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Federal Stimulus Money for Electronic Health Records: Quick Read Summary for Chiropractors

By Daniel Redwood, DC

In this issue of Health Insights Today, we feature two interviews with health information technology experts: Joe Brisson, a consultant to doctors, corporations and government, and Steven Kraus, DC, an Iowa chiropractor who founded a health care software company. This "Quick Read" summarizes the key points in those interviews.

The American Recovery and Reinvestment Act (ARRA) of 2009, also known as the "stimulus bill," includes \$19 billion for converting the U.S. health care system from paper to digital over the next decade. Health care system participants ranging from hospitals to insurance companies to doctors (including chiropractors) are given a strong push into the digital age, with significant financial incentives to implement electronic health records (EHR) starting next year.

Doctors who implement qualified EHR protocols can receive a maximum of \$44,000 in reimbursements from the federal government. *It appears that this will be entirely tied to the Medicare program*, which insures elderly and disabled Americans, with money paid in the form of increased reimbursement rates for Medicare visits. Those who demonstrate meaningful use of EHR in 2010 can receive up to \$18,000 in 2011, \$12,000 in 2012, and decreased amounts for the next two years, up to a maximum of \$44,000. No funds allocated for EHR implementation under the stimulus bill will be available after 2014, although Congress could later enact laws to extend the reimbursement program.

According to Steven Kraus, DC, based on meetings with staff at the U.S. Department of Health and Human Services, there were early indications that federal reimbursements would be available only to doctors who bill Medicare at least \$25,000 per year in approved services. However, as we go to press, this policy has not been finalized and it appears that the eventual regulations may allow reimbursement on a pro-rated basis for chiropractors (and other practitioners) whose annual approved Medicare billings fall below the \$25,000 threshold. At the average chiropractic Medicare payment of \$33 per visit, an average of 16 Medicare visits per week is needed to reach \$25,000 in annual approved Medicare billings.

It is expected that reimbursement will be calculated at 75 percent of Medicare billings, up to the annual caps. In addition, doctors must also demonstrate "meaningful use," defined as creation of an EHR for 80 percent of patients, on a system certified as interoperable with other certified systems in widespread use. The EHR needs to be a part of case management and improving quality of care. This is why most current digital note generators will not qualify as interoperable EHR, since they do not provide meaningful use other than enhanced legibility of the doctor's notes.

Why the Government Is Pressing for Digital Conversion

While EHR may have the capacity to benefit health providers economically through increased intra-office efficiency and decreased overhead, this is not the primary driving force behind the push for digital conversion by federal and state governments. The overarching policy goal is to increase quality of care and decrease costs to the overall health care system through creating information systems in which practitioners have quick access, in a well-organized and prioritized format, to relevant aspects of a patient's health record. For a chiropractor, examples of this would include prompt electronic access to x-rays or MRIs taken at a local hospital, as well as information on relevant aspects of a patient's history, diagnoses, lab results, medications, and treatments recommended by other doctors.

While a patient's paper records have historically contained such information, this is often spread out across several doctors' offices, and the desired data is often hidden deep within an inches-thick paper file. Accessing this

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information can require a significant amount of time for staff members to locate and then fax or mail the documents, with delays not uncommon. Qualified EHR programs are designed to create lists, reminders, alerts and warnings so that the busy doctor is not required to rely solely on his or her memory for relevant information about a patient. Thus, reduction of doctor errors is a key selling point of integrated EHR systems. Moreover, because many patients see several doctors, adverse interactions between drugs or other treatments may be minimized by a properly functioning EHR system, as would various redundancies of care. An additional benefit of EHR is that the electronic files are backed up offsite, eliminating the possibility of destruction by fire or flood, as occurred with Hurricane Katrina, when countless Gulf Coast doctors lost all of their patient records.

Also driving the move toward EHR is the fact that broad implementation of such systems will allow quick access to large amounts of data for researchers to use in determining effectiveness. This may become part of the federal government's comparative effectiveness research agenda, now being revived for the first time since the mid-1990s, when Congress forbid the Agency for Health Care Policy and Research (AHCPR), and later its successor agency, the Agency for Healthcare Research and Quality, from developing condition-based guidelines. This followed an outcry from surgeon groups upset that the AHCPR guidelines on acute low back pain had denounced excessive and inappropriate early use of surgical procedures, in guidelines that also identified spinal manipulation as one of only two doctor-delivered procedures for low back pain supported by the scientific literature.

The Question of Confidentiality

A significant area of concern about the shift to EHR relates to the creation of a single cradle-to-grave record containing an individual's complete lifetime health record. For example, if someone was treated for drug dependency, or depression, or incest-related rape at a young age, should this information be readily accessible by every doctor (or staff member) involved in their care for an unrelated condition at age 50? And should it be available to potential employers, insurers, voters (if the patient runs for office), or to anyone using the World Wide Web if a rogue medical staff member decides to upload a digital document?

The answer, according to Joe Brisson of HIT Associates, is that no document (even those at the CIA) can ever be considered perfectly secure, but that anyone accessing or forwarding such a document without permission would be subject to very harsh penalties. The security settings in certified interoperable EHR systems can precisely identify all who have accessed a particular document. As Brisson puts it, for a doctor spreading such confidential information without permission, "it would be the last time you ever practice." Both Brisson and Steven Kraus, DC, of Future Health Software, also note that a patient's records are not all stored at one location. Interoperable EHR systems work by swiftly gathering requested information from multiple sources, not by keeping them all in one database.

Significantly, Dr. Kraus emphasizes that "the patient is in control of what gets shared." Patients must approve the sharing of records, and can decide what is to be included in any data transmission between offices. Patients will have personalized health records (PHR), composed of all their available health data. If the patient does not approve the sharing of certain data, it cannot legally be shared.

Kraus also reports, based on conversations with staffers at the Department of Health and Human Services and the Office of the Coordinator for Health Information Technology, that these agencies are acutely aware of possible fears of "Big Brother," and that the idea of creating a massive, centralized database "is not even on the table right now, because it is widely understood that there is no way the American public would accept it at this time." For now, the data will remain decentralized. It will be up to future citizens and governments to ensure that it remains so.

Daniel Redwood, DC, is Editor-in-Chief of *Health Insights Today*.