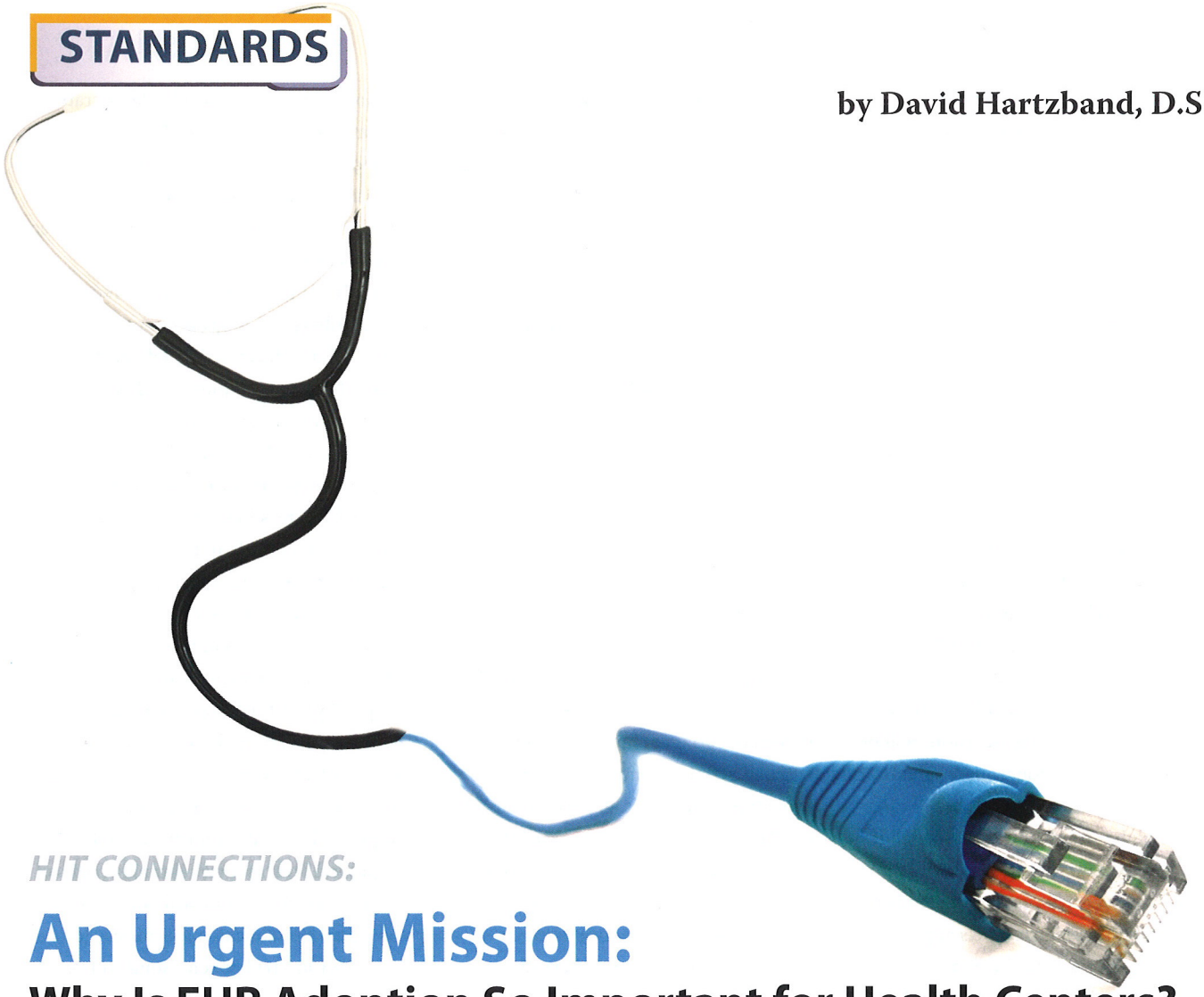
STANDARDS

by David Hartzband, D.Sc.



