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## WEBINAR TRANSCRIPT

### Meaningful Use and Its Implications For Your Practice

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**Panelist(s):** Dr. David Blumenthal, National Coordinator for Health Information Technology and Dr. Michael Zaroukian, FACP, Chief Medical Information Officer for Michigan State University.

**Category:** Meaningful Use

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**Dr. Barr:**

Thank you all for joining this evening's presentation. On behalf of the American College of Physicians, our partners Cientis Technologies, and the sponsor for this presentation, Hewlett Packard, let me welcome you to the first webinar of the new online community, AmericanEHR Partners. Our goal is to provide a national, credible transparent resource to support the selection, purchase, implementation and optimization of health information technology in practices of various sizes and in various specialties.

AmericanEHR Partners launched on July 13th, just about 3 weeks ago. As of July 31st, there are over 3,600 registered users and visitors from more than 1,200 cities across the United States with access to information on the site, and the interest continues to grow. Almost 500 people have registered for tonight's presentation and many more have indicated an interest in viewing the recorded session once it is posted to the AmericanEHR site, which will occur approximately 48 hours after the completion of the event. In the coming weeks, we will continue to add content, the EHR users' survey results, and new features. We always welcome your comments and suggestions. Just send us an email at [feedback@americanehr.com](mailto:feedback@americanehr.com).

It is my sincere pleasure to welcome 2 distinguished speakers. Drs. David Blumenthal and Mike Zaroukian will take us through the topic for today's event: Meaningful use and its implications for your practice.

I will introduce our first speaker momentarily, but first a bit about the format. Each speaker will give a 15 to 20 minute presentation. Dr. Blumenthal will not be using slides tonight. During the presentation please enter your questions, as Jennifer has described, into the Q&A box on the bottom right of your screen. At the end of the second presentation by Dr. Zaroukian, I will moderate the questions and ask our speakers as many of them as possible.

Our first presenter is Dr. David Blumenthal. Dr. Blumenthal serves as the National Coordinator for Health Information Technology under President Barack Obama. In this role, he is charged with building an interoperable, private and secure nationwide health information system and supporting the widespread meaningful use of health information technology. Dr. Blumenthal received his undergraduate medical and public policy degrees from Harvard University and completed his residency in internal medicine at Massachusetts General Hospital. Prior to his appointment to the Administration, Dr. Blumenthal was a practicing primary care physician, Director of the Institute for Health Policy and the Samuel O. Thier Professor of Medicine and Professor of Health Policy at the Massachusetts General Hospital Partners Health Care System and Harvard Medical School. I'd also like to acknowledge that Dr. Blumenthal is a fellow of the American College of Physicians.

Dr. Blumenthal, thank you for joining us and please go forward.

*(time stamp 03:00)*

**David Blumenthal:**

Thank you very much. I want to thank the American College of Physicians for their leadership in working to improve the health of Americans. They have been a very valued partner to the Office of the National Coordinator and the Administration during the process of producing our policies for implementing the HITECH law, which I will describe a little more in a moment. I want to thank also Dr. Barr for having me today and acknowledge the help that Dr. John Tooker has been, and I am looking forward to working with Steve Weissman [Weinberger], who is a colleague of mine from the Harvard community.

I also think that this AmericanEHR Partners program, of which this program is a part, is exactly the kind of program that we at the Office of the National Coordinator hope will be routine for the leadership

of physicians nationally, because, as I will reiterate again later on, we really think that the leadership for the transformation of U.S. healthcare has to come from the professional community, and that physicians have to lead that professional community as we build a 21st century healthcare system. I am right now in a position to influence and take part in the work of the Office of the National Coordinator of Health Information Technology.

As Dr. Barr suggested, I was and am first and foremost a primary care physician. I'm not an informatician or a technology specialist. As a matter of fact, my introduction to technology came in my role as a primary care physician when the hospital I worked at put an EHR on my desk. It was not something I was looking for and not something I particularly welcomed, but I quickly found that my younger colleagues took to it like ducks to water and that to keep up with them and be part of my working member practice group, I really had to learn how to use electronic health records. I did that. I needed some help to do it, but I got through it and I found that it was really improving my practice personally and my capacity to serve my patients in very important ways in terms of connecting me with the events of their medical lives, knowing what medicines they were on, knowing what the cardiologists, pulmonologists and neurologists were recommending, knowing what the surgeon had done at last visit, knowing what the biopsy result and what the mammogram results were. It made me much better in my role as a general internist and convinced me that it was a technology that was going to reshape health care as we knew it. That was why, when the chance came along to participate in this role that I went ahead and did it. It wasn't out of my love of technology. It was out of commitment to improving the health care of patients, and that's really the focus of our office and of our program. It is first and foremost about making patient care better, making individual patient care better, and population health better. As we get on to discussing meaningful use, which I am sure is on everyone's mind, I want to reiterate that the framework for meaningful use that was produced by the Center for Medicare and Medicaid Services and the Office of the National Coordinator, is firmly grounded in thinking about and striving for improving the practice of medicine and the practice of care for patients, and moving us into a future in which quality and efficiency of healthcare improve continually.

