formulary, history, drug interaction, routing, refills, etc.).
- **Electronic exchange of health information** — The provider utilizes an EHR system to exchange electronic notes, charts, lab results and other medical documents with the goal of better care coordination.
- **Submission of clinical quality measures** — The provider participates in electronic exchange of clinical quality measures, including process and outcome metrics, to be specified by the Department of Health and Human Services.

Beyond these initial guidelines, the specifics of exactly what constitutes "meaningful use" remain to be seen. It is expected that each year the definition will be expanded, setting the bar higher and requiring more features and more data exchange.

E-prescribing makes it possible to have silos of healthcare data out there,” says Dr. Jessee. “It’s going to be absolutely essential that these EHR systems communicate with each other.”

From another perspective, Dr. Andrew Ury notes that EHR is not about capturing data for the sake of capturing data. “Out of the proliferation of health information that’s captured, EHR gives us the ability to measure and monitor that information from a quality perspective. We can use that data to improve the health of our population with some basis in fact, as opposed to a basis that’s sometimes secondhand or anecdotal.”

As a board-certified family practitioner and CEO of Practice Partner, a practice management software provider, Dr. Ury has observed with a keen eye the growing demands on practitioners: “As physicians, we are being pushed to provide and document better quality of care at a time when reimbursements are falling and overhead is going up. It’s obvious that we have to do things differently.”

THE CERTIFICATION PUZZLE

It’s not enough to simply be a meaningful user of EHR technology. Providers must be meaningful users of a certified EHR system.

Just as a comprehensive definition of "meaningful use" is still working its way through the federal rule-making process, so is a definition of exactly what constitutes a "certified" EHR product.

The certification process and standardization criteria have not yet been determined, but were scheduled for completion by the end of 2009.

"It’s going to get confusing before it gets clear," notes Van Kuiken. "It’s a process that will have a disruptive effect over the next five years, albeit one with eventual benefits."  

Most likely, certification requirements will be based on standards that have already been adopted by the Certification Commission for Healthcare Information Technology (CCHIT), the private, nonprofit organization recognized by the federal government as the certification body for health information technology.

CCHIT is charged with certifying that EHR products meet standards in:

- **Functionality** — The ability to create and manage electronic records for all of a practice’s patients, as well as automate the flow of work in the office.
- **Interoperability** — The ability to receive and send electronic data between an EHR and outside sources of information such as labs, pharmacies and other EHRs in practice offices and hospitals.
- **Security** — The ability to keep patient information safe and private.

Regardless of how certification criteria wash out, there will most certainly be challenges.

"Depending on EHR criteria defined by the Secretary of Health and Human Services, you may have a product that was previously certified but does not now qualify for the stimulus incentives," notes Dr. Jessee. "Then there are some early-adopting practices that have cobbled together a ‘modular’ EHR by taking technology from multiple sources … e-prescribing from one product, reporting from another product. It remains to be seen how these will be certified.”

In an effort to bring some order to the EHR marketplace, CCHIT has created three new, HITECH-specific certification options:

- **EHR-C** — A rigorous certification for comprehensive EHR systems that significantly exceeds minimum federal standards requirements. This certification offers maximum assurance of EHR capabilities and compliance.
- **EHR-M** — A modular certification program for e-prescribing, personal health records, registries and other technologies. Focusing on basic compliance with federal standards and security, this certification would appeal to providers who prefer to combine technologies from multiple certified sources.
- **EHR-S** — A simplified, low-cost, site-level certification that would enable providers who self-develop or assemble EHRs from non-certified sources to also qualify for the Recovery Act incentives.

MEDICAID VS. MEDICARE

Differences in incentive payments under Medicaid include:

- Upfront financing is available through Medicaid for physicians who lack the funds to invest in EHR.
- Unlike with Medicare, Medicaid providers who do not adopt qualified EHR technology will not be penalized with payment reductions.
- EHR implementation is optional instead of a requirement for state Medicaid programs.

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<th>Medicaid Incentives</th>
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Incentives and Beyond

Experts stress that uncertainty about how EHR technology will be certified should not be a reason for postponing adoption. "If you're starting from scratch, add it to your contract negotiations with vendors that their product will be warranted and that they must do what is necessary to qualify the product for incentive money," Dr. Jessee advises.

