Switching EHRs: Find the system for you

OCTOBER 25, 2015
VOL. 92 NO. 20

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Patient portal strategies: Lessons from a doctor

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THE LAST WORD

Congressional posturing on meaningful use
While the FLEX-IT 2 Act may seem like a good idea, it may not work in reality, writes John Frank.

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"I don’t believe [interoperability] can be achieved, so long as data remains locked within the EHRs on the landscape today."

—ROBERT ROWLEY, MD, FAMILY PHYSICIAN

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63% of physicians seeking a new EHR are looking for a system that has a greater ability to customize than their current EHR.

READ MORE ABOUT SWITCHING EHRS: PAGE 54

"Usability of [of EHRs] was somewhat of an unintended casualty on the road to getting more people to use these systems."

—TITUS SCHLEYER, DMD, PHD, DIRECTOR FOR BIOMEDICAL INFORMATICS, REGENSTRIEF INSTITUTE

READ MORE ON PAGE 28
The conventional wisdom is that small, independent primary care practices are at a disadvantage in the digital world, because they have fewer resources with which to purchase, support, and upgrade EHRs than do large multispecialty groups and hospital-owned practices. But the results of the 2015 Medical Economics survey on health information technology turn that assumption on its head. They indicate that, in some respects, small primary care groups are in the vanguard of health IT.

The survey respondents include a broad range of physicians in different practice settings. But 53% of them are primary care doctors; by comparison, only a third of practicing U.S. physicians are generalists. Fifty-one percent of the respondents work in practices of one to four physicians; in contrast, nearly 60% of the nation’s physicians practice in groups of one to nine doctors. So the 2015 Medical Economics Physician EHR Survey sample is skewed to smaller and primary care practices.

Considering these features of the sample, it might seem counterintuitive that 48% of the physicians who had EHRs said they had attested to Meaningful Use Stage 2 as of July 2015. Applying the government’s estimate that 78% of office-based physicians have EHRs to the total number of practicing doctors, one can calculate that fewer than 10% of doctors with EHRs of any kind (though possibly somewhat more with certified EHRs) have attained stage 2 meaningful use.

What this comparison suggests is that primary care doctors in small practices might have a greater interest than other physicians in achieving meaningful use. One possible explanation is that the remaining EHR incentive money and the penalties for not attesting to meaningful use motivated the primary care physicians more than it did higher-earning specialists and doctors in larger groups.

It is also easier for physicians who are experienced and comfortable with their EHRs to meet the meaningful use criteria. Here primary care doctors have the advantage, having adopted EHRs earlier, on average, than did other kinds of specialists. This is one reason why primary care doctors tend to be more satisfied with their EHRs than are other kinds of specialists, according to a recent survey by AmericanEHR Partners and the AMA. The researchers noted that it takes an average of three years for physicians to get used to working with EHRs.

In the AmericanEHR survey, which reflects the broad population of physicians, only 34% of respondents said they were satisfied with their EHRs, many fewer than in previous years. By contrast, 51% of the Medical Economics respondents—just slightly less than in 2014—said they were somewhat or very satisfied with their EHR.

If there is a correlation between satisfaction and length of use, the higher percentage of respondents in our survey who were satisfied with their EHRs may be related to the fact that 29% of respondents with EHRs had their systems for five to nine years, and 32% had them for three to four years.

What all of these data point to is a simple fact that the pundits seem to have missed: The size of a practice and its resources matters less to EHR success than the motivation of its physicians.

Ken Terry is an award-winning healthcare journalist specializing in health information technology. He is a contributing editor for Medical Economics.

First Take

Small practices lead the way on EHRs

“In some respects, small primary care groups are in the vanguard of health IT.”

READ MORE INSIDE Switching EHRs the right way PAGE 54
PCMH promises more than it delivers

In response to your article, “PCMH Accreditation: Is it worth it?” (July 10, 2015)—the short answer is ‘no.’

I left my former practice because it declined significantly after they implemented this plan. Of course it sounds great to be “patient centered”—what could be wrong with that? However, in my experience what was supposed to be patient centered was actually data centered—numbers and percentages ruled the day.

Another aspect of the PCMH is that each patient is assigned to one physician. Again, it sounds good but when the goal is to have 24/7 availability, will the patient actually have access to their doctor at all times? Of course not. In order to fulfill the access goal, the PCMH model requires hiring additional ancillary staff. It appears helpful on the surface, but in my experience it put layers of staff between me and my patients.

In the article’s insert, Dr. Holly highlighted “listening to a patient—and treating the whole person” as key to the medical home. This is absurd. A practice doesn’t need to have a PCMH label to treat patients with respect and as individuals. While PCMH sounds like the latest, greatest thing, it is much ado about not much, and in my experience impedes the doctor/patient relationship.

Amy Rosenthal, MD
ORANGE COUNTY, NORTH CAROLINA

EHRs have brought many benefits to medical practice

I am tired of reading in your publication the letters from anti-EHR dinosaurs, citing the same tired old complaints and criticisms. It is time you presented the other side.

I purchased my EHR in 2006, well in advance of the incentive payment offer. I got it because it presented a better way to run my office. I researched it thoroughly and chose a robust but flexible and customizable EHR. I did not try to find the cheapest one available, but instead looked for one that would do what I needed. I have not been disappointed.

Prior to EHR, my charts (after 20 years in practice) were often quite thick and unwieldy. Although I would spend much of each visit with my eyes on the paper chart either trying to write as the patient spoke, or ruffling through pages seeking prior information or results, I would still every night bring home an armload of charts to be finished after hours.

Now I am able to keep more, not less, eye contact with the patient during a visit, with my laptop on my

Patients are too eager to get antibiotics

Your article summarizing the most overprescribed antibiotics (“Health Affairs reveals the 5 most overprescribed antibiotics,” June 25, 2015) is yet another reminder of this deeply entrenched decades-old problem. Having recently re-entered primary care after years of practicing medicine in another setting, I am repeatedly frustrated by the extent of patient demand for antibiotics.

The public has become accustomed to “a pill for every ill,” with the goal of a quick fix. Multiple patients have been unsatisfied leaving my office empty-handed, having received only reassurance and education about dealing with their (non-bacterial) conditions without antibiotics. We physicians need more help from the public media to change tenacious misperceptions.

Mary Schuler, MD
JENKINTOWN, PENNSYLVANIA

Have a comment? Send your thoughts to medec@advanshar.com
Facebook.com/MedicalEconomics @OneMedEcon

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Continued on page 6
Continued from page 5

Practicing medicine is no longer worthwhile

I read Elmer Toro, MD’s letter, “Meaningful Use Doesn’t Improve Quality of Care,” (July 25, 2015) with both a sense of irony and frustration. I agree completely with his sentiment.

I had sent you a letter published in December 2012 expressing my opinion that EHRs did not reduce workload, but to the contrary increased work, caused additional expense and acted as an instrument to aid auditors in denying/degrading reimbursement.

It seems nothing has changed. We have let the bureaucrats and insurance companies co-opt how we practice medicine without any substantive benefit to our patients.