*(time stamp 07:07)*

Now we knew, from previous work, that if we were going to spread the availability and use of electronic health records, we had to overcome 3 major barriers that physicians and hospitals and other providers were telling us got in the way of their use of electronic health systems. The first of those was financial—the cost of acquiring and maintaining electronic health records. The second was logistical and technological—the fear that the physician, especially smaller groups, would purchase the wrong record or one that wasn't up to what they needed to do, that they wouldn't be able to implement it, that it might go down at critical times, and that they wouldn't be able to maintain it. The third was the lack of an infrastructure for exchange, and the lack of technical capability in communities around the country to move information up the street or across the street from one geographic location to another so that it could follow patients and connect physicians and other health professionals and hospitals to give a unified picture of patient care.

A HITECH law, which was part of the stimulus legislation passed in 2009, systematically addressed each one of those barriers, and though meaningful use is foremost on many folks' minds, I think it is really important for people to understand that this is a comprehensive program, not just a program about meaningful use; it has many other moving parts, and I'll try to just touch on them. First and foremost, of course, there is the meaningful use regulation. It's a complicated regulation, and I don't propose to try to summarize all its major provisions here today. What I would like to say is that it is ambitious but, we think, achievable. We think it's achievable by physicians in large groups or employed physicians. We also think it's achievable by small practices and solo practices, and for the latter group, smaller and solo practices, we are

putting in place mechanisms to provide special help to get over some of the barriers we talked about. Of course, the financial benefits have been described in some detail. If you are a meaningful user of the electronic health record and sustain that status from 2011 to 2015, you can receive up to \$44,000 in extra Medicare compensation or \$63,750 in extra Medicaid compensation. If you are not a meaningful user in 2015, there may be Medicare penalties coming forward. That's not true, by the way, of folks who are qualifying as meaningful users under Medicaid. We noticed that the original regulation we published last December received an awful lot of comment. We were told by a lot of groups, including the ACP, that it was too demanding, too inflexible, too much an all or nothing kind of a rule, and we listened and we changed it. It now has optional, qualifying objectives. There is a menu of 10 objectives of which you need to pick 5, and then there are 15 other required objectives to be a meaningful user. All the thresholds and the measurement requirements that you have to get through to be a meaningful user have been reduced. The absolute number of requirements that you have to meet have been reduced. The ACP continues to recognize that some practices and some individuals will have a heavy list to get to meaningful use. I think it is fair to say that they think the rule has been modified sufficiently and that it is fair and achievable at the current time.

*(time stamp 11:39)*

I know there is a lot of anxiety about whether there will be enough certified electronic health records available in enough time to get on the escalator, and to get started in becoming a meaningful user. Let me say something about timing. The program for meaningful use begins January of 2011 for physicians. You can begin to qualify as a meaningful user on January 1, 2011, but it is not true that you have to be ready when the clock strikes midnight this coming January. In fact, you can start being a meaningful user on October 1, 2012, and still qualify under Medicare for the full \$44,000. In other words, you can become a meaningful user 2 years from this October and collect all the incentive monies that are made available under this law. You have 2 years to wait and see what records are on the market, 2 years to try them out, and 2 years to work with them before you announce to Medicare that you are ready to become a qualified, meaningful user and ready to try to meet the requirements under meaningful use. We will have certified electronic health records on the market as of this October, and I think there will be plenty of time for people to look at what's available and make informed choices if they don't already have an electronic health record.

Now I mentioned that there is more to this program than meaningful use. One of the things the Congress understood and instructed us to do was to try to overcome that second barrier I talked about. The first barrier is financial. The second has to do with logistical and psychological barriers. We have set up a system around the country of 60 regional extension centers. These are local support services. You can imagine them as kind of meaningful use HIE geek squads. They are available specifically to help small practices in underserved areas and in primary care to obtain meaningful use. They are there to provide elbow-to-elbow, shoulder-to-shoulder help to folks who think they need it. They are there to help not only install electronic health systems, but to help maintain them, to help answer questions about them, to help manage problems if they go down and to make your transition to meaningful use as painless as it can possibly be.

We are also doing a bunch of other things. Some of you may be located in certain communities. There'll be about 17 of them when we finish that are so-called beacon communities. These are programs in which we've focused particular resources to try to improve health care outcomes and improve health care efficiency. You can find out what those communities are by going to <http://healthit.hhs.gov>, the website of the Office of the National Coordinator. There are many other programs that we have underway. They are described on our website. If you want more detail about meaningful use you can also go either to our

website or to the Center for Medicare and Medicaid website at the federal government.

