Investigate Funding Alternatives to Support Successful EHR Implementation

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The New England Journal of Medicine, on July 3, 2008, published eye-opening research regarding the rate of electronic health record (EHR) adoption in the United States. The study revealed that fewer than 20% of physicians have implemented EHRs to date.1 Not surprisingly, those least likely to convert from paper to electronic records are smaller, independent practices or those not affiliated with a large health system.

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The study—and anecdotal evidence—reveals that the two most significant barriers to EHR utilization are “fear” and “funding.” Many physician practices fear that the conversion will be too difficult and disruptive. At the same time, they are concerned about how they will be able to fund the investment, as well as the impact the transition will have on their bottom line.

The fear factor must be addressed internally. When practice leaders determine that the time has come for EHR adoption, they must undertake disciplined implementation planning and launch change management initiatives to support the effort. Workflow processes must be reengineered because even the best manual system will fail within an automated environment. Reasons for the transition must be clearly communicated, while physician and nurse champions must be identified to serve as liaisons with the end user. Staff time must be dedicated to ensuring that the implementation is well considered and well executed.

What may not be readily known is that resources to address funding concerns are available not only internally, but externally as well. When undertaking the transition from paper to electronic records, practices need to be aware of opportunities for financial support and assistance, and understand which strategies and tactics will increase their

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CONDUCT COST ANALYSIS

When assessing financial resources that might be needed for a transition to automation, the first step any practice should take is to conduct a thorough cost analysis. It is vital that both administrative and clinical leaders educate themselves about the true expenses associated with EHR adoption—and about the value it can provide. Too often, physician practices look only at the price tag of a particular software and hardware solution. This kind of limited analysis puts them at a distinct disadvantage for two reasons:
1. They are relying upon how the vendor (health information technology, or HIT, provider) frames the cost of its product, which may or may not be inclusive of related expenses, rather than coming to an objective conclusion about what the bottom line cost eventually will be. When presenting an estimate, for example, some HIT providers include only the installed price of the software—which is the “tip of the iceberg” and may represent 50% or less of the entire project cost. Practices, however, also must factor in expenses related to hardware purchases, infrastructure upgrades, paper record scanning or abstraction, staff training time, and a temporary decrease in productivity.
2. By focusing on software license “price,” practices may overlook “value.” As with many other pieces of equipment, “cheap” does not always translate to a “good deal.” Practices need to consider which features will allow them to increase efficiency and improve outcomes, and consider how the technology will support them over the long term. They must recognize that they are not purchasing an EHR system just for today, but for tomorrow and the tomorrow after that.

CALCULATE LONG-TERM ROI

It is also vital before making a purchasing decision to calculate return on investment (ROI). Many HIT providers will supply an ROI tool to assist in the process, often available on their Web sites so that practice leaders can undertake the exercise at their own convenience.

There are a number of factors that practices should consider when calculating ROI relative to EHR adoption:

- **Current transcription expenses**: The EHR system will eliminate these costs almost immediately after implementation. The savings will continue to accrue over time.
- **Cost of paper supplies and manual processing**: Practices will no longer need to purchase charts and forms, and will reduce staff time invested in pulling, finding, and re-filing charts.
- **Office space dedicated to paper records**: These areas will be freed to be used for revenue-producing activities like additional exam rooms, laboratory facilities, etc. One Midwestern practice added seven new exam rooms in the space previously occupied by medical records, transforming a cost center into a revenue center.
- **Back office personnel**: Some larger practices (e.g., more than three providers) will be able to reduce medical records staff or redeploy them in other areas such as collections to strengthen the bottom line.
- **Charge capture**: EHRs ensure all charges are captured and the correct level of E/M code is billed. This information is automatically forwarded to the practice management system for faster billing and timely payment. The typical result is somewhat higher, and definitely timelier, payments.
- **Productivity**: Physicians no longer need to set aside time for dictation and can therefore see more patients during office hours.

CONSIDER EMERGING PAY-FOR-PERFORMANCE IMPLICATIONS

Besides cost reduction and increased productivity, practices need also to consider the effect EHRs might have on pay-for-performance (P4P) participation—and how it can impact ROI due to increased revenue.

These initiatives are emerging at an ever-increasing rate. The Centers for Medicare & Medicaid Services (CMS) has taken the lead in this arena, beginning with Doctor’s Office Quality–Information Technology (DOQ-IT) project to support the effective use of information technology to improve quality and safety for Medicare beneficiaries. This program, while not offering financial benefits, did form the basis for what has emerged more recently: the launch of the Physicians Quality Reporting Initiative (PQRI) and an enhancement of DOQ-IT called the Medicare Care Management Program (MCMP). Private payors have followed suit, while communities and employers have entered the game with initiatives like the Bridges for Excellence program. CMS likewise launched a five-year demonstration project in spring 2008, open to 1200 physician practices and providing financial incentives to those using certified electronic health records to meet specific clinical quality measures (based upon indicators from the MCMP program).

At the heart of these efforts is data collection and analysis. Practices relying upon EHRs and automation are able to capture necessary information in a wide variety of formats, plus the veracity of the data is virtually unimpeachable. Some P4P programs require use of an EHR system and increase the level of reward payment for practices adopting these systems.