As a cardiologist, in addition to all the hoops we are forced to jump through and the frustrations that all physicians contend with, including MOC, fear of Medicare audits, PQRI, insurance company restrictions/ precertification rules, and malpractice, I have also had to contend with recertification of my nuclear and echo lab every three years, which is tedious, time consuming redundant and expensive task, as well as recertification in nuclear cardiology every 10 years.

Taking stock of these issues, my age, the fact that after 34 years in practice continuing to work will not appreciably change my lifestyle, while dealing with these issues offers more risks than benefits, I have decided to retire. I think this is unfortunate, since I do believe that I still have something to offer to my patients. However the atmosphere for the practice of medicine has become so toxic that it is no longer worthwhile. I wonder how many other experienced physicians are leaving the practice of medicine prematurely because of these issues?

Jeffrey S. Rothburd, MD
BABYLON, NEW YORK

Physician extenders deserve opportunities

In his letter, “Physician extenders have too much autonomy,” (July 20, 2015) the author overlooks the fact that the scope of the primary care physician (PCP) except in rural areas has become so limited that the skills and knowledge required today are much different than those of 20 years ago.

Most PCPs are so inundated by paperwork and telephone calls and reading and reacting to lab reports and consultations and getting pre-authorizations for medications and testing from insurers, not to mention coordinating the care of hundreds of patients, that they don’t have the time necessary to take care of complicated problems.

Many PCPs no longer see hospital patients or nursing home patients. PCPs refer many patients to consultants and act with them in coordinating care. Their labors are limited to such things as uncomplicated diabetes, hypertension, stable cardiac disease, headaches, upper respiratory illnesses and other non-life threatening illnesses. Qualified nurse practitioners can handle many of these problems. It would be wrong to deny them the opportunity.

Experts predict a shortage of about 40,000 PCPs by 2020, so clearly there is a great need for qualified people to provide primary care.

The author is right that there is a danger that nurse practitioners may overreach and be hit with malpractice suits. But isn’t this a risk that all PCPs face every day when in the rush to see more patients they spend less time with them and may miss a symptom?

The point is that as long as nurse practitioners act within the limits of their training they deserve the chance to use the skills they have learned.

Edward Volpintesta, MD
BETHEL, CONNECTICUT

Have a comment? Send your thoughts to medec@advanstar.com

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Jeffrey S. Rothburd, MD
BABYLON, NEW YORK

NEW LONDON, CONNECTICUT

Steven P. Johnson, MD

Edward Volpintesta, MD

BETHEL, CONNECTICUT
The board members and consultants contribute expertise and analysis that help shape the content of Medical Economics.
Physicians chose their profession to help people, not fill out paperwork. But if your practice accepts insurance, coding is unavoidable. With that in mind, we present advice from the experts on how best to approach coding and documentation and make them a part of your daily routine—while ensuring your practice is paid for all the services it provides.

**COPD resource center**
The latest updates on treating chronic obstructive pulmonary disorder.
MedicalEconomics.com/tag/chronic-obstructive-pulmonary-disorder

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How to protect your practice from HIPAA violations.

**Video in the exam room**
Experts discuss what physicians can do to protect themselves while meeting patient needs.

**Payer negotiation tips for small practices**
Negotiating with payers is one of the necessary evils that independent physician practices must endure.

**Meaningful Use**
A government report says some MU-certified #EHRs aren’t meeting design rules for user-friendliness.
http://ow.ly/S3cNX

**Continuity of Care**
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http://ow.ly/NMLAq

**Remote Monitoring**
Remote patient monitoring is starting to fulfill its promise of better patient care.
http://ow.ly/StNB4
Nearly half of primary care physicians considering early retirement

Would you say that recent trends in healthcare are...

- Causing you to consider retiring earlier than you thought you would?
- Causing a delay in your retirement plans?
- Not having an impact on your retirement plans?

18% 17% 56%
47% 34% 27%

Physicians Nurse practitioners/Physician assistants

apid changes in healthcare have left many primary care physicians with mixed feelings about the profession, with about 47% planning for early retirement as a result, according to a new national survey conducted by the Kaiser Family Foundation and the Commonwealth Fund.

“The survey results indicate that primary care providers’ views of many of these new models are more negative than positive,” the survey authors wrote. “Market trends in healthcare have been affecting physicians’ satisfaction for more than 20 years. It will be important to monitor providers’ satisfaction with delivery reform efforts.”

Kaiser Family Foundation & Commonwealth Fund poll
Affordable care Act

ACA narrows racial gaps in health coverage

The number of Americans without health insurance shrank from 2013 to 2014, as did the gap in coverage rates between whites and on-whites, according to two new studies.

The latest report on health insurance coverage from the U.S. Census Bureau finds that 10.4% of the population lacked health insurance in 2014, compared with 13.3% in 2013. The increase in coverage occurred among both people with private insurance and those with some form of government coverage.

The greatest percentage-point increase in coverage was among what the report labels direct-purchase, which grew by 3.2 percentage points to include 14.6% of Americans. That was followed by a 2.0 percentage point increase of those covered by Medicaid, to 19.5% of the population.

The rate of private coverage went up by 1.8 percentage points to 66%.

A second study, published online in Health Affairs, shows that the gap in the uninsurance rate between black and white adults narrowed from 10.7% to 6.7% between the third quarter of 2013 and the end of 2014. At the start of the period 25.5% of black adults and 14.8% of white adults were uninsured, compared with 17.2% and 10.5%, respectively, at the end of the period.

Hispanic adults also saw a decline in the percentage of uninsured, from just over 40% to 31.8%, narrowing the uninsurance gap with whites from 25.3% to 21.3%.

Data for the Census Bureau report came from the Current Population Survey Annual Social and Economic Supplement, while the Health Affairs study data came from the 2014 National Health Interview Survey.

A third recent report, prepared by the National Academy for State Health Policy, breaks down the decline in the number of uninsured according to whether the state established its own exchange or uses the federal exchange. Among the former group—which includes 14 states and the District of Columbia—Kentucky had the largest decrease, at 41%. Among states using the federal marketplace, North Dakota and Ohio tied for the largest decreases at 24%.

While uninsurance declined for all groups in the expansion states, whites saw no significant declines in the non-expansion states. Consequently the difference in white/black uninsurance rates fell from 7.4 to 3.3 percentage points in the expansion states but from 11.1 to 4.8 percentage points in non-expansion states.

For Hispanic adults the disparity with whites also declined in both expansion and non-expansion states to 19.3 and 23.0 percentage points, respectively in 2014. The study does not specify the actual percentages of uninsured among Hispanic adults, but notes that in expansion states, surprisingly, the ratio of Hispanic to white uninsurance was higher in 2014 than 2013.

The Census Bureau report found that insurance coverage remains strongly correlated with education and household income. In 2014, 95% of Americans age 25 to 64 with a graduate or professional degree were insured, compared with 82.2% of high school graduates and 69.4% of those without a high school diploma.