I want to conclude my prepared remarks by saying that I believe, as I said before, ultimately the transition to a modern health information system is going to be a professionally-led transition. When I was learning to be a physician, I learned to take my histories and physicals and write up my laboratory and x-ray results and EKG and urinalysis, and do my differential and plan according to a formula that was presented to me in a little red book that Harvard Medical School gave to all the people who were learning how to do records on paper. No one in the federal government taught me how to use paper. It was the profession, my mentors and my teachers, who taught me how to be a competent physician in the paper world, and that is how we have to teach physicians, young physicians to be competent in the electronic world. Using information and recording patient information, is a core professional competence. We all learn it as part of becoming physicians. We now need to learn it in the electronic form. I have 2 children in medical school and I assure you that they are going to learn that competence and that they are not going to practice medicine on paper. I think it's time that we caught up with that generation. This is an inevitable transition. It is as inevitable as the progress of science and technology. The federal government is here mostly to kick it off, but it's groups like the American college of physicians and their leadership of this program that, I think, are soon going to be setting the trend and setting the pace for improving health care through modern information management. We are delighted to be able to partner with them in this endeavor. We do view this as a partnership. We want to listen and hear and learn as we perfect the meaningful use and other regulations about how we can make that transition easier for you in your practices, whatever size they are, whatever age you are, and whatever your plans are professionally.

I'll conclude there and just say again, thank you to the College. I've never been prouder to be a member of the College or to be a fellow. I'm delighted with its leadership and I hope to be able to support it going forward. Michael, back to you.

*(time stamp 18:02)*

**Dr. Barr:**

Thank you so much, Dr. Blumenthal. I appreciate your presentation and your comments, and again I encourage folks to please enter your questions into the Q&A box at the bottom right. We're getting a nice line of questions to be asked at the end of the presentation of our next speaker.

Now I'd like to introduce Dr. Michael Zaroukian. Dr. Zaroukian is Professor of Medicine and Chief Medical Information Officer at Michigan State University. He is also Medical Director of Clinical Informatics and Care Transformation for Sparrow Health System where he also serves as EHR Project Medical Director. Dr. Zaroukian uses an EHR on a daily basis in his primary care internal medicine practice which achieved a strong financial and quality return on investment from EHR implementation, including designation as a patient-centered medical home. Dr. Zaroukian is a past president of a large national, EHR user group, a fellow of the American College of Physicians, and currently serves on the ACP Medical Informatics Subcommittee, the HIMSS Ambulatory Information Systems Steering Committee, and the American Medical Association Health IT Advisor Group.

Dr. Zaroukian, thank you very much for joining us on this presentation. The floor is yours.

*(time stamp 19:18)*

**Mike Zaroukian:** Thank you very much, Dr. Barr. Good evening everyone. It's my pleasure to discuss some of these issues with you tonight from the perspective of the physician and the practice that is trying to move in the direction of meaningful use and to try to help provide some perspective from someone who's been down that path on a number of issues.

First of all, for example, why is it worth striving to become a meaningful user? As Dr. Blumenthal indicated, this will be a bit of a climb for some and a larger climb for others, and it is important to be able to help everyone understand why this is so worthwhile.

Secondly, what does it take to actually make meaningful use a habit? In other words, how do you make it an unconscious competence that is just part of how you do your work, so it hardly seems at the end like something you particularly have to strive to do but part of your muscle memory in your own practice and that of your colleagues?

Thirdly, we need to understand some of the essentials for meaningful EHR use so that you know what to focus on, and the process of getting started. If you're at the starting line at this point and you're trying to understand what are some of the first tasks that need to be accomplished or some of the decisions that need to be made or some of the issues that need to be tackled, what specifically should you focus in for these first 2 years, 2011 and 2012, to help make sure that you meet stage 1 of meaningful use? How in your own office can you work together with the rest of your care team and your colleagues to get meaningful use done and all of the side benefits from it in patient care quality, safety and so on?

Let me start with the first part, the why strive. The why of this, I think, has been quite well described already by Dr. Blumenthal, but suffice it to say that correctly designed, implemented and appropriately used health IT can indeed support greater effectiveness, efficiency, quality and other aspects such as timeliness, safety, equity, patient-centeredness, and even help with workforce vitality. These are all important reasons, and these are the reasons we went into medicine anyway to try to be there for our patients in all the ways that quality represents.