Currently, many P4P programs are voluntary and represent “bonus” income. In the future, however, industry leaders anticipate that as much as 30% of practice income will be derived from P4P pay. Further down the
line, practices will be penalized for opting out or not meeting minimum quality standards. A prime example is the new CMS e-prescribing incentives, which go into effect January 1, 2009.

**INVESTIGATE FUNDING SOURCES**

Why is it so important to invest significant effort on a cost and quality analysis?

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Several years ago, when the EHR trend was young, grants became available (and, in fact, still are today) from federal, state, and local programs. Healthcare is currently seeing a trend toward public and private nonprofit foundations interested in offering research grant opportunities to demonstrate improvements in care. Often, physician groups have developed partnerships with pharmaceutical companies and private insurers who are willing to help fund HIT investments. These later relationships will come with a “price tag,” requiring recipients to provide data in areas like pharmaceutical usage as it relates to clinical outcomes and patient satisfaction. However, if physicians satisfy themselves that there is no compromise to privacy and security of patient data in these instances, the financial benefit can be significant.

More and more, practices are working with area hospitals and health systems to support EHR implementations. In the not-so-distant past, Stark rules regulating self-referral activities disallowed significant hospital participation in these purchases, limiting their contribution to $500. These regulations were relaxed in 2007, however, as policy makers recognized that collaboration was vital to widespread adoption of HIT systems. Hospitals can now fund up to 85% of the EHR system purchased by a community physician practice. In addition, they can take advantage of a one-time federal tax break in 2008 to write off some of the cost.

**MATCH PRACTICE NEEDS WITH FUNDER REQUIREMENTS**

To increase the likelihood of a mutually beneficial relationship between funder and practice, consider these seven tips:

1. Recognize up front that most funders will require that the EHR system purchased has been certified by the Certification Commission for Health Information Technology (CCHIT) within the past 12 months. This means practices must make sure that the EHR system they select is compliant—or intends to soon become compliant—with the most recent CCHIT standards.

2. Keep in mind that the EHR purchase is, in reality, an investment in total practice transformation. Implementation of an EHR system alters the workflow of virtually every process and will impact the day-to-day duties of every staff member. It is essential that planning for process reengineering be thorough and that staff member buy-in is achieved throughout the conversion. This commitment needs to be clearly laid out in funding proposals so the potential funders are comfortable that the medical provider has made a commitment and is not simply trying to “mechanize their paper practice”—a sure sign of trouble.

3. Be very clear about what the funding organization requires in return. A pharmaceutical company may ask that practices track the frequency that select types of drugs are prescribed (e.g., medication to treat attention deficit hyperactivity disorder or ADHD). Others may want to capture data to populate databases reflecting incidences of specific diseases (e.g., rheumatoid arthritis or diabetes). If your practice does not treat patients using these drugs or who suffer from these conditions, the relationship will not be beneficial to either party. (Parenthetical note: The automation available through the recently funded EHR will ultimately allow the practice to fulfill these requirements. Automated documentation of quality improvements will form the foundation for any metrics the practice provides to the funder in order to validate the ROI the funder is receiving from its investment.)

4. Consider hiring a grant consultant or writer if you are going to approach federal, state, or local municipalities, or public and private foundations. Grantors operate under a specific set of rules and expectations with which medical personnel are unlikely to be familiar. Likewise, grant-writing is a specific talent, one that might not be among the core skill sets present in either administrative or clinical staff.

5. Do not view the funding process as a single event. Continually be on the lookout for new opportunities. Patient advocacy groups are playing an ever-increasing role, for instance, particularly in the development of personal health records. Likewise, malpractice carriers
view EHRs as a viable strategy to reduce exposure to risk. One Ohio practice, for example, used its EHRs to negotiate a 50% reduction in annual premiums—from $400,000 a year to $200,000.

6. Don’t go to the other extreme with funding either. Practices should not view funding as the sole means of HIT purchase assistance, but rather as a partial means of support. Internal resources may be applied to the total cost, and in some cases, leasing may prove to be a viable option.

7. Find out what kind of help you can get from your HIT provider in implementing your funding strategy. NextGen Healthcare, for example, has developed a Funding Assistance and Grants Resource Center. Dedicated professional staff members are available to guide clients and selected prospects through this funding acquisition process. Center personnel support a practice as its funding search gets underway, connecting the practice with grant writers and editors, for instance, or communicating via e-mail about new resources. In four years of activity, the NextGen Center has helped clients gain more than $35 million in funds for clinical care improvements through automation, money that is typically disbursed directly to medical providers to invest as they wish.

There is little question that EHRs are here to stay. Industry leaders recognize the vast potential they offer to increase quality of care, improve patient safety, streamline operations, and enhance successful participation in P4P. It is time—if not well past—for practices of all sizes and specialties to begin investigating strategies to speed implementation and to put the barriers of fear and funding behind them.

But, like any idea that is just about to come of age, the early adopters have greater control over their destiny than do those who follow. Funding automation today is regarded as an opportunity, but the market signs indicate that these funding “opportunities” may soon turn to “financial penalties” if EHRs aren’t adopted. Forward-thinkers would do well not to wait for this inevitability before they act.

REFERENCE