Payer consolidation

3 ways insurance mergers will affect physician practices

The recent mega-mergers in the payer industry are creating concern among healthcare providers across the country and leading them to ask how far this trend will go and how they can respond. Providers can anticipate at least three consequences:

1. Fee-for-service (FFS) rate increases will be reduced.

The most obvious impact is that payer consolidation aggregates buyer power, thereby lessening providers’ negotiating leverage. This means that some providers will see fewer (and smaller) rate increases in an already very challenging reimbursement environment.

2. Corporate integrations will be consuming payers’ attention.

Partnering to create solutions with payers is going to be harder while payers are undergoing the gritty work of integrating operations among merged companies. Providers should expect that new collaborations, particularly those requiring customizations on infrastructure such as IT, may be delayed or deferred.

3. Encroachments on provider roles may accelerate.

One of the drivers of payer consolidation is payers’ desire to develop complementary capabilities, including population health and provider-like capabilities. For example, Humana has been building its portfolio of employed physician practices, while Aetna has long invested in care management. Together, these can form a more comprehensive portfolio of assets with higher performance potential if properly integrated. Pursuit of and investment in these capabilities may lead to reduced patient volumes for providers, higher barriers to providers thinking of expanding their own services, and customer confusion where both the payer and provider are pursuing those functions.
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Practices are considering the cost and best way to invest in new tech. Here are some strategies to make it work.

**by JANET KIDD STEWART, Contributing author**

**HIGHLIGHTS**

- Practice technology costs are being funneled into EHR software, mobile devices such as tablet computers, and outsourcing firms that keep practices running.
- Many practices today use subscription fees rather than buying technology outright, but that isn’t always the best strategy.

**WITH PRACTICES** now caught between huge demands for digitizing records and shorter-than-ever product innovation cycles for technology upgrades, they need to be choosier about which investments will pay off.

Kenneth Kubitschek, MD’s internal medicine group in Asheville, North Carolina, has never shied away from technology investments. “We’ve always felt like the efficiencies outweighed the costs, though we weren’t always sure about that right away,” he says.

Kubitschek’s 13-provider group has declined thus far to purchase a new patient portal that lets heart, diabetes, and weight management patients stream daily (or even more frequent) information about their conditions to their doctors.

“That doesn’t mean forever, but for right now we’re passing on some of these products,” says Kubitschek, who is a member of the Medical Economics editorial advisory board. “We’re waiting to see how we’re going to handle all this new information we’re going to receive on patients. If I’m getting your blood pressure 16 times a day, trying to stay on top of what’s going on can be a massive task.”

As for other new technology buys, Kubitschek’s practice likes to see the technology evolve to the point where the benefits outweigh the costs, both in financial terms and staff time devoted to training, he says.

That kind of balance makes sense, of course. But how can physicians maintain that when they are under pressure to modernize, particularly with new demands involving electronic health records (EHRs)?

Many small groups don’t do cost accounting that would put technology spending in context with revenues, experts say, and larger practices’ spending varies by type of practice and where the group is on the equipment upgrade cycle. A large accountable care organization might spend 3% or more of revenues on information technology alone, for example, while costs for more narrowly-focused organizations might be half of that.
Regardless of the spending size relative to revenue, it’s clear that health IT spending is still on the rise, and practices are feeling the pinch. According to a January 2015 report from the Centers for Medicare & Medicaid Services, the portion of U.S. physicians using electronic health records grew from 18% in 2001 to 78% in 2013—fueled, in part, by subsidies made available through the Meaningful Use program.

A poll this year of 5,700 small group and solo practitioners by Black Book Rankings found that 48% of practices that switched their EHR systems recently reported that the resulting financial burden put their practices in an unstable financial position.

And more costs await many practices. While system implementation problems declined between 2013 and this year, the survey found, 91% of practitioners said lack of interoperability among physicians, hospitals, clinics, and labs was their biggest concern. That suggests another round of system replacements is ahead.

“As risk sharing increases, so will the demand for meaningful, robust data sharing between providers and payers, regardless of the model EHR employed,” says Doug Brown, president of Black Book Market Research.

AVOIDING A BAD BUY
So how can practices stay current on the latest technology without putting themselves in financial jeopardy?

Prioritizing is an important first step, says John Lovelock, research vice president for The Gartner Group, a consulting firm that forecasts information technology spending by industry. Practices are spending less on computers and other hardware such as printers, and fixed networking costs are declining, he says.

The savings are being funneled into EHR software, mobile devices such as tablet computers, and outsourcing firms that keep practices running, Lovelock says, so that overall costs aren’t necessarily dropping, even though prices in some categories are. “Physician software sales are growing at 9% a year for the next five years,” he says.

Like Kubitschek, Lovelock believes that managing device-oriented patient data is going to be the next major challenge for practice budgets. “The whole trend in [patient] wearables (devices capable of sending health data to doctors offices) puts physicians on the beach when this wave of data comes in. It’s going to require a huge change in practice design and commensurate systems,” Lovelock says.

For now, he says, practices are putting more money in the cloud and less into owning software licenses and maintaining their own servers as they manage the data they already have. “It’s no longer viable for many practices to own their own data center,” he says. “The trick is knowing where the heart of your practice is going to be in the next three years, then finding the technology that handles that function” and prioritizing that in your budget, he says.

That’s fundamentally different than letting technology trends drive spending, he says, and why it’s important to manage those top-level decisions yourself rather than deferring to the techies. “The problem for many physicians is that they aren’t tech experts and so they have to trust the recommendations of someone selling them a product,” says Richard Bloomfield, Jr., MD, a pediatric hospitalist and director of mobile technology strategy at Duke University School of Medicine.

Bloomfield says his father, a solo practitioner in family medicine, has resisted adopting an EHR system thus far. “He still uses a transcriptionist. While I’m passionate about technology, it’s not always the best solution. Sometimes people want technology because they think it will solve a
“It’s no longer viable for many practices to own their own data center. The trick is knowing where the heart of your practice is going to be in the next three years, then finding the technology that handles that function.”

— JOHN LOVELOCK, RESEARCH VICE PRESIDENT, THE GARTNER GROUP

problem. Sometimes that’s true and sometimes not.”

Hiring a third-party adviser not connected to a vendor is one solution, but simply adopting a healthy skepticism is essential, Bloomfield says. "When someone is asking me about buying the latest widget, I ask, 'What problem are you trying to solve? And is this the most cost effective way to do that?'

"I'm the first to say that having gone through the transition from dictating notes to entering notes myself into the EHR, it is painful. There is nothing easier than dictating notes and having a transcriptionist take care of it," Bloomfield says.

Bloomfield believes that the massive data trove that EHRs will produce will incentivize patients to take better care of themselves and will point physicians to better treatment plans and outcomes, though he concedes that is still a goal, not reality. In the meantime, arm yourself with a few key best practices when making your next budget decision about tech spending:

1/ Suspend disbelief

Particularly if you practiced for many years without computer technology, it can be easy to adopt such a skeptical attitude that you go overboard and shun all new ideas. Don’t do that, says Lee Orsag, CHBC, chief executive officer of Altex Business Solutions, an IT support company specializing in practice management software.

"So many times clients can be short-sighted and resistant to change, and yet so many tools today cost very little and help practices file claims more efficiently, post payments more efficiently and allow all that data to be tracked automatically," he says. "Because they don’t understand it or because it costs $30 a month, they’ll spend days posting a Medicare claim that could be done in hours."

