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Integrating Information Technology Into Your Practice Interview with Steven Kraus, DC

Steven Kraus, DC, is chair of the Iowa Board of Chiropractic Examiners and a former president of the Iowa Chiropractic Society. He is the Iowa delegate for the American Chiropractic Association (ACA) and a member of ACA's Medicare committee. Dr. Kraus is also the president and CEO of Future Health, Inc., an electronic health records and chiropractic practice management company with 40 employees.

Dr. Kraus has practiced chiropractic for over 20 years and serves as clinic director of a multidisciplinary clinic in Carroll, Iowa, which includes two chiropractic physicians, a family practice physician, a certified physician assistant, a physical therapist, physical therapist assistants, an athletic trainer, and two massage therapists. His clinic has been visited by Iowa Governor Tom Vilsack (now Secretary of Agriculture) and Senator Tom Harkin, who mention it frequently when encouraging the healthcare community to embrace the collaborative effort of disciplines working together and using EHR technology.

He is a sought-after speaker on a wide range of health-related topics, including health electronic health records, clinical documentation, Medicare regulations and guidelines, integrative practice, and the role of chiropractic in the health care system.

What does an individual chiropractor gain by converting to EHR, both within the practice and when interacting with doctors or insurance companies outside the practice?

There are three main things that they gain: efficiency, quality of care, and financial incentives now or avoiding the financial penalties when this is mandated in the future. Number one is the efficiencies in the office, which range from overhead cost savings to streamlined communications within the different departments of the office, and the possibility of lowering other areas of overhead. One example: consider the time it takes to pull charts in the morning and then file those charts again. Assume that a staff member has to open the file, pull some papers out, two-hole punch another document, place it in the file and put the two prongs back. We've done time trial studies to try to measure the cost savings. We estimate that the average chiropractic clinic (which sees 140 patient visits per week), would save \$2600 annually through staff time saved while accomplishing the same goals with electronic health records. So that's one simple example of efficiency.

The second thing the doctor gains is better quality of care. The real purpose of an EHR is not just to digitize the notes. If that were the case, then technically you could argue that dictating your notes would be the way to go, because it's all neatly typed out in a Word document. But that's not the intent of an EHR. The reason they want a "qualified" or "certified" EHR, which is described with terms like "interoperable," is because the purpose is to improve the quality of the care. That's the reason they're driving health care professionals to do this. It's not just for your own office efficiency, but for improved quality so that there are logs, repositories, alerts and reminders for case management, and so that the information can be shared electronically with other health care providers.

Could you give a typical example related to chiropractic practice?

Let's say you've given home exercises and nutrition recommendations to patients. What is the doctor's method for following up on patient compliance with those recommendations? The beautiful thing about technology is that it can help us manage cases on a timely basis. It becomes overwhelming for the busy practitioner to remember exactly what he might have recommended to every patient. He might have to go back and look deep in the paperwork of the chart.

Health Insights Today

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Summer 2009, Volume 2, Issue 3

Page 2

The EHR will automatically generate lists or logs for certain types of patients and point to the kind of follow-up that they need. In the medical world, with diabetes, following up with certain medications and certain exercise regimens for these patients requires time. How does the doctor remember, with all 200 of their patients who have the diagnosis of Type II diabetes? With a chiropractor, it might be following up with MRI results. The EHR would alert you that the MRI result had come in. Maybe the patient isn't coming back in until they find out if there is a disc herniation. This provides the reminder. It helps us to manage our cases better. This is just one of many possible examples.

EHR will also allow us to follow certain guidelines more easily. In chiropractic, there's the CCGPP [Council on Chiropractic Guidelines and Practice Parameters], the NCQA [National Committee for Quality Assurance] low back guidelines, the Mercy guidelines and many individual insurance company guidelines. How in the world is the average chiropractor supposed to keep track of that, when they differ from each other, when one third party payer wants it this way and Medicare wants it that way?

