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EHR/EMR: “Meaningful use,” stimulus money, and the Serenity Prayer

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Theologian Reinhold Niebuhr said, “God, grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference.”

When we read the more than 1,000-page Department of Health and Human Services release on the electronic health record/electronic medical record (EHR/EMR) and consider such concepts as “meaningful use,” stimulus money, pay for performance, clinical quality measures, etc., we feel overwhelmed, frustrated, and ready to switch professions. This feeling has been experienced by physicians many times in the past two decades.

Are we better prepared this time? Our collective otolaryngology leadership at the Academy and all the senior societies were ahead of the game years ago. They have been developing practice guidelines, quality measures, and the like. The otolaryngology leadership also understands the gravity of the medical profession's moving into the digital age.

While embarking on the digital age, we have to preserve as sacrosanct the patient-doctor encounter, the human experience. We need to continue to allow patients to freely express their symptoms. Doctors need to be allowed to keep sympathetic eye contact with the patient and concentrate on listening to the history and performing the physical, and reading and analyzing the test results. Then, together with the patient and the patient's family, they can formulate a treatment plan, prescribe, and order further sophisticated tests (if necessary). Simultaneously, without interrupting workflow, doctors need to be able to collect and enter certain data in a “structured manner” to fulfill “meaningful use.” All these have to be achieved without forcing the doctor to treat fewer patients per day, which leads to less patient access and decreased revenue.

Why is the EHR/EMR so important? If the Centers for Medicare & Medicaid Services (CMS) is going to fix the “sustainable growth rate” without a 23% cut in Medicare fees and without bankrupting Medicare, it needs to introduce pay for performance (P4P). To participate in P4P, physicians need an EHR/EMR. If CMS and the pharmacy chains insist on supporting the use of retail health clinics and still maintain quality of care, they need telemedicine to visually link the physician assistant/nurse practitioner clinics to doctors. EHR/EMR, again, is the tool to coordinate and record telemedicine consultation.

To participate in “meaningful use” and receive the \$44,000 in stimulus money from Medicare, one needs an EHR/EMR certified by the ONC-ATCB (Office of the National Coordinator-Approved Testing and Certification Body). If we are to have meaningful tort reform, we have to demonstrate that we follow the standard of care, adhering to recognized practice guidelines. Here again, EHR/EMR is needed. Hence, our goal is to adopt the right dose of the technology and at

the right time.

Technology is like fire; it can help you or it can kill you. To quote Dr. Vondell Clark of North Carolina, “As we develop these electronic interfaces, it would be wise to remember why we practice medicine, and to develop devices that are more transparent and do not get between us and our patient.” [Dr. Clark's Letter to the Editor in *Medical Economics* can be found in its entirety at:

<http://medicaleconomics.modernmedicine.com/memag/Primary+Care+Medicine/Letters-to-the-Editors/ArticleStandard/Article/detail/154639.>]

In order to receive the stimulus money, one must first locate a user-centric, ONC-ATCB-certified EHR/EMR, and then perform the following steps. Step 1 is to measure and record a total of 3 of 6 core Clinical Quality Measures (CQMs) (table 1).

Table 1. Core Clinical Quality Measures

1. Hypertension: BP (NQF 0013)
2. Preventive care: Tobacco use, intervention (NQF 0028)
3. Adult weight screening and follow-up (NQF 0421, PQRI 128)
4. Weight assessment and counseling for children and adolescents (NQF 0024)
5. Preventive care: Flu vaccination for patients ≥ 50 years of age (NQF 0041) (PQRI 110)
6. Childhood immunizations (NQF 0038)

In addition, one needs to measure and record 3 more CQMs (table 2).

Table 2. Three of 38 CQMs from a different list

1. Pneumonia vaccination status for older adults
2. Appropriate testing for children with pharyngitis
3. Smoking and tobacco use monitoring

Then, one needs to perform the 15 core objectives (table 3).

Table 3. Fifteen core objectives

1. Perform computerized physician order entry (CPOE) (>30% of patients, one med per patient only, order and track).

2. Generate/transmit e-Rx (>40% of patients).
3. Report clinical quality measures (see tables 1 and 2).
4. Include one clinical decision support rule (e.g., if a patient's diagnosis is external otitis, treat with otic drops and not systemic antibiotics).
5. Provide patients with an electronic copy of their health record, *upon request* within 3 business days (flash drive, disk, patient portal/print; >50% of patients).
6. Provide clinical summaries for each office visit (history and physical, Rx, test results, Rx plan, educational materials; >50% of all office visits).
7. Perform drug-drug, drug-allergy checks.
8. Record demographics (date of birth, language, sex, race, ethnicity (>50% of patients)).
9. Record current diagnoses (ICD9, etc.; >80% of patients have at least one entry or indication that no problem is known).
10. Maintain active medication list (>80% of patients have at least one entry or an indication that the patient is not currently prescribed any medication).
11. Maintain an active medication allergy list (>80% of patients have at least one entry or an indication of no known medication allergies).
12. Chart vital statistics: height, weight, body mass index (>50% of patients ≥ 2 years of age).
13. Record smoking status for patients ≥ 13 years old; >50% of patients).
14. Exchange clinical information with other providers (with patient's approval).
15. Protect electronic health information (HIPAA, screen name, alphanumeric passwords, security levels, encrypted, "babysitter password," iris scan, fingerprint, "catch-22").