HIT CONNECTIONS:

# An Urgent Mission:

## Why Is EHR Adoption So Important for Health Centers?

According to available data, adoption of electronic health care (EHR) systems is generally low. Research from the Health IT Policy Committee of the Office of the National Coordinator (ONC) for Health Information Technology at the U.S. Department of Health and Human Services (HHS) indicates that although the majority of providers, including health centers, that have adopted EHR systems have demographic, medication, limited-order entry and results management capability available, they lack decision support or population health functionality.

So how are community health centers doing compared to these general results? In a recently released NACHC survey report on HIT adoption (*A National Survey of Health Information Technology (HIT) Adoption in Federally Qualified Health Centers*, May 2009); 23 percent of health centers surveyed said they used an EHR and were "fully electronic," 26 percent said they used an EHR but were still "part paper," and 51 percent said they did not use an EHR. Given that just over one-third of all health centers responded, this data suggests that eight percent of all community health centers are fully electronic, and nearly 10 percent (9.5%) are part paper and part electronic, for a total of 17.5 percent of all health centers using an EHR.

These figures closely match findings of the HRSA Office of Health IT Adoption (OHIT) that indicate 17 percent of physician offices overall are using an EHR. Applying the description of a *fully functional* EHR that appeared in the *New England Journal of Medicine* (DesRoches, C. et al., NEJM, June 2008), the NACHC survey further found that only seven percent of the responding centers (the equivalent of six health centers) met all of the criteria for fully functional e-prescribing, and none of the health centers reporting that they used an EHR met the criteria for full functionality. Even when the criteria were relaxed, only two health centers would be considered completely functional. This is critical because while *meaningful use* requirements are still to be fully determined, ultimately health care providers will be required to meet the goals in order to be eligible for incentive payments through the American

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Recovery and Reinvestment Act (ARRA) for purchase and implementation of HIT systems.

**Improvement of Adoption in Community Health Centers**

The NACHC survey, authored by Michael Lardiere, NACHC Director of Health and Information Technology, also looked at the main impediments to EHR adoption in community health centers, which include the following:

- **Provider support and a focus on productivity** are crucial to successful adoption. One of the most important and difficult issues in adoption is the need to incorporate the EHR system into the clinical process. This sometimes requires design of provider and non-clinical workflows. Health centers risk loss of productivity—and income—unless the workflow and alignment issues are addressed upfront. Similarly, provider support is essential. Unless providers can be shown that patient care and clinical outcomes are improved by the use of an EHR, they have little incentive to make the effort to adopt a system. **These issues, which often speak to the culture of the organization, are possibly the most critical in the adoption process.**
- **Funding**, especially funding beyond acquisition of a system, for training, system maintenance, infrastructure upgrades and ongoing operational support is often not covered in initial (acquisition) grants. Without such funding, however, it is not possible to ensure the adoption and use of an EHR or any software system. The ARRA provides limited funding for initial adoption, and—as incentive payments kick in only after the system is in use and meaningful use is demonstrated—Medicaid reimbursement does not help in the early phases of adoption.
- **Inability to integrate** with existing software used in the health center is also important, although more easily addressed. Most modern EHRs are capable of sharing HL7 data (health care industry standard) with other software, but it takes real work and expertise to be able to do so. The adherence to data sharing standards is not a guarantee of integration, and health centers will need to plan for this expense and effort.
- **Finally, the applications must meet health center needs.** There is a long history in the development of software technology—not just health IT—of technical developers designing applications that impose a structure, workflow

## What does "fully functional" EHR mean?

According to the Centers for Disease Control and Prevention's National Ambulatory Medical Survey (NAMC) of 2,700 physicians, the difference between full EHR function versus basic EHR function for office settings is that basic EHRs provide patient demographics, medication and clinical notes capability, as well as limited order entry (mainly e-prescribing) and results management functionality, but no clinical decision support, public health informatics or population health functions; full EHRs, on the other hand, offer the broader clinical and population features. A 2008 survey by the American Hospital Association offered similar yet somewhat more hospital-oriented definitions and adds discharge summaries to the "basic function" list.