The second part that I think all of us are aware of is the urgent need to contain health care costs in the United States and to help make sure that we're getting better value for the care that we deliver. The per capita costs, as we know, in the U.S. are far higher than in literally any other country. Yet the average quality tends to lag behind many other countries that spend significantly less. We need to be able to, as they say, bend that cost curve to make sure that value is improved while quality is maintained or improved as well. Then there are some incentives and penalties, of course, that many of you have heard of. We know that meaningful use dollars are out there to help us in the transition and that those dollars are significant enough to both pay attention to and to really help people get through that initial cost of getting the implementation up and running. In my own practice, it actually was very similar to the \$44,000 that's available in Medicare for us to go live in our first year of use. It does seem to match that initial investment necessary to get up and running in that regard. That is, I think, helpful, and was inspirational from my perspective in terms of would it be enough to help people get where they need to go. Then, of course, payment penalties start to occur if people are not meaningful users by 2015. We do need to be aware that both for quality, and for the financial health of our practices, that we all need to get there and we need to stay there.

*(time stamp 23:19)*

Finally, I think the big piece to remember is that payment reform in one form or another is coming. We're starting to see some examples where payment is becoming more and more based on evidence of quality

delivered, not just on the quantity of care services that are provided, and that there is increasingly payment for care coordination: Medical homes, as in my practice lately, preventive services, early detection, chronic disease management and the like. We're also beginning to see increasing talk and planning around what we call bundle payments—the notion of single bundle payment for services that may be provided by more than one physician or organization even. This will help reinforce the shared responsibility for quality. We have, in the end, to make sure that as we work together within and between our practices that we're providing patients with the highest quality and with the greatest value. We need to do things such as get payment for resource use optimization and gain sharing, the most common of which many of you are probably experiencing now, is some incentives towards generic prescribing where, again, equivalent quality can be delivered at lower cost. Then there is the development of a kind of new care organization. Many of us in practices are going to be in situations where we either become, or are connected with, an accountable care organization. Again, our ability to thrive and do well, both financially and with patient care quality, will relate to our ability to be valuable contributors to the kind of quality that accountable care organizations will provide, while at the same time optimizing value.

Whether to be or not to be, if you will, a meaningful user, what will this look like in terms of differences in the end? A few simple differences that are probably obvious to all is the notion that you'll either be able to get dollars that will help reward your investment and striving and the needed changes that our health care system has facing it, or those dollars won't be available for the needed change, and it's part of the choice that should help us drive in the direction of meaningful use. Similarly, to have the kind of data in our practices in a structured format, one that allows informed decision support and allows us to both demonstrate and improve our quality and value, is a natural consequence of the kinds of rules and criteria that are in meaningful use. In the absence of the kind of transition required, we would simply have fewer data to be able to either demonstrate or improve quality and value, and to do so would be both more strenuous and more costly.

Thirdly, for some of these payment reform models that I described a moment ago, the readiness and eligibility for those is certainly supported again by having both structured data and the ability to demonstrate improved quality, whereas in the absence of meaningful use, it is very much more difficult to demonstrate the readiness to participate in some of these models. Finally, the lower payments, which we described earlier, may amount to as much as 5% if meaningful use is not met by a large fraction of individuals.

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The next step, from my perspective, would be the issue of how to make meaningful use a habit, and making anything a habit basically requires 3 areas of focus. One is to look at and recognize and agree with the notion of why this is worth striving for in the first place. What is our goal and what is our purpose? For many of us in primary care, and I believe across specialities as well, it was pretty easy to resonate with the office of the National Coordinators and CMS' goals and objectives for the kind of care quality we were seeing, the nature of the patient engagement, care coordination, population health, and the privacy and security considerations. Almost no one that I talked to saw any of those goals as not being worthy goals, and that, I think, helps drive the kind of adoption that we're looking for.

The second is to know exactly what is it that we're being asked to do. Again, I think the ONC has done a great job of making it clear, and increasingly understandable and increasingly achievable in terms of the measures that we were asked to achieve early on, and will do so going forward with the second and third phases of meaningful use.

Then, finally, there is a sense of how to do it, which is the notion of providing the kinds of support that you heard discussed already with regard to being able to get the assistance you need, if you need more experienced hands, or assistance from people with certain types of technological or change management expertise. At the same time, you need to balance a degree of standardization, such as data transmission, with the flexibility to be able to enter data in a way that works with your practice, and to have some such ability around the types of things you report so that they are highly relevant to your own practice.