Automated claim posting also can catch errors before they are officially submitted to payers, he says. He cites the example of a client who was considering adding an automated claims-processing system for whom Altex tested a sample of 102 claims. "We found 10 claims with errors, which means those would have bounced back under the old system and would have had to be refiled with Medicare. Those bounce-backs really add up in terms of staff time."

Another common mistake among practices is succumbing to short-sightedness regarding future outlays, he says. "It's very economical for a 25-computer practice to upgrade [software systems] once a year, but if you tend to wait two to three years, you have to buy it again," he says. In addition to managing the upgrade cycle, providers also need to determine whether owning or leasing equipment makes sense. "Some physicians just at any cost want to own equipment and avoid monthly payments."

2/ Negotiate

When searching for tech vendors, don’t forget to negotiate every time, experts say. Look for new players wrapping together several services, such as EHR and billing management software, for a lower combined price, says Judy Boesen, principal at Medical Practice Enhancement Services LLC in Colorado Springs, Colorado. Some vendors will charge 2.9% of billings to perform both tasks rather than a set fee, she says.

And don’t forget future costs, says Brown of Black Book Market Research. For example, in the survey, practices reported significant unexpected EHR add-on fees as contracts progressed to their later years. Nearly 80% reported higher-than-anticipated increases for implementation assistance. And nearly 70% said they were caught off-guard by additional staffing required to manage their EHR systems.

In practices with more than...
six physicians, annual spending on information technology rose 55% from a median $16,044 per physician in 2008 to $25,028 this year, according to Black Book surveys, while Medicare fee-for-service rates stayed basically flat during that period.

“That’s significantly affecting 2016 purchase planning for other capital equipment, staffing and supplies,” says Brown. Total operations staff per 10,000 patients increased from 4.9 to 8.1 during the period.

Meanwhile, small and solo practitioners expressed even more pain than their large-practice counterparts, he says, citing “ongoing losses in productivity and changes in workflow, escalating costs to maintain IT and related staffing and static reimbursement. Their current go-to solution has been to replace their original EHR with a cloud-based option and to outsource billing and collections.”

Scrutinizing tech vendor contracts is critical for maintaining costs, notes Ronald Sterling, CPA, principal consultant with Sterling Solutions Ltd. “It has to be a results-oriented contract,” he says. “Make sure [the vendor] will maintain the features that are relevant to your practice,” including connectivity needed to link with health exchanges and other entities. Also insist on language that requires the vendor to continue upgrading the product, he says.

While many practices today use subscription fees rather than buying technology outright, that isn’t always the best strategy, Boesen says. “Costs for hardware have really come down and even in software it’s sometimes more cost-effective to own,” she says, so it’s important to do a comprehensive pro-forma when deciding which path to take.

Experienced physicians tend to want to pay for a physical server in their office rather than using a cloud-based system, Orsag says. “They want something they can put a cup of coffee on,” he says. “They don’t want to lie awake at night wondering where their data is.”

Remember that each method has its advantages and drawbacks, experts say.
Technology

Financing technology

“The problem for many physicians is that they aren’t tech experts and so they have to trust the recommendations of someone selling them a product.”

—RICHARD BLOOMFIELD, JR., MD, DIRECTOR OF MOBILE TECHNOLOGY STRATEGY, DUKE UNIVERSITY SCHOOL OF MEDICINE

Maintaining hardware can be costly, labor intensive and vulnerable to damage, but cloud-based services can be equally costly and either method potentially poses a data breach risk.

In the Black Book survey, practitioners said five-year total costs under a cloud-based, software service model were $54,295 per physician, compared with $62,394 for practices using in-house servers.

6/ Run the numbers
Another way to control technology costs is by outsourcing, Kubitschek says. In addition to deciding whether to purchase software for managing self-reported patient health data, his practice is experimenting with outsourcing fees for the new Medicare codes for chronic disease management.

“It’s a telephone service where people call on your patients to check on them, make sure they’re getting to appointments and taking their medications,” he says. “I’m working on a pro forma right now to see if it would be better to hire this out. We don’t have a real good feel yet which way will be better. It’s kind of an unknown and you’d have to convince patients they want to participate and get their consent. I hesitate to start hiring for this when we don’t know how many would sign up.”

7/ Use a decision tree
Kubitschek performs an informal litmus test on most technology purchase decisions: Is it beneficial to the patient? Does it help the practice from an efficiency standpoint? If it’s a benefit to the practice, is it at least neutral for the patient?

“It’s always a balancing act of coming up with the best use of new technologies” without blowing the practice’s technology budget, he says. “I remember when e-mail first came out, we had a couple of physicians who insisted every email had to be printed out, and then a reply was dictated and put back in electronically. That didn’t last long.”

8/ Determine the upside potential
If there’s any good news to the grim data on technology costs, it may be that some of these systems are doing a better job with coding, says Boesen, so that some of these new costs are being recovered.

“In my experience practices do much better coding when they are using an EHR system,” she says. “All of your charge data is electronically transferred to a practice management system. It lets you review the note when getting ready to file a claim so you can make sure the doctor charged for everything. At one practice I found an average of six missed charges a day, [before the EHR] so there are some pluses.”

For Julie Gunther, MD, a family physician in Boise, Idaho, with a direct-pay practice model, having an EHR system that also manages e-mails and texts with patients has paid for itself in a different way. On a recent family vacation, the solo doctor stayed in touch with patients electronically, answering non-emergency questions when she found some down time.

The 24/7 on-call aspect, doesn’t bother her, she says, because she’s better able to manage her work load and schedule throughout the year. Fewer dollars invested in staff and sophisticated payer-management systems—she recently picked up a $400 printer at Costco rather than leasing—as also means she can spend more on office décor and other patient-focused amenities.

“I have a partner starting shortly, so in the future if patients need a face-to-face meeting they can see her,” she says. “For now, I have a personal cell phone to stay in touch and that’s really all I need.”
Recommend ALEVE®, with the strength of naproxen sodium. Give your patients all-day relief from minor OA pain with just 2 doses.

With ALEVE®, your patients can have FEWER DOSES. FEWER INTERRUPTIONS.

Your patients on Extra Strength Tylenol® and Advil® may require more frequent dosing if their pain persists, so they may have more interruptions throughout their 24-hour day.

FEWER DOSES. FEWER INTERRUPTIONS.

Recommend ALEVE®, with the strength of naproxen sodium. Give your patients all-day relief from minor OA pain with just 2 doses.

Strong on pain. Long on relief.
If you use electronic health records (EHRs), chances are you’ve asked yourself some version of the question, “Why can’t I find an EHR that helps me provide better care for my patients, lets me run my practice more efficiently, and is easy to use?”

It’s certainly a reasonable question to ask. After all, EHRs have been on the market for about 20 years now, and in the last four years their manufacturers have received more than $30 billion in indirect government subsidies through the meaningful use program. Yet in the 2015 Medical Economics Physician EHR Survey, doctors’ mean ratings of their EHRs was only 5.3 out of a possible 10.
**Overall Opinion of EHR**

What physicians think about the overall quality of their system

What do physicians think about their EHR system? Does it work for them or is it more of a hindrance? Metrics and ratings aside, this rates how physicians feel in their gut about their purchasing decisions.