## What is "meaningful use"?

The ARRA provides up to $49 billion for the adoption of HIT—mainly electronic health records—through Medicare- and Medicaid-based incentive payments to providers and health care organizations. Providers will have to show "meaningful use" of EHR technology in order to qualify for the funding.

On July 16, the Health IT Policy Committee of the HHS Office of the National Coordinator for HIT approved guidelines for meaningful use. These recommendations have been submitted for approval by David Blumenthal, M.D., National Coordinator for Health IT, and will be submitted to the Centers for Medicare and Medicaid Services for final release later this year. While it is not yet known how these guidelines will play out or be enforced, they fall into five general policy areas: improving quality, safety efficiency and reducing health disparities; engaging patients and families; improving care coordination; improving population and public health; and ensuring adequate privacy and security for personal health records. These policy priorities and associated care goals translate into specific objectives for data capture, tracking and performance improvement, as well as measures for each care goal, for the years 2011, 2013 and 2015. Meeting these guidelines will require the adoption of EHR as well as other technologies.

or set of functions that do not meet users' needs. This is just as true for EHR systems as it is for any other software application. It is essential that the health center determine that the EHR being considered meets the specific (and possibly unique) needs of its users. Many current EHR systems are highly configurable so that a health center can adopt the EHR to its workflows and work styles, not the other way around.

Although most health centers are in the process of selecting an EHR system to acquire and adopt, the majority of health centers have yet to begin using such systems. It is important to understand that the *acquisition* of an EHR (or any HIT application) is only the beginning of the *adoption* process. Careful planning before acquisition and during adoption is essential, including infrastructure upgrades as well as workflow redesign, and is necessary to get from acquisition to the productive use of an EHR.

Of those health centers currently using EHR systems, most would not likely meet the recommended *meaningful use* requirements—improving quality, safety efficiency and reducing health disparities; engaging patients and families; improving care coordination; improving population and public health; and ensuring adequate privacy and security for personal health records—as currently defined.

Clearly, meeting these expectations will necessitate that health centers carefully plan how their EHRs are deployed and used over the next few years, which is true of HIT adoption in general. What undoubtedly will qualify as meaningful use is when a health center adopts an EHR productively so that its use improves patient care and health outcome.

The key to successful EHR adoption involves preparing a health center for using an EHR and—perhaps even more critical—consistently and productively using the technology. Experience has shown that it can take at least one to two years to progress from EHR selection to any actual use. Financial incentives for the now-approved guidelines are tied to adoption year, rather than calendar year, which means that health centers must meet the 2011 measures in the first year of meaningful use regardless of what calendar year it is. In any case, the length of time needed to get to meaningful use of an EHR (Computerized Physician Order Entry (CPOE) or other computer-based information system) means that health centers need to start now; otherwise they will not realize any benefit or financial incentive from using HIT until 2015 or later.

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## BOARD Q & A

**Q** **Must the board of directors review and approve the health center's IRS Form 990 before it is filed?**

**A** Although the board is not required to approve the health center's Form 990, the health center must report on the Form 990 whether or not the Form 990 was provided to the organization's board of directors before it was filed with the IRS. According to the Form 990 instructions, an organization can respond in the affirmative only if a complete copy of the final Form 990, including all required schedules, as ultimately filed with the IRS, was provided to each voting member of the board (either in paper or electronic form) before it was filed with the IRS. Health centers must also describe the process, if any, by which the organization's officers, board members, board committee members, and/or members of the organization's management team reviewed the Form 990 (whether before or after it was filed with the IRS), including: (1) specifics regarding who conducted the review; (2) when they conducted it; and (3) the extent of the review. If no review was or will be conducted, that must be reported on Form 990.
This question conveys a clear IRS message on "corporate responsibility." The IRS does not expect every board member to review the Form 990 prior to filing or to participate in its preparation. However, it does expect every board member to have a copy of the form and, presumably, to be familiar with what is reported on it.

*E-mail your questions for Board Q&A to communityhealthforum@nachc.com.*