As I think about my own practice's move towards what has, for us, been a considerable distance along the path towards meaningful use, it started at the beginning, as it does for all us. I think of this process like a kind of aerobic conditioning—the crawl, walk, jog, and then run model. For those who have not yet adopted, installed or implemented EHR, there's going to be a climb that you will experience in this process. That's a pretty steep climb in and of itself, although it has become significantly easier with some of the advances over the last several years in systems and implementation methodologies, and I think we'll improve further with the kinds of help that the regional extension centers, the beacon community partners, and some of the hospital systems may be give you in your EMR implementations. That's one piece, but that really only gets us to the adoption itself to what I would basically call a slow walk. The little animation here, in a way, is emblematic. Just having an EMR in place will not get you anywhere necessarily. You may be only walking unless you take it to the next step which is another climb in terms of exactly how an individual uses EHR, and that is in a way that captures important data and allows those data to move around to the various places that are needed to either inform decisions or communicate with colleagues or patients. That's when the meaningful use payments will start to arrive for Medicare and Medicaid individuals. As was mentioned, that first step of adoption will be enough to qualify for payments. I will say, from my own perspective, that even though I will qualify under Medicare, the changes that were made in this rule have made the process of that climb to data capture a much more manageable task for those of us who are trying to take that next step. Although it will be strenuous enough to be a noticeable part of our training, it should be quite achievable with the time that we have available and the tools that are also available to us.

*(time stamp 31:22)*

That's what 2011 looks like and that, of course, is our focus today. Then there will another climb to more advanced clinical processes that help, if you will, to deliver even more of the kinds of services that ought to make the difference in 2015 to measurably improved outcomes. That's where we go from jogging to running, and that's the consequence of being able to stay on this escalator, as Dr. Blumenthal called it, and keep progressing in this path.

With that, I would just say there are 3 things that I suggest are very important to focus on, and are big themes for getting to meaningful use. They are listed in the slide that you see here and they are relatively straightforward in their own way. The first rule is to have an EMR or EHR that works, and that's the task of making sure that when you come into work every day the lights go on, the computer starts, and the products that you're using work the way you expect them to. That's really what the people you may have at your disposal for information technology are responsible for. It's your responsibility to take good care of patients. The people who assist you with the technology need to be trusted and reliable with regard to giving you a system that works. That doesn't mean it has to work perfectly, but it has to work reasonably well enough for you in typical, desirable work flows to be able to take the next step, and that is to use it regularly. As you can see in this slide, "if you build it they will come" is not necessarily true. Part of the meaningful incentive is to help make sure that EMR is not only in place, but that it is used and, in the third phase, that it is used in a way that does transform care, which is what meaningful use is all about. Those of you who are not only in practices but leaving your practice will recognize the practice executive leadership

component of the second step here, which is basically to help make sure that everyone understands and moves forward, and to help them understand how critical it is to the success of your practice and to the quality of the care of your patients. Then the transformation process happens with the consequences of the multiple other aspects of meaningful use that are outlined in the rules in this stepped criteria towards meaningful use.

With that, what are some of the early tasks and decisions and issues to deal with? I think one of the first things is to look at how ready is your practice to implement this technology? From my perspective it comes down to 3 things. The first is how ready are the providers and staff? How much do they agree that EHR technology is essential to their future effectiveness? Are they willing to work together and help each other out as they move towards adoption in meaningful use? How supportive is the practice leadership in making sure that the resources are available and that individuals stay on board with getting meaningful use done? Thirdly, what is the IT capacity either within the practice or by contracting who can help the practice achieve meaningful use?

*(time stamp 34:42)*

The second step, then, would be to create a plan, and that's going to be my early advice for anyone who hasn't yet taken steps. Although you have a significant amount of time to get to meaningful use, there's no time like the present to start with your planning in that regard. That, of course, includes not only planning to make sure your readiness is high, but also, to select or, if you have any EHR already, to upgrade your EHR, make sure it's qualified for meaningful use, and then be able to take the next steps.

One aspect of that plan probably will center on the notion of whether you feel as if you can do this on your own, simply you and a vendor, or whether you would like to connect to some other existing system that may have EHR. For example, in my community, both Michigan State University and Sparrow Health System are in a position to be able to offer a community outreach-type program to practicing physician offices who would like to use a shared medical record type of approach while keeping their practice financials private, and I think we'll see more and more of that made available. In addition, other independent health delivery networks may also do such things. Again, you may be able to get that kind of support from regional extension centers or beacon communities or others like that.

Then you want to make sure that everyone in your practice gets on board and stays on board because meaningful use is both initiating and maintaining the kinds of progress that have been discussed. It always starts with reminding ourselves why we're really doing this in the long run, and in the end, it's all about the patient and how to make sure that they get the care that they deserve, and that we've committed our professional careers to. It's important to involve physicians and other stakeholders early on, so that they feel part of the decisions, and that they feel like they're making decisions rather than having decisions made for them. You need develop and support champions and super users, particularly if you have more than one office or a situation where individuals may need significant at-the-elbow kinds of support. You should have people who are particularly skilled both at use, at advocacy and at problem solving and trouble shooting for individuals who are struggling. It's also important to both train and verify competencies. As physicians, we certainly remember when we learned how to do our first histories and physicals, and how much those were scrutinized by those trained us for formatting, as well as content, and informativeness. So I think it's perfectly reasonable, that along with all the other technology that we've had to prove ourselves competent at, we should participate actively in training and in verifying our skills. At that point, then, you want to look at and get feedback on the kinds of things that matter. My little animation here is to help also remind us that perfection is not the goal here, and it's not really achievable anyway. The key is to try to find out how we're doing and continuously improve on those things that matter.