Then one needs to perform 5 of the 10 noncore objectives (table 4).

Table 4. Address 5 of 10 noncore operational objectives

1. Implement drug formulary checks.
2. Incorporate lab test results as structured data (>40% of patients).
3. Generate lists of patients by specific conditions (ICD9, etc.).
4. Send reminders to patients for preventive/follow-up care (>20% of patients ≥ 65 years or ≤ 5 years old).
5. Provide patients with timely electronic access to their health information (>10% of patients).
6. Provide patient education materials (>10% of patients).
7. Perform medication reconciliation for patients received from another care setting or provider of care (>50% of patients).
8. Provide summary of care/referral letters (>50% of transitions of care).
9. Submit electronic immunization data to immunization registries (at least one test).

10. Provide surveillance data to public health agencies (at least one test).

The stimulus award from Medicare will be phased in from 2011 to 2014. [Figure 1](#) illustrates the amount of money we will receive. (Note: A provider can receive stimulus money from either Medicare or Medicaid; this article discusses participation in Medicare. Participation in Medicaid is more complicated and varies from state to state.

Figure 1. Chart shows the phase-in of Medicare incentive payments (columns = first calendar year the eligible provider [EP] receives a payment; rows = amount of payment each year if the EP continues to meet requirements).

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later
CY 2011	\$18,000				
CY 2012	\$12,000	\$18,000			
CY 2013	\$8,000	\$12,000	\$15,000		
CY 2014	\$4,000	\$8,000	\$12,000	\$12,000	
CY 2014	\$2,000	\$4,000	\$8,000	\$8,000	\$0
CY 2016		\$2,000	\$4,000	\$4,000	\$0
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0

[Figure 2](#) illustrates the additional 10% incentive if the physician practices in an underserved area.

Figure 2. Chart shows the health professional shortage-area bonuses for the Medicare incentive program (columns = first calendar year the EP receives a payment; rows = amount of payment each year if the EP continues to meet requirements).

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later
CY 2011	\$1,800				
CY 2012	\$1,200	\$1,800			
CY 2013	\$800	\$1,200	\$1,500		
CY 2014	\$400	\$800	\$1,200	\$1,200	
CY 2014	\$200	\$400	\$800	\$800	\$0
CY 2016		\$200	\$400	\$400	\$0
TOTAL	\$4,400	\$4,400	\$3,900	\$2,400	\$0

If a Medicare provider is not in compliance, its 2015 Medicare reimbursement will be reduced by 1%, in 2016 by 2%, and in 2017 and beyond by 3%.

If the doctor or the office manager takes the time to read the requirements carefully, it is not so hard, provided the EHR/EMR selected can help to accomplish the 12 steps outlined in table 5 without creating downtime, upheaval, and inefficiency.

Table 5. Workflow (must be capable of doing these steps efficiently)

Steps for the clinician

1. Record patient ID, date of birth, social security number, language, ethnicity, race, sex.
2. Record medications/allergy to medications.
3. Record review of systems (ROS).
4. Record:
 1. Previous history of present illness (HPI) and physical examination (chief complaint, history, and physical).
 2. Current HPI and physical examination (chief complaint, history, and physical).

Write on the tablet (stored electronically, not on paper; eliminate paper charts); type or use handwriting recognition application; use voice recognition application; or dictate to transcriptionist.

Macros must be editable (“one-size-fits-all” is frowned upon); generate notes for quality care and do not use macros just to upcode).

Use customized digital history and physical examination (decision tree).

Steps for the enabler, the tool, and the EHR

5. Have quick and intuitive access to test reports (filing cabinets).

6. E-prescribe and list the physician's frequently used meds for efficiency.
7. Order and track tests; have an “In Box” to receive all test results for the doctors to read and

assign before filling in the patient's e-chart.

8. Order and track referrals.
9. Order and track future surgery.
10. Code for reimbursement and use code guide to code accurately, not upcode.
11. Schedule next appointment.
12. Generate referral letter, educational materials, and instructions to patients.

It is best to assign the staff to perform the steps outlined in table 6. The most important factor related to an EHR/EMR is that the doctor must be allowed to perform what the doctor does best—i.e., the history and physical, analysis of test results, and formulating and executing the treatment plan.

Table 6. Collection of structured data by staff

1. Demographics
2. Medication list
3. Allergy to medication list
4. ICD9s
5. Vital signs, height, weight, body mass index
6. Smoking history
7. Lab results
8. Family and social history
9. ROS

The installation of the EHR/EMR must be achieved with minimal downtime and practically no disruption of office routine. If properly implemented and with a physician or staff “champion” in the office, EHR/EMR can lower the office overhead in terms of reducing office space and staff, and it can provide other advantages. For example, more than one person can access the medical record simultaneously; no one needs to hunt down the chart and refile it; the medical record is accessible anywhere, anytime, especially when one is on call or in the hospital. Remember, however, that the world can never be 100% paperless, and, likewise, our practices can never be 100% paperless. Be wary if someone tells you to become totally paperless.

It is not so bad. It can be done. Let us create a win-win, making lemonade out of lemons, looking at the cup as half full instead of half empty. Cheer up and feel free to ask for help.

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