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**Total EHR score**

Average score of all metrics

The 2015 Medical Economics Physician EHR survey asked physicians to rate their systems based on 29 metrics, including technical support, quality metrics, clinical support, Meaningful Use, and more.

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And even that result was more positive than some others. In a report published earlier this year by the AmericanEHR consortium, for example, only 33% of respondents said they were “satisfied” or “very satisfied” with their EHR, and fewer than a third said they would purchase the same software again.

Similarly, a landmark 2013 Rand Corporation study of factors affecting physician professional satisfaction found that EHRs lead to lower satisfaction due to the technology’s poor usability, the time required for data entry, and interference with face-to-face patient care, among other reasons. If consumers had similar opinions of technology giants like Apple or Amazon those companies would have been out of business long ago.

So why aren’t EHRs evoking more enthusiasm from their customers? And going forward, what will it take for vendors to create products that are more user-friendly? The latter issue becomes especially urgent as practices increasingly are paid based on patient outcomes, rather than the volume of patients they treat.

Medical Economics put those questions to experts and consultants in the field of health information technology. Their answers fall into two broad, interrelated categories: The products themselves, and the ways they are purchased and used.

**CAPTURING THE EXAM ROOM INTERACTION**

While most EHR systems are pretty good at functions such as e-prescribing or providing a portal for patient communication, they fall short when it comes to doing what primary care doctors generally value most: capturing the exam room interactions that lie at the heart of the physician-patient encounter. That’s because such interactions are usually free-flowing and not easily recorded—if at all—by the templates on which most EHR systems rely.

“Doctors don’t walk into the exam room and say, ‘I’m going to ask you a series of questions the way it’s designed on this form,’” says Mark Anderson, FHIMSS, chief executive officer of AC Consultants in Montgomery, Texas, and a former hospital chief information officer. “They want the patient to tell them what the
THERE’S A REASON HIS SOLO PRACTICE IS SO SUCCESSFUL. HE’S GOT 4,300 PEOPLE WORKING FOR HIM.

When we work as one, staying independent is a healthy option. work as one

athenahealth
Cloud-based services for medical groups and health systems.
Many EHR systems provide assistance with managing claim denials to ensure a physician practice’s revenue is not disrupted. Especially as physicians adjust to using the ICD-10 code set, having a system that can help protect revenue is a must.

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## Vendor support

Vendor’s ability to resolve technical problems with your EHR

Is your vendor there when you need them? Glitches and system crashes can derail a physician’s day and harm a practice’s workflow, not to mention the aggravation of waiting on the phone instead of seeing patients. Technical support and vendor-supplied training are key when shopping for an EHR system. Nothing leads to buyer’s remorse faster then poor customer service.

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In 3 head-to-head studies of 6-12 months in >3400 patients

**ULORIC powerfully lowered sUA to target levels <6 mg/dL**$^{2,3*}$

- ULORIC 80 mg was proven superior to allopurinol 300 mg at lowering sUA
  - 70% of patients on ULORIC 80 mg (N=1258) had a sUA level of less than 6 mg/dL at the final visit vs 40% on allopurinol (N=1260)**

- The 40-mg starting dose of ULORIC effectively lowered sUA similarly to allopurinol 300 mg$^2$
  - 45% of patients on ULORIC (N=757) had a sUA level of less than 6 mg/dL at the final visit vs 40% on allopurinol (N=1260)**

**Individual results may vary based on factors such as baseline sUA levels.**

**ULORIC was superior to allopurinol in a subgroup of >1400 gout patients with mild to moderate renal impairment**$^{28||}$

- 50% of patients on ULORIC 40 mg (N=479) had a sUA level <6 mg/dL at the final visit vs 42% on allopurinol 300/200 mg$^1$ (N=501) [p<0.05], and 72% of patients on ULORIC 80 mg (N=503) [p<0.05 vs allopurinol and ULORIC 40 mg]$^{2,4}$

- No dose adjustment is necessary in patients with mild to moderate renal impairment$^2$
  - For patients who do not achieve the sUA target level of <6 mg/dL after 2 weeks with ULORIC 40 mg, ULORIC 80 mg is recommended

There are insufficient data in patients with severe renal impairment and no data in patients with severe hepatic impairment. Caution should be exercised in these patients.$^2$

---

sUA=serum uric acid.

*Based on results combined across three phase 3 studies; ULORIC 40 mg was included only in one of the studies, and ULORIC 80 mg and allopurinol were included in each of the studies.$^2$

$^1$In the APEX trial, allopurinol patients (n=10) with serum creatinine >1.5 mg/dL and ≤2 mg/dL were dosed at 100 mg daily. In CONFIRMS, allopurinol patients (n=145) with estimated creatinine clearance (Cl$_{cre}$) ≥30 mL/min and Cl$_{cre}$ ≤59 mL/min were dosed at 200 mg daily. All other patients received 300 mg daily.$^2$

$^p<0.001$ vs allopurinol.$^1$

*CONFIRMS study (6 months).$^2$

*Mild to moderate renal impairment is defined as estimated Cl$_{cre}$ 30-89 mL/min.$^4$

*Allopurinol patients (n=145) with estimated Cl$_{cre}$ ≥30 mL/min and Cl$_{cre}$ ≤59 mL/min were dosed at 200 mg daily.$^2$
ULORIC (febuxostat) is not indicated to treat CKD\(^2\)

There are insufficient data in patients with severe renal impairment; therefore, caution should be exercised in these patients.\(^2\)

**Indication**

ULORIC is a xanthine oxidase (XO) inhibitor indicated for the chronic management of hyperuricemia in patients with gout. ULORIC is not recommended for the treatment of asymptomatic hyperuricemia.

**Important Safety Information**

- ULORIC is contraindicated in patients being treated with azathioprine or mercaptopurine.
- An increase in gout flares is frequently observed during initiation of anti-hyperuricemic agents, including ULORIC. If a gout flare occurs during treatment, ULORIC need not be discontinued. Prophylactic therapy (i.e. ~ NSAIDs or colchicine) upon initiation of treatment may be beneficial for up to six months.
- Cardiovascular Events: In randomized controlled studies, there was a higher rate of cardiovascular thromboembolic events (cardiovascular deaths, non-fatal myocardial infarctions, and non-fatal strokes) in patients treated with ULORIC \([0.74 \text{ per 100 P-Y (95\% CI 0.36-1.37)}]\) than allopurinol \([0.60 \text{ per 100 P-Y (95\% CI 0.16-1.53)}]\). A causal relationship with ULORIC has not been established. Monitor for signs and symptoms of MI and stroke.
- Hepatic Effects: Postmarketing reports of hepatic failure, sometimes fatal, have been received. Causality cannot be excluded. During randomized controlled studies, transaminase elevations greater than three times the upper limit of normal (ULN) were observed (AST: 2%, 2%, and ALT: 3%, 2% in ULORIC and allopurinol-treated patients, respectively). No dose-effect relationship for these transaminase elevations was noted.