*(time stamp 38:05)*

For part of that, quality is going to be the key. The other part of it is getting the kinds of return on investment financial issues that help drive continuing adoption and use as well. You need to align rewards and accountability with these goals and then focus on the sustainability which again, for many of us, includes the issue of payment reform with particular emphasis on payment for quality and the ability to communicate and coordinate care.

With that, we also want to address the 3 aspects of technology adoption. The technology itself is what we often focus on, but really keeping in mind the people and the processes to get these done is important. It is important to know the specific core measures you must meet and the other menu items that you can choose to meet. Dr. Blumenthal alluded to them, and I'll show you a couple of slides, without going through them in detail, but for reference after the presentation to show you how to work the optimized EHR training in the work flows to make meeting these measures easier.

In these slides, I simply have listed the kinds of items that are part of the 15 required, and I think a number of you have already seen in the New England Journal article or in one or another types of summaries of this information. There are a significant number of structured data entry requirements. The items that you see in blue here are all numbers that have been relaxed from a previous set of requirements, and which many of us who have this as part of our careers consider much more achievable. They are very representative of the kind of muscle memory physicians need to develop in terms of this kind of documentation, and they can also be done in part by staff. I'll show you a suggestion about this in a moment. These are others of the 15 in that regard, other kinds of activities that, as you look at them, you can both resonate with their relevance to the delivery of quality care, and also, as you look at the measures themselves, imagine the ability to be able to do these within the time frames that are available. We can come back and discuss some of these in the Q&A if desired.

What I wanted to also comment briefly on is these menu items. This was important for many of us. Some of these for some of our practices are going to be easier to meet than others. While there are a set that everybody should meet, it's nice to be able in the early days of our implementation to choose certain ones that we either see as more important or easier for us to accomplish in our transition period, such as whether to do drug formulary checks or using the EMR to generate a list of patients by specific conditions such as diabetes. There are other ones that are available and again the key issue is to look at them and see which ones seem to be the best fit for your practice and that you either prioritize based on your own sense of what quality would dictate or what you think is achievable in your practice without as much, perhaps, disruption or change in current work flows.

*(time stamp 41:35)*

Finally, the notion here in these slides—and again they're mostly for your reference—is how to work together to get some of this done. Physicians may often be concerned that they have an awful lot more documentation to do than they did before. The purpose of this slide is to help you understand the notion of how the front office can handle some of these tasks and get them entered into the record for you in a structured way. Some data, such as recording height, weight, blood pressure, smoking status, medication reconciliation, updating problems and allergy lists, etcetera, can be done by and verified by you, but also done by others, whereas there are other areas where you certainly are responsible for agreeing with and finding relevant and accurate, such as implementing a decision support rule and maintaining a problem list. Then there are other things that the system ought to be able to do for you completely, assuming you can get it set up in a way that works. Laboratory results coming in as EHR structured data would be a classic

example of that, or generating reports that you need to demonstrate use or report on your own measures.

The other slides that I have here are, again, just a reference. They're just another way of showing how different people in an office can help you with various aspects of either the quality measures or the reporting that's necessary to do some of these. I make them available for you for inspection and for consideration as to how you might implement these in your own practices. Again, this is an example of a slide where the purple indicates that this is something where the system can almost all of these for you, and therefore it is certainly worth trying to make sure you both get EHR and configure it in a way that can support these goals. Similarly for care coordination, which is what this slide is about, and then also for population and public health, again, the system can do these for you.

In summary, what I would suggest that office-based physicians should do is, if they already have EHR, then make sure is that it's both qualified for meaningful use. Again, all the major vendors are working hard to make sure that they're meeting those criteria. You also need to make sure on your end that you're using it in a meaningful way, that problems are entered in a structured manner and medications are entered in the same way, prescriptions transmitted electronically wherever possible, and so on. Then, positively engage your practice leadership to help make sure that the EHR is optimized for and made use of meaningfully by everyone in the practice. That's what the patients benefit from the most, anyway.

On the other hand, if you don't yet have EHR, my suggestion would be that while you have some time to make good decisions, you shouldn't wait in terms of making sure that you have a plan, or that you make a plan and then have a graduated approach to acting on it in a way that helps get you there in a timeframe that is important to achieve. Decide if you want to go it alone, or if you want help from others, and if you do, look around to see who among your trusted organizations or associations have experience and resources available to you, and use those.