So it organizes this information and tells you how to proceed consistent with the guidelines you are choosing to follow.

Exactly. The software knows which classification the patient is in and it guides you through the procedures in that guideline. Now, the majority of EHRs today do not do all of this. And the majority of chiropractic software does not qualify as a true EHR.

Who determines what qualifies?

CCHIT, the Certification Commission on Health Information Technology. This is a nonprofit agency that has been endorsed and used as the certifying body by the federal government since 2006. Medicare and the ONCHIT [Office of the National Coordinator for Health Information Technology] reference CCHIT as the valid certifying body.

And you have developed software that you use in your own paperless clinic in Carroll, Iowa, and which is marketed to others.

Yes. Our company now has over 40 employees and we have over 1000 users in 48 states using the Future Health system called the Virtual Office Suite (VOS). I developed this company out of frustration that there wasn't an existing system out there that met the needs of the chiropractor. I used to own four different digital documentation systems and billing systems and I was frustrated that they couldn't manage the practice. They might have been able to manage billing, but they weren't managing the overall integration of the clinic, scheduling, documentation, storage of the documents, and practice management information. We needed to take all these different components of a practice and integrate them so that alerts, reminders and tracking systems were in place so that the doctor could really manage his clinic. Also, it was all about speed. Previously, I couldn't create a compliant note quickly enough. With the other systems I had purchased, it was actually taking me longer to document in that digital format than it was with my own customized paper system, with check-offs and circling of data. That's what led me to dive into the software world several years ago.

Is your software now certified by CCHIT?

No, it is not. We are in that process now. As of January 2009 there was no chiropractic specific software that was CCHIT certified. It's important to become certified, because in order to participate in the economic stimulus funds (although the regulations are not yet set in stone), it looks virtually certain that in order to receive payments from the stimulus funds, you will have to use a CCHIT certified system.

Health Insights Today

A SERVICE OF CLEVELAND CHIROPRACTIC COLLEGE

Summer 2009, Volume 2, Issue 3

Page 3

I understand that the federal reimbursement to doctors (including chiropractors) for the purchase and implementation of this software will only be available to doctors through Medicare.

That is exactly correct. I read the bill inside and out, and I also have information that's not in the bill, straight from the Department of Health and Human Services, where I had meetings last week. The framework is there, but the specific details still have to be worked out. In a nutshell, the money will come through your Medicare check.

Does the chiropractor have to have a certain volume of Medicare billings to qualify?

This is not yet certain. We are likely to know the answer by end of 2009. Early information about the plan indicated that a provider would have to bill \$25,000 annually to Medicare (in approved billings) to qualify for any reimbursement, but more recent information indicates the possibility that reimbursement might be available on a pro-rated basis for those chiropractors who bill Medicare less than \$25,000 per year. Let's work those numbers backwards. With the average Medicare reimbursement for chiropractic services at \$33 per visit, that comes down to 63 Medicare visits a month, or 16 visits a week. If you have that many Medicare patient visits per week, you will likely qualify.

How does the government calculate the amount that the qualifying doctor is reimbursed for the software?

It's based on the amount you are billing Medicare, not on the dollar amount you spent on the software. It's based on 75% of what you billed to Medicare, but paying you a maximum of \$18,000 in 2011, which is the first year that anyone will receive such payments. Then in 2012, the maximum is \$12,000. The maximum that a doctor can receive in total reimbursement is \$44,000. You might have only spent \$10,000 on your software, but they also recognize that there was also money spent on your training, hardware, and implementation and that you might have lost some income because you had to slow down for four weeks when you first implemented EHR. But if you don't implement in 2010, you won't be eligible for the 2011 payments. You'll have to wait until the following year. And the amounts get reduced each year, so you can't get the full \$44,000. Again, these rules are not set in stone but this is the framework that they are leaning towards. Early adopters have the financial edge.