Obtain liver tests before starting treatment with ULORIC. Use caution in patients with liver disease. If liver injury is detected, promptly interrupt ULORIC and assess patient for probable cause, then treat cause if possible, to resolution or stabilization. Do not restart treatment if liver injury is confirmed and no alternate etiology can be found.

- Adverse reactions occurring in at least 1% of ULORIC-treated patients, and, at least 0.5% greater than placebo, are liver function abnormalities, nausea, arthralgia, and rash.

Please see the accompanying brief summary of the ULORIC full Prescribing Information on adjacent pages.

**Learn more at ULORIC.com/HCP**

**References:**

2. ULORIC (febuxostat) prescribing information. Takeda Pharmaceuticals.
ULORIC (febuxostat) tablet for oral use

INDICATIONS AND USAGE
ULORIC is a xanthine oxidase (XO) inhibitor indicated for the chronic management of hyperuricemia in patients with gout. ULORIC is not recommended for the treatment of asymptomatic hyperuricemia.

CONTRAINDICATIONS
ULORIC is contraindicated in patients being treated with azathioprine or mercaptopurine [see Drug Interactions].

WARNINGS AND PRECAUTIONS

Gout Flare
After initiation of ULORIC, an increase in gout flares is frequently observed. This increase is due to reduction in serum uric acid levels, resulting in mobilization of urate from tissue deposits. In order to prevent gout flares when ULORIC is initiated, concurrent prophylactic treatment with an NSAID or colchicine is recommended.

Cardiovascular Events
In the randomized controlled studies, there was a higher rate of cardiovascular thromboembolic events (cardiovascular deaths, non-fatal myocardial infarctions, and non-fatal strokes) in patients treated with ULORIC (0.74 per 100 P-Y [95% Confidence Interval (CI) 0.36-1.37]) than allopurinol (0.60 per 100 P-Y [95% CI 0.16-1.53]) [see Adverse Reactions]. A causal relationship with ULORIC has not been established. Monitor for signs and symptoms of myocardial infarction (MI) and stroke.

Hepatic Effects
There have been postmarketing reports of fatal and non-fatal hepatic failure in patients taking ULORIC, although the reports contain insufficient information necessary to establish the probable cause. During randomized controlled studies, transaminase elevations greater than three times the upper limit of normal (ULN) were observed (AST: 2%, 2%, and ALT: 3%, 2% in ULORIC and allopurinol-treated patients, respectively). No dose-effect relationship for these transaminase elevations was noted [see Clinical Pharmacology].

Obtain a liver test panel (serum alanine aminotransferase [ALT], aspartate aminotransferase [AST], alkaline phosphatase, and total bilirubin) as a baseline before initiating ULORIC.

Measure liver tests promptly in patients who report symptoms that may indicate liver injury, including fatigue, anorexia, right upper abdominal discomfort, dark urine or jaundice. In this clinical context, if the patient is found to have abnormal liver tests (ALT greater than three times the upper limit of the reference range), ULORIC treatment should be interrupted and investigation done to establish the probable cause. ULORIC should not be restarted in these patients without another explanation for the liver test abnormalities.

Patients who have serum ALT greater than three times the reference range with serum total bilirubin greater than two times the reference range without another explanation for the liver test abnormalities are at risk for severe drug-induced liver injury and should not be restarted on ULORIC. For patients with lesser elevations of serum ALT or bilirubin and with an alternate probable cause, treatment with ULORIC can be used with caution.

ADVERSE REACTIONS

Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

A total of 2757 subjects with hyperuricemia and gout were treated with ULORIC 40 mg or 80 mg daily in clinical studies. For ULORIC 40 mg, 559 patients were treated for ≥6 months. For ULORIC 80 mg, 1377 subjects were treated for ≥6 months, 674 patients were treated for ≥1 year and 515 patients were treated for ≥2 years.

Most Common Adverse Reactions
In three randomized, controlled clinical studies (Studies 1, 2 and 3), which were six to 12 months in duration, the following adverse reactions were reported by the treating physician as related to study drug. Table 1 summarizes adverse reactions reported at a rate of at least 1% in ULORIC treatment groups and at least 0.5% greater than placebo.

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>Placebo (N=134)</th>
<th>ULORIC (N=1279)</th>
<th>allopurinol* (N=1277)</th>
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<tbody>
<tr>
<td>Liver Function Abnormalities</td>
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<tr>
<td>Nausea</td>
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<tr>
<td>Arthralgia</td>
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<tr>
<td>Rash</td>
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<td>0.5%</td>
<td>1.6%</td>
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</table>

* Of the subjects who received allopurinol, 10 received 100 mg, 145 received 200 mg, and 1122 received 300 mg, based on level of renal impairment.

The most common adverse reaction leading to discontinuation from therapy was liver function abnormalities in 1.8% of ULORIC 40 mg, 1.2% of ULORIC 80 mg, and in 0.9% of allopurinol-treated subjects.

In addition to the adverse reactions presented in Table 1, dizziness was reported in more than 1% of ULORIC-treated subjects although not at a rate more than 0.5% greater than placebo.

Less Common Adverse Reactions
In Phase 2 and 3 clinical studies the following adverse reactions occurred in less than 1% of subjects and in more than one subject treated with doses ranging from 40 mg to 240 mg of ULORIC. This list also includes adverse reactions (less than 1% of subjects) associated with organ systems from Warnings and Precautions.

Blood and Lymphatic System Disorders: anemia, idiopathic thrombocytopenic purpura, leukocytosis/leukopenia, neutropenia, pancytopenia, splenomegaly, thrombocytopenia.

Cardiac Disorders: angina pectoris, atrial fibrillation/flutter, cardiac murmur, ECG abnormal, palpitations, sinus bradycardia, tachycardia.

Ear and Labyrinth Disorders: deafness, tinnitus, vertigo.

Eye Disorders: vision blurred.

Gastrointestinal Disorders: abdominal distention, abdominal pain, constipation, dry mouth, dyspepsia, flatulence, frequent stools, gastritis, gastrointestinal reflux disease, gastrointestinal discomfort, gingival pain, haematemesis, hyperchylorhydria, hematochezia, mouth ulceration, pancreatitis, peptic ulcer, vomiting.

General Disorders and Administration Site Conditions: asthenia, chest pain/discomfort, edema, fatigue, feeling abnormal, gait disturbance, influenza-like symptoms, mass, pain, thirst.

Hepatobiliary Disorders: cholelithiasis/cholecystitis, hepatic steatosis, hepatitis, hepatomegaly.

Immune System Disorder: hypersensitivity.

Infections and Infestations: herpes zoster.

Procedural Complications: contusion.

Metabolism and Nutrition Disorders: anorexia, appetite decreased/increased, dehydration, diabetes mellitus, hypercholesterolemia, hyperglycemia, hyperlipidemia, hypertriglyceridemia, hypokalemia, weight decreased/increased.

Musculoskeletal and Connective Tissue Disorders: arthralgia, joint stiffness, joint swelling, muscle spasms/twitching/tightness/weakness, musculoskeletal pain/stiffness, myalgia.