PRIVACY PROVISIONS: WHO'S WATCHING THE DATA?

While digital data exchange is certainly more efficient than sending photocopies of charts through the mail or by fax, it does open a Pandora's box of security concerns.

Accordingly, HITECH expands existing regulations under the Health Insurance Portability and Accountability Act (HIPAA) for covering protected health information (PHI).

Tracking of Disclosures — Practices using EHR are required to track all disclosures of a patient’s PHI. Patients may request a record of any disclosures the practice makes for purposes of treatment, payment and healthcare operations for up to three previous years. Practices that have an EHR as of January 1, 2009, must comply with disclosure provisions as of January 1, 2014. Practices that acquire an EHR after January 1, 2009, must comply by January 1, 2011, or the date that the practice acquired the EHR, whichever is later.

Breach Notification — Practices must notify by letter within 60 days each patient (or next of kin) whose PHI has been disclosed due to a security breach. In cases where a breach impacts more than 500 patients, the practice is required to notify local media and HHS, where a breach impacts more than 500 patients, the practice is required to notify local media and HHS, as well as the Secretary of Health and Human Services. In the end, it will probably be the risk of penalties, which will be quite burdensome, that will drive adoption for hospitals.

Disclosure Restrictions — Patients may restrict disclosures to health plans if the patient has paid in full, out-of-pocket. Here, practices are required to use de-identified patient data or only disclose the minimum data needed to carry out administrative transactions.

Expansion to Business Associates (BAs) — HIPAA requirements and penalties have been expanded to cover business associates and apply certain provisions (e.g., breach notification) to vendors of personal health records and health information exchanges.

Electronic Access — Practices using EHR must provide patients (upon request) with a copy of their record on a CD-ROM, Web site or other electronic means. Practices will be able to charge the labor cost involved in carrying out such requests.

New Enforcement Provisions — Through a new four-tier system, civil penalties will be levied beginning in 2011. These penalties start at a level of $100 per violation and increase to a maximum of $50,000 per violation. Also underway is the establishment of a "whistleblower" provision by which individuals would receive a percentage of the penalties collected. "If you thought HIPPA was a challenge, this is going to be even more difficult," notes Dr. Jessee. "You basically need to have an audit trail that will keep track of where you send protected information ... every claim you send and every referral you make to a physician where you are providing confidential information."

MEDICARE INCENTIVES FOR HOSPITALS

The government has a vested interest in moving patient care outside the four walls of acute care facilities," notes McKinsey & Company’s Steven Van Kuiken of the $20 billion in incentives being made available to hospitals that demonstrate meaningful use of EHR. "Acute care facilities should be thinking about how they can use technology to reach outside of their walls and better integrate patient care."

Starting in 2011, eligible acute care facilities can receive reimbursement under the Medicaid program for costs incurred in acquiring certified EHR technology, as well as for support services, such as EHR maintenance and training. The incentives are reduced after 2013.

Hospitals eligible for the Medicaid incentive include children’s hospitals and hospitals that have a Medicaid patient volume of at least 10 percent.

Hospital incentive payments will be spread over a four-year period:
- Year 1 = full incentive payment
- Year 2 = 75 percent
- Year 3 = 50 percent
- Year 4 = 25 percent

Incentives will be determined using a formula that considers the following:
- A base incentive of $2MM
- The hospital’s inpatient Medicare volume
- Total annual discharges
- The hospital’s charity care volume

The first-year incentive payment would be calculated as a base amount of $2 million, plus $200 per discharge for each discharge between 1,150 and 23,000, multiplied by the hospital’s Medicare share.

SAMPLE MEDICARE PAYOUT

(Assumes hospital with 10,000 discharges, 25 percent Medicare share and 25 percent charity care)

| Base Amount: | $2,000,000 |
| Discharge Amount | +$1,770,200 |
| Total | $3,770,200 |
| Factor (Medicare & Charity) x .3333 | + $1,256,608 |

WASHINGTON MONTHLY - 2009

"Astonishingly, twenty years after the digital revolution, only 1.5 percent of hospitals have integrated IT systems today—and half of those are government hospitals."