So that's an incentive to implement early.

By the time 2014 ends, there's no expected reimbursement at all. After that, starting in 2015, they will start reducing your Medicare payments by a little bit more each year if you don't have it implemented. Also, it's not just that you bought the software. You also have to show that you are "meaningfully" using it, based on individual reporting measures. For example, chiropractic physicians currently qualify for three individual reporting measures in the PQRI program (Physician Quality Reporting Initiative): pain assessment, functional outcome assessment, and use of a qualified EHR (defined as one that is CCHIT certified or includes searchable laboratory reporting, a medication list and a problem list). So chiropractors will have to report on their claim forms on every visit that they are using a certified EHR.

Based on these criteria, our software is Medicare qualified in the current PQRI program and we are now in the process of becoming CCHIT certified by the end of this year. My prediction is that there will be approximately four or five chiropractic software vendors that will become CCHIT certified between now and the first part of 2010.

How much does EHR software cost?

Health Insights Today

A SERVICE OF CLEVELAND CHIROPRACTIC COLLEGE

Summer 2009, Volume 2, Issue 3

Page 4

I can give you figures for a chiropractic “qualified” EHR system. Again, this is much more than just a digital note generator. It should have the ability to communicate with or retrieve data from other computerized systems outside your clinic and also with any digital systems in your office, such as a digital x-ray or computerized inclinometry systems. It would need to be able to accept, for example, an MRI image from the local hospital into your EHR system. CCHIT also has requirements for administrative controls and security settings for each document, and requires controls for who has the right to view certain documents. For example, does your staff need to have access to certain documents? All of this must be compliant with HIPAA regulations.

For the initial software, you are looking at somewhere between \$12,000–\$14,000 for a true EHR and then when you buy hardware and go to the cost of training your staff, you are probably looking at an additional \$5,000–\$10,000. So for the average chiropractor, it’s in the \$20K range, assuming they need some new hardware.

The average chiropractic office has 2.5 office staff and one chiropractor. They are working out of two adjusting rooms, and we recommend putting a work station in each room. Walking around with a tablet has been proven to be sexy but neither practical nor efficient. Having a simple, reliable \$450 work station in each room will work, and then you’re networked within your office so you control your own data. From a survey we did in May 2008, 76% of all chiropractors want the patient data in their own office and to have control of it, as opposed to using a 100 percent web-based application, with the data stored somewhere else. I do believe that we’ll start to see that change over time, since the younger generation is more comfortable with the web hosting their data and trusting the outside world with their data. In either case, you would have off-site data backup.

What we are now talking about with electronic health records is having each individual in the United States with a cradle-to-grave record kept, which follows you everywhere you go. This has really never been done before. What about concerns of confidentiality? For example, what about a 50-year-old not really wanting it to be known that he or she had an episode with drugs or depression, or being raped or sexually abused, or whatever, at age 15?

I understand the concern. While some might want to achieve such a comprehensive record eventually, at this stage of health information technology, it’s nothing close to that. *There is not going to be just one location for somebody’s full EHR.* What more than likely is going to happen is that your patient, Mrs. Jones, has a cardiologist, a chiropractor, a GP and a gynecologist. Four different doctors, and all four doctors have a separate EHR, using different software, but with the interoperability for these EHRs to communicate certain data between them, *if the patient authorizes certain data to go between them.*

That’s a key point.

Yes. The patient is still in control of what gets shared. So this leads to the advent of the PHR, the personalized health record. The patient will instruct the doctors to transmit their data to their PHR, that they are in control of. And then when Mrs. Jones goes to a fifth doctor, she can simply click the desired items, such as the obvious demographics, the history, and so on, and submit that to the fifth doctor. So now if she’s got an orthopedic problem and needs hip surgery, she can transmit the data that she chooses directly to that surgeon. That is how I see it happening.

There may be Big Brother people out there who want to have a master repository somewhere. But that 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.

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