I'll stop here and turn things back over to you, Dr. Barr, and we can take some questions.

*(time stamp 45:07)*

**Dr. Barr:**

Thanks very much, Dr. Zaroukian. I appreciate that great presentation, and we have several questions in the queue. What I'm going to try and do is pose as many of them as possible in the remaining time.

Dr. Blumenthal, there are a few questions here about support for practices along the lines of whether ONC is going to engage experienced users of the EHRs to be physician tutors. Will the QIOs be helpful to assist physicians attaining meaningful use, and what kind of assistance is available for practices? Perhaps this is an opportunity to talk about regional extension centers and other ideas that the office has regarding support for practices either coming to EHRs new or already using EHRs and wanting to get up to speed on meaningful use.

**David Blumenthal:**

Thanks for that question. The Office of the National Coordinator has set up 60 of these regional extension centers. They cover the entire geographic expanse of the United States. They are by grant requirement focusing on primary care physicians in small practices and in underserved areas, also in community health centers and on critical access hospitals. Their goal is to help physicians decide which system to purchase, to help them install it, to help them run it, and to help them become meaningful users, and then to help them get value for their practice and their patients. The different regional extension centers—there are 60 of them—are taking different approaches. I do expect that some will engage physician opinion

leaders and tutors. Some may actually get medical students working with them since a lot of medical students learn these records pretty fast. Others will make resources available through webinars like this, through materials online. There is going a variety of approaches. Some of them are quality improvement organizations. About a third of those 60 are already quality improvement organizations who applied for and got funding.

I think the way to start with the planning—planning is a critical part of this and it's a great thing to emphasize—is to go to <http://healthit.hhs.gov> and find out who is your regional extension center. Give them a little time to get set up, because they've just been funded and they're getting going. Some may not be ready to go at a gallop. Contact them, get registered with them, and find out what they have to offer. If you don't like what they have to offer, let us know. By the way, there will be, I'm sure, other sources of support. They won't probably be quite as affordable, but there are lots of consulting companies and lots of vendors who are getting into this business of supporting physician adoption and meaningful use as well.

*(time stamp: 48:12)*

**Dr. Barr:** Thanks, Dr. Blumenthal. I want to also point out on the AmericanEHR Partner site we do have a [list of the regional extension centers](#) to reference if you happen to be on that site.

There are several questions regarding the mechanics of payments: When they would occur, how they are structured, and I'm going to ask Dr. Blumenthal to go over that in general terms, but I also want to direct folks again to the AmericanEHR Partner site. In the blog section, we did have a [short blog](#) about CMS tips which explains many of the answers to the questions we've gotten during the presentation. But, Dr. Blumenthal, do you want to go again roughly over the mechanism for applying for meaningful use and when the first payments could be paid to a meaningful user?

*(time stamp 48:58)*

**David Blumenthal:** Sure. You will be able to register starting in January of 2011, and it is possible that you could qualify for meaningful use as early as May of 2011. There will be a procedure to register on the CMS website as a qualifying meaningful user, that is a physician or practice that is in the process of meaningful use in electronic health records. The first payment, as I said, could occur as early as May. There will be lump sum payments. One could also register, as I said, as late as October of 2012. For the details of payment, I would refer you to the CMS website. That's not my area of expertise. The CMS has its own procedures for recognizing physicians who qualify for extra payments and then cutting the check and sending them for those.

*(time stamp 50:08)*

**Dr. Barr:** Thanks, Dr. Blumenthal. There is a question about where to find vendors recommended by Medicare and I don't think that Medicare's going recommend any vendors, but what Dr. Blumenthal and Dr. Zaroukian talked about was the certified EHR technology and that process, and for those of you who are looking for EHRs, that's one of the main purposes of the AmericanEHR Partners site where there is a comparison tool. Not every EHR is on there. As soon as the certification process described by our speakers is underway and there are products certified, we'll be making certain that the site identifies those and you'll be able to compare and contrast information about the EHRs that are participating in the site, as well as satisfaction

data about those EHRs when we have sufficient data, more than 10 raters for any of those products. I would encourage you to look at the site, and you can also filter by the size of practice and other demographics. As we get more numbers, that will become more meaningful.

Dr. Zaroukian, there is one particular question about sharing information electronically. It is concerned about physicians that might feel a little unprotected from litigation once information is shared or exchanged between health care providers. I wondered if you have any comments about that, and whether there are any protections that you are aware of for physicians in practice?