Starting in 2015, eligible hospitals that have not demonstrated meaningful use of EHR technology will face a market basket reduction under Medicare. The annual market basket adjustment for eligible hospitals not using EHR will be reduced by:
- 33.33% for 2015
- 66.66% for 2016
- 100% for 2017 and each subsequent year

The Secretary of Health and Human Services is authorized to exempt hospitals from payment penalties on a case-by-case basis (e.g., a rural hospital without sufficient Internet access).

In addition, qualifying critical access hospitals can apply for a cost-based reimbursement of EHR technology. They are also entitled to prompt payment from the Centers for Medicare and Medicaid Services (CMS), rather than the annual or periodic incentive payout in place for other hospitals.

"Hospitals should really consider this a down payment on improving HIT performance," notes Paul Browne, chief information officer, Trinity Health Systems, a 44-hospital system based in Michigan. "The incentives are greater for physician practices than for acute care facilities. In the end, it will probably be the risk of penalties, which will be quite burdensome, that will drive adoption for hospitals."
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LEGISLATION REMOVES LEGAL HURDLES

Recent exceptions to the Stark regulations and anti-kickback safe harbors now allow hospitals, group practices and other specified health organizations to help physicians get new data-related technologies such as EHR at a reduced cost. Some private carriers have also established grants to help providers acquire EHRs.

Organizations that provide healthcare items or services covered by federal healthcare programs can cover up to 85 percent of the cost of EHR-related software and training services.

“This provides incredible opportunities for hospitals,” notes McKinsey & Company’s Van Kuiken. “Doctors are not experienced buyers of technology. So hospitals can position themselves as a trusted source of information and technology for the physicians in their community.”

The approved organizations include:
• Hospitals
• Group practices
• Pharmacies
• Health plans
• Community health services
• Laboratories

CASE STUDY: THE CLEVELAND CLINIC

To appreciate the potential of EHR at the acute care level, consider the Cleveland Clinic’s MyPractice Community, an efficient electronic medical record system specifically developed for busy private practice community physicians.

Under the larger umbrella of Cleveland Clinic’s eHealth Services, MyPractice Community lets providers access patient data inside their medical practice, at home and while in a Cleveland Clinic hospital. They enjoy seamless, secure connectivity to laboratories, retail pharmacies and even transcription companies. They can post test results through a secure server, allowing patients to view information via the MyChart application. In turn, patients can schedule appointments, request refills and correspond with their physicians.

“As our nine hospitals, our main campus and our community doctors’ are all speaking to each other electronically,” notes Cleveland Clinic’s Kelli Kutsko.

As a result, Daphne Bascomb, M.D., a Managing Director for Cleveland Clinic’s eHealth Service program, says the health system and its referring physicians are experiencing:
• Better care of the patient when presenting in ER/inpatient
• Better sharing of information between primary care and specialty physicians
• Better communication of results with the MyChart patient portal
• Better quality of care supported by Health Maintenance and Best Practice alerts for chronic problems

WHAT’LL IT COST?

The quick answer is that nobody knows for sure. EHR prices will certainly vary across practices of differing size, complexity and area of specialty.

“With new players and new technology coming into play, it may take a while for the dust to settle and prices to stabilize,” says Van Kuiken.

But a landmark study by the Medical Group Management Association Center for Research and the University of Minnesota School of Public Health sheds some light.

Key findings from the study include:
• Purchase and installation costs for EHR averaged $32,406 per full-time-equivalent (FTE) physician.
• The smallest practices paid an average of $37,204 per FTE physician.
• Because they were able to spread the cost of the technology over more doctors, larger practices reported an average cost of $24,988 per FTE physician.
• Monthly maintenance costs averaged $1,177 per FTE physician, with larger practices paying more than smaller medical groups, most likely due to the added complexity of EHR systems designed for multiple locations and clinical modalities.
• Cost overruns (the vendor’s initial estimate compared to actual implementation costs) averaged 25 percent. Medical groups with 21 or more FTE physicians reported the highest difference, with the average cost overrun almost 37 percent more than the initial vendor estimate.

A University of California–San Francisco study of 14 solo and small-group primary care practices found that the average practice covered its EHR costs in 2.5 years. In that study, initial EHR costs averaged $44,000 per full-time-equivalent FTE provider, and ongoing costs averaged $8,500 per provider per year.

WHAT’S THE UPSIDE?