Nervous System Disorders: altered taste, balance disorder, cerebrovascular accident, Guillain-Barré syndrome, headache, hemiparesis, hypoaesthesia, hypoaesthesia, lacunar infarction, lethargy, mental impairment, migraine, paresthesia, somnolence, transient ischemic attack, tremor.

Psychiatric Disorders: agitation, anxiety, depression, insomnia, irritability, libido decreased, nervousness, panic attack, personality change.

Renal and Urinary Disorders: hematuria, nephrolithiasis, pollakiuria, proteinuria, renal failure, renal insufficiency, urgency, incontinence.

Reproductive System and Breast Changes: breast pain, erectile dysfunction, gynecomastia.

Respiratory, Thoracic and Mediastinal Disorders: bronchitis, cough, dyspnea, epistaxis, nasal dryness, paranasal sinus hypersecretion, pharyngeal edema, respiratory tract congestion, sneezing, throat irritation, upper respiratory tract infection.

Skin and Subcutaneous Tissue Disorders: alopecia, angio edema, dermatitis, dermographism, ecchymosis, eczema, hair color changes, hair growth abnormal, hyperhidrosis, peeling skin, petechiae, photosensitivity, pruritus, purpura, skin discoloration/alteration, skin lesion, skin color abnormal, urticaria.

Vascular Disorders: flushing, hot flush, hypertension, hypotension.
Laboratory Parameters: activated partial thromboplastin time prolonged, creatine increased, bicarbonate decreased, sodium increased, EEG abnormal, glucose increased, cholesterol increased, triglycerides increased, amylase increased, potassium increased, TSH increased, platelet count decreased, hematocrit decreased, hemoglobin decreased, MCV increased, RBC decreased, creatinine increased, blood urea increased, BUN/creatinine ratio increased, creatine phosphokinase (CPK) increased, alkaline phosphatase increased, LDH increased, PSA increased, urine output increased/decreased, lymphocyte count decreased, neutrophil count decreased, WBC increased/decreased, coagulation test abnormal, low density lipoprotein (LDL) increased, prothrombin time prolonged, urinary casts, urine positive for white blood cells and protein.

Cardiovascular Safety

Cardiovascular events and deaths were adjudicated to one of the pre-defined endpoints from the Anti-Platelet Trialists’ Collaborations (APTC) (cardiovascular death, myocardial infarction (and non-fatal stroke) in the randomized controlled and long-term extension studies. In the Phase 3 randomized controlled studies, the incidences of adjudicated APTC events per 100 patient-years of exposure were: Placebo 0 (95% CI 0.00-6.16), ULORIC 40 mg 0 (95% CI 0.00-1.08), ULORIC 80 mg 1.09 (95% CI 0.44-2.24), and allopurinol 0.60 (95% CI 0.16-1.53).

In the long-term extension studies, the incidences of adjudicated APTC events were: ULORIC 80 mg 0.97 (95% CI 0.57-1.56), and allopurinol 0.58 (95% CI 0.02-3.24).

Overall, a higher rate of APTC events was observed in ULORIC than in allopurinol-treated patients. A causal relationship with ULORIC has not been established. Monitor for signs and symptoms of MI and stroke.

Postmarketing Experience

Adverse reactions have been identified during postapproval use of ULORIC. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship.

Hepatobiliary Disorders: hepatic failure (some fatal), jaundice, serious cases of abnormal liver function test results, liver disorder.

Immune System Disorders: anaphylaxis, anaphylactic reaction.

Musculoskeletal and Connective Tissue Disorders: rhabdomyolysis.

Psychiatric Disorders: psychotropic behavior including aggressive thoughts.

Renal and Urinary Disorders: tubulointerstitial nephritis.

Skin and Subcutaneous Tissue Disorders: generalized rash, Stevens Johnson Syndrome, hypersensitivity skin reactions.

DRUG INTERACTIONS

Xanthine Oxidase Substrate Drugs

ULORIC is an XO inhibitor. Based on a drug interaction study in healthy subjects, febuxostat altered the metabolism of theophylline (a substrate of XO) in humans. Therefore, use with caution when coadministering ULORIC with theophylline.

Drug interaction studies of ULORIC with other drugs that are metabolized by XO (e.g., mercaptopurine and azathioprine) have not been conducted. Inhibition of XO by ULORIC may cause increased plasma concentrations of these drugs, leading to toxicity. ULORIC is contraindicated in patients being treated with azathioprine or mercaptopurine [see Contraindications].

Cytotoxic Chemotherapy Drugs

Drug interaction studies of ULORIC with cytotoxic chemotherapy have not been conducted. No data are available regarding the safety of ULORIC during cytotoxic chemotherapy.

In Vivo Drug Interaction Studies

Based on drug interaction studies in healthy subjects, ULORIC does not have clinically significant interactions with colchicine, naproxen, indomethacin, hydrochlorothiazide, warfarin or desipramine. Therefore, ULORIC may be used concomitantly with these medications.

USE IN SPECIFIC POPULATIONS

Pregnancy

Pregnancy Category C: There are no adequate and well-controlled studies in pregnant women. ULORIC should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Febuxostat was not teratogenic in rats and rabbits at oral doses up to 48 mg/kg (40 and 51 times the human plasma exposure at 80 mg/day for equal body surface area, respectively) during organogenesis. However, increased neonatal mortality and a reduction in the neonatal body weight gain were observed when pregnant rats were treated with oral doses up to 48 mg/kg (40 times the human plasma exposure at 80 mg/day) during organogenesis and through lactation period.

Nursing Mothers

Febuxostat is excreted in the milk of rats. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when ULORIC is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in pediatric patients under 18 years of age have not been established.

Geriatric Use

No dose adjustment is necessary in elderly patients. Of the total number of subjects in clinical studies of ULORIC, 16% were 65 and over, while 4% were 75 and over. Comparing subjects in different age groups, no clinically significant differences in safety or effectiveness were observed but greater sensitivity of some older individuals cannot be ruled out. The Cmax and AUC24 of febuxostat following multiple oral doses of ULORIC in geriatric subjects (≥65 years) were similar to those in younger subjects (18 to 40 years).

Renal Impairment

No dose adjustment is necessary in patients with mild or moderate renal impairment (Clcr, 30 to 89 mL/min). The recommended starting dose of ULORIC is 40 mg once daily. For patients who do not achieve a sUA less than 6 mg/dL after two weeks with 40 mg, ULORIC 80 mg is recommended.

There are insufficient data in patients with severe renal impairment (Clcr less than 30 mL/min); therefore, caution should be exercised in these patients [see Clinical Pharmacology].

Hepatic Impairment

No dose adjustment is necessary in patients with mild or moderate hepatic impairment (Child-Pugh Class A or B). No studies have been conducted in patients with severe hepatic impairment (Child-Pugh Class C); therefore, caution should be exercised in these patients.

Secondary Hyperuricemia

No studies have been conducted in patients with secondary hyperuricemia (including organ transplant recipients); ULORIC is not recommended for use in patients whom the rate of urate formation is greatly increased (e.g., malignant disease and its treatment, Lesch-Nyhan syndrome). The concentration of xanthine in urine could, in rare cases, rise sufficiently to allow deposition in the urinary tract.