*(time stamp 51:32)*

**Mike Zaroukian:**

It's an interesting question. Speaking as a non-lawyer, I would say that part of the thing to look at here is to look at how non-electronic information was shared and the electronic equivalent of that information. If the question is intended to basically ask once information generated in your practice is shared elsewhere, if and how does that pose a legal risk to you, I think the key issue is that if it's been provided in the context and the same manner according to the same HIPAA regulations for sharing information, that in and of itself should not represent any increased risk. I think one of the keys is going to relate to the issue of patient permissions and to what degree will patients have the ability to determine and direct the release of their own information for purposes other than direct patient care. I don't know of any specific federal laws right now that are in the HIE space. I do know that there's a lot of work being done right now with regard to additional rules and regulations and guidelines around health information exchange as it relates to privacy and security. But to my knowledge, there's no specific guidance on that yet.

*(time stamp 52:57)*

**Dr. Barr:**

Thanks, Dr. Zaroukian. We are getting close to the top of the hour and there are wonderful questions. I want to make sure everybody knows that these questions will be answered afterwards via email and/or posted responses will be made online from either the staff of the American College of Physicians or colleagues in other speciality societies and certainly our colleagues and others on the AmericanEHR Partners, and we will try to answer as many as we can in the next 2 or 3 minutes. So let me stop talking and ask the next question.

Dr. Blumenthal, could you clarify about who is an eligible professional under the Medicare and the Medicaid program because there are some questions about whether nurse practitioners and physician assistants can qualify on either or both.

*(time stamp 53:43)*

**David Blumenthal:**

The eligible professional is defined by the Medicare program and the Medicaid programs. Under Medicaid, there are a large variety of professional, including not only physicians but dentists, nurse practitioners and midwives who are eligible. I encourage you to go to the CMS website if you have a specific question about a type of professionals because there is information on this unit's website. For the Medicare, if you are eligible for Medicare compensation as a provider for care, then you are eligible for incentives. However, if you are employed by a hospital as an inpatient physician employee, you will not be eligible for such compensation. If you are in an outpatient setting, you will be, but if you are an intensivist who is employed, for example, or an anesthesiologist who is employed full time, you may not be eligible.

*(time stamp 54:52)*

**Dr. Barr:** Thanks, Dr. Blumenthal. Dr. Zaroukian, how do you think meaningful use could work in a smaller, solo practice? Is it feasible, and have you seen any examples?

*(time stamp 55:05)*

**Mike Zaroukian:** Yes. In some ways it will be easier because there will be fewer individuals to coordinate to achieve meaningful use and less need to, if you will, to deal with the compromises that occur in any larger practice where a one person solution may not be optimal for another. The key issue I think, as Dr. Blumenthal pointed out, is smaller and more rural, less connected practices will have a greater difficulty amassing the expertise necessarily to set up the technology and change management and other parts of this. This is where the regional extension centers and other types of resources, hospital affiliations or beacon communities, etcetera, where those are available to a solo practice they can be a big help allowing you to stand on their shoulders and use their expertise to get it done. But from the perspective of is it achievable within that practice, a solo or a small group practice, the answer is absolutely, yes. In some ways there'll be fewer barriers of certain kinds that make the biggest difference which is people and processes.

*(time stamp 56:15)*

**Dr. Barr:** Good. Thanks. I'm going to try and take at least one more question for Dr. Blumenthal. In the regional extension centers there seems to be a focus on primary care physicians. Can specialists still take advantage of the services? Are they available to such specialists for example?

*(time stamp 56:32)*

**David Blumenthal:** They are available. No one will be turned away, but the regional extension centers will allocate their resources first to primary care physicians. There are many kinds of resources that they may make available: Help with purchasing records, with choosing records, with installing records, materials on websites that are provided at very low marginal costs to physicians who call and ask for them. But in terms of the really intensive person-to-person assistance, I think that that's likely to go primarily to primary care physicians.

*(time stamp 57:11)*

**Dr. Barr:** Thanks very much, and I recognize that we are now at the top of the hour, perhaps a little past, and I want to thank the audience for some great questions and I want to assure you that we will do our best to respond via email to these questions or post responses to questions that are pertinent to a wide audience on the AmericanEHR site.

As we come to the end of the session, let me once again thank Dr. Blumenthal and Dr. Zaroukian for their presentations and their attempts to answer all of their questions, as many as I could get through in the last few minutes. I also want to thank Hewlett Packard for their support so that we could offer this free webinar from AmericanEHR Partners. A recording of this event will be posted to the AmericanEHR Partner's site shortly, probably within 48 hours once we've processed it.

Please visit [www.americanehr.com](http://www.americanehr.com). We continue to add new content and features to help practices choose, purchase, implement and optimize certified health information technology. Thank you all very much for your attention and hope to hear you again on another webinar. Thank you, Dr. Zaroukian. Thank you, Dr. Blumenthal, and thank you to Dr. Blumenthal's staff for making sure this all worked out.

**David Blumenthal:** Thank you.

**Mike Zaroukian:** Thank you.