The costs and learning curve of embracing EHR technology can be substantial. But that investment can pay off handsomely, allowing busy providers to slash paperwork and spend more time with patients. Just as important, many providers are finding that the efficiencies created by EHR can help them attain the elusive work/life balance.

Efficiency — Paper charts are notorious for being unavailable or incomplete during patient visits — particularly if the patient is visiting several clinics or has been to the emergency room lately. With an electronic system, “chart pulls” occur at the push of a button. And, when patients call with questions, they can be answered immediately, instead of having to call back after searching for and pulling the chart.

Primary care physicians report that use of an electronic health record improves the quality of care delivered to patients, including reduced medication errors, improved test result follow-up and better communication with other clinicians.

Journal of General Internal Medicine, 2009

Quality care — EHRs greatly support physicians in their efforts to improve quality. EHRs help make certain that health maintenance (e.g., a mammogram or tetanus shot) is being performed. They can also check for drug interactions when prescriptions are written. Practice-wide, EHRs can assist physicians with population-based medicine; looking, for example, at diabetic patients by LDL or Hemoglobin A1C.

Financial benefits — EHRs promise decreases in lost charges, increases in relative value units or charges per visit, decreases in claims denial and improvements in billing cycle time (when used in conjunction with electronic billing). When you fully document a patient visit, you improve chart capture. With improved coding comes improved cash flow and additional collection of co-pays up-front. Published estimates on improvements in chart capture range from 3 percent to 15 percent.
3 STAGES OF RETURN
When weighing the potential benefits of EHR, it’s important to understand that adoption is a process. As a general rule, practices progress through three stages of economic return:

Stage 1: Operational efficiencies. Physicians and staff begin to enjoy faster access to accurate data and experience some initial workflow automation.

Benefits: Reduced overhead and staffing needs.

Stage 2: Increased clinical productivity. Standard care protocols, order management, and outcomes analyses become supported as more information is entered into the system.

Benefits: Quality improvements, regulatory compliance, and reduced risk exposure.

Stage 3: Distinct competitive advantage. A practice using EHR begins to carve out a distinct competitive advantage.

Benefits: The marketplace rewards those practices providing more responsive care to an increasingly selective customer.

WHERE ARE YOU AT?
Currently utilizing EHR — Consider yourself a true early adopter. However, to receive incentive payments, you must demonstrate meaningful use — simply purchasing and implementing an EHR system is not enough. Stay in touch with your EHR vendor for more details about the definition of meaningful use and what qualifies as a certified product. If your use of the system is lacking, the vendor should be able to offer additional training and/or programs that can help increase EHR utilization.

Finally, discuss any certification issues with your vendor; determine when products will be certified or re-certified, and add the stipulation that your products should meet the appropriate level of certification for incentives.

Not currently utilizing EHR — Get going; do your homework, and make informed decisions! Vendors are awaiting final compliance requirements and certification standards from the government, so there is certainly a risk of investing in a system that might not qualify for incentives down the road. But this can be easily addressed during contract negotiations. Under the present circumstances, EHR vendors realize they will have to extend some buyer-favorable terms and conditions in order to sell their systems. Make sure your EHR system is a qualifying system when you buy it, and request that the vendor warrants its qualifying status over time.

Finally, get up to speed by attending professional society meetings and seeking guidance from those with specific expertise in healthcare IT legislation.

MAKING EHR WORK
EHR is more than just an investment in technology — successful implementation requires a focus on people and process management.

Find a strong physician proponent. At least one leading physician in the practice should champion the move to electronic records.

Purchase a system suited to the practice. Have the physicians — not just the office manager, IT person or CEO — define what they want an EHR system to do.

Look for vendors with a track record. Purchasing expensive technology creates a lock-in effect — the company you start with is typically the company you stay with.

Plan in advance. Plan for a phased implementation with clear timelines that allow for sufficient training.

Get tech support for the long haul. Readily available support is a "must" to deal with start-up challenges and ongoing glitches.

EHR Timeline
1. Evaluate your workflows
2. Develop selection criteria
3. Select a vendor
4. Develop your implementation plan
5. Install EHR
6. Connect to other providers
7. Train your physicians
8. Full functionality

WHY "WAIT AND SEE" MAY NOT WORK
The problem with waiting until the dust settles and the rules are finalized is that the market may experience a huge surge in demand as practices rush to implement the system.

“Looking at the potential problems and risks, it may be better to simply jump in and get your feet wet with EHR,” says Dr. Jessee. “If you wait, you’re likely to face long waits for the product. And as demand goes up, there’s the potential for the price to go up, too.”

Indeed, the Congressional Budget Office predicts that 90 percent of physicians will be using EHR in a matter of just a few years. That means that 60 to 70 percent of the market will be vying for vendor attention in the coming years. Even prior to the Stimulus Act, some vendors had waiting lists of up to six months.

Just as important, planning and sourcing an EHR purchase takes time. There are more than 300 EHR system vendors out there, and the transition to a new EHR system can be a timely process when you factor in how long it takes to select, implement, train staff and start using an EHR. Typically, the time requirements of the steps increase in proportion to the size of the group.

Potential Benefits of EHR Adoption:
• Reduced medical errors and unnecessary tests
• Improved preventative care
• Faster delivery of medications
• Improved coding and better claims management
• Increased revenue and decreased expenses
• Increased patient satisfaction
• Improved clinical trials and research

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Problems with Waiting:
• Long waits for products
• Insufficient vendor resources for install/training/maintenance
• More demand + higher prices

FINDING THE MONEY
Because most healthcare practices do not retain earnings, capital equipment such as an EHR is funded directly from physician income. Given the buy-now-get-reimbursed-later structure of the EHR incentive program, healthcare providers may find they don’t have the money to invest.

“Our perspective is that you get your trusted financial advisor involved upfront in the decision-making process,” says Nick Spanakis, group practice manager, PNC Healthcare Business Banking. “Whether that’s your healthcare accountant, your practice management firm or your healthcare banker, they can help you review the choices and provide some counsel based on what they’ve seen with their other clients.”

In general, EHR financing options include:

Leasing — “The simpler and more straightforward the leasing arrangement, the better off you are,” says Spanakis. “Take the time to compare your lease options either with the vendor, your bank or other

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financing solution. We found that healthcare attorneys are great partners in making sure that the doctors are getting into the right lease arrangement.”

Cash — “It should only be done if you have an extremely strong positive cash flow and consult your accountant,” says Spanakis. “It’s important to have some cash reserves, or at least a line of credit to access in case of emergency.”

Term Loans — “We’ve seen that many of our physician practices have chosen terms typically between three to five years, seven years on the topside,” Spanakis says. “This is largely because they feel cautious about not being able to pay for the full system prior to it becoming obsolete.”

Lines of Credit — “A good number of the physicians we work with prefer lines of credit because they like the control factor it provides them,” says Spanakis. But he warns that funding an EHR with a line of credit can be tricky in cases where most or all of the credit is used for the purchase of the system. “We’ve seen as a best practice where the group will take out a loan or a lease to pay for the system and then establish a line of credit to handle any unforeseen circumstances or to provide working capital for further needs.”

THE ROAD AHEAD

In short, EHR is no longer an option; it is fast becoming a necessity for doing business in the world of medicine. “The game has definitely shifted,” says MGMA’s Dr. Jessee. “If you had asked me a couple of years ago, I would have said you may want to wait and see. My inclination now is to do it. The risks are just too high to wait.”

ADDITIONAL RESOURCES:

For an in-depth discussion of the impact of EHR incentives on hospitals, you are invited to join Steven Van Kuiken and Paul Browne for a rebroadcast of their teleseminar, Incentives and Beyond: Maximizing the Opportunities from Moving to “Meaningful Use” of EHR at pnc.com/hcseminars.

Also available on the web site is a replay of the teleseminar 2009 Economic Stimulus Plan: Financial Incentives for Physicians to Adopt and Use EHR. Presenters include Jon Straffon, executive director – Cleveland Clinic My Practice Community, Kelli Kutsko, director of sales and implementation – Cleveland Clinic My Practice Community and Dr. William F. Jessee, president and chief executive officer, Medical Group Management Association.

Healthcare businesses are a priority for PNC. We strive to understand objectives and make financial recommendations that will save time and help practices operate more efficiently. We have a team of healthcare bankers who work one-on-one with physician practices and hospitals.

This document is meant to be informative, not to provide legal or investment advice, but rather to provide insight into issues of interest. Consult your legal counsel and/or financial or tax advisor before taking action on matters included in this white paper.