OVERDOSAGE

ULORIC was studied in healthy subjects in doses up to 300 mg daily for seven days without evidence of dose-limiting toxicities. No overdose of ULORIC was reported in clinical studies. Patients should be managed by symptomatic and supportive care should there be an overdose.

CLINICAL PHARMACOLOGY

Pharmacodynamics

Effect on Uric Acid and Xanthine Concentrations: In healthy subjects, ULORIC resulted in a dose dependent decrease in 24-hour mean serum uric acid concentrations and an increase in 24-hour mean serum xanthine concentrations. In addition, there was a decrease in the total daily urinary xanthine excretion. Also, there was an increase in total daily urinary xanthine excretion. Percent reduction in 24-hour mean serum uric acid concentrations was between 40% and 55% at the exposure levels of 40 mg and 80 mg daily doses.

Effect on Cardiac Repolarization: The effect of ULORIC on cardiac repolarization as assessed by the QTc interval was evaluated in normal healthy subjects and in patients with gout. ULORIC in doses up to 300 mg daily, at steady-state, did not demonstrate an effect on the QTc interval.

Pharmacokinetics

Special Populations

Renal Impairment: Following multiple 80 mg doses of ULORIC in healthy subjects with mild (Clcr, 50 to 80 mL/min), moderate (Clcr, 30 to 49 mL/min) or severe renal impairment (Clcr, 10 to 29 mL/min), the Cmax of febuxostat did not change relative to subjects with normal renal function (Clcr, greater than 80 mL/min); AUC and half-life of febuxostat increased in subjects with renal impairment in comparison to subjects with normal renal function, but values were similar among those with renal impairment groups. Mean febuxostat AUC values were up to 1.8 times higher in subjects with renal impairment compared to those with normal renal function. Mean Cmax and AUC values for three active metabolites increased up to 2- and 4-fold, respectively. However, the percent decrease in serum uric acid concentration for subjects with renal impairment was comparable to those of ULORIC in subjects with normal renal function (56% in normal renal function group and 55% in the severe renal function group).

No dose adjustment is necessary in patients with mild to moderate renal impairment [see Use in Specific Populations]. The recommended starting dose of ULORIC is 40 mg once daily. For patients who do not achieve a sUA less than 6 mg/dL after two weeks with 40 mg, ULORIC 80 mg is recommended. There is insufficient data in patients with severe renal impairment; caution should be exercised in those patients [see Use in Specific Populations].

ULORIC has not been studied in end stage renal impairment patients who are on dialysis.
Hepatic Impairment: Following multiple 80 mg doses of ULORIC in patients with mild (Child-Pugh Class A) or moderate (Child-Pugh Class B) hepatic impairment, an average of 20% to 30% increase was observed for both Cmax and AUC0∞ (total and unbound) in hepatic impairment groups compared to subjects with normal hepatic function. In addition, the percent decrease in serum uric acid concentration was comparable between different hepatic groups (62% in healthy group, 49% in mild hepatic impairment group, and 48% in moderate hepatic impairment group). No dose adjustment is necessary in patients with mild or moderate hepatic impairment. No studies have been conducted in subjects with severe hepatic impairment (Child-Pugh Class C); caution should be exercised in those patients [See Use in Specific Populations].

NONCLINICAL TOXICOLOGY
Carcinogenesis, Mutagenesis, Impairment of Fertility
Carcinogenesis: Two-year carcinogenicity studies were conducted in F344 rats and B6C3F1 mice. Increased transitional cell papilloma and carcinoma of urinary bladder was observed at 24 mg/kg (25 times the human plasma exposure at maximum recommended human dose of 80 mg/day) and 18.75 mg/kg (12.5 times the human plasma exposure at 80 mg/day) in male rats and female mice, respectively. The urinary bladder neoplasms were secondary to calculus formation in the kidney and urinary bladder.

Mutagenesis: Febuxostat showed a positive mutagenic response in a chromosomal aberration assay in a Chinese hamster lung fibroblast cell line with and without metabolic activation in vitro. Febuxostat was negative in the in vitro Ames assay and chromosomal aberration test in human peripheral lymphocytes, and L5178Y mouse lymphoma cell line, and in vivo tests in mouse micronucleus, rat unscheduled DNA synthesis and rat bone marrow cells.

Impairment of Fertility: Febuxostat at oral doses up to 48 mg/kg/day (approximately 35 times the human plasma exposure at 80 mg/day) had no effect on fertility and reproductive performance of male and female rats.

Animal Toxicology
A 12-month toxicity study in beagle dogs showed deposition of xanthine crystals and calculi in kidneys at 15 mg/kg (approximately four times the human plasma exposure at 80 mg/day). A similar effect of calculus formation was noted in rats in a six-month study due to deposition of xanthine crystals at 48 mg/kg (approximately 35 times the human plasma exposure at 80 mg/day).

PATIENT COUNSELING INFORMATION
See FDA-Approved Patient Labeling (Patient Information)

General Information
Patients should be advised of the potential benefits and risks of ULORIC. Patients should be informed about the potential for gout flares, elevated liver enzymes and adverse cardiovascular events after initiation of ULORIC therapy.

Concomitant prophylaxis with an NSAID or colchicine for gout flares should be considered.

Patients should be instructed to inform their healthcare professional if they develop a rash, chest pain, shortness of breath or neurologic symptoms suggesting a stroke. Patients should be instructed to inform their healthcare professional of any other medications they are currently taking with ULORIC, including over-the-counter medications.

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Deerfield, IL 60015

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ULR015 R4_Brf

For more detailed information, see the complete prescribing information for ULORIC (febuxostat) tablets at Uloric.com or contact Takeda Pharmaceuticals America, Inc. at 1-877-825-3327.

L-TXF-0313-5
ing the system.”

Adding to the frustration of many employed physicians, Friedberg notes, is the fact that hospitals and health systems often customize the systems they purchase, in ways that the physicians may or may not like, but can do little to alter. Vendors sometimes will cite this as a reason for user unhappiness, an explanation that Friedberg dismisses.

“It’s a little disingenuous for the vendor to say, ‘it’s not our fault, the hospital put in all these customizations that are making you unhappy,’” Friedberg says. “But the truth is, the hospital probably did that for a reason, which is that the core EHR product wasn’t functional. They needed to change it to make it work for their physicians.”

RAND’s 2013 study showed that while EHRs improved physician satisfaction in some ways and detracted from it in others, the key determinant for almost all doctors was the technology’s impact on patient care. “If they thought they were doing the right thing by their patient, they went home happy,” he says. “But if they felt like something was limiting their ability to do well by their patients they were frustrated and miserable.”

THE CHALLENGE FOR SMALL PRACTICES

Smaller, physician-owned practices face a different challenge in purchasing an EHR. Unlike in a large system, the physician is making the buying decision. The problem there, Friedberg says, is “you’re taking people whose expertise is in clinical care and asking them to make a big technology purchasing decision. And it’s hard for them to know exactly what impact each product will have on their clinical life.”

Compounding their challenge is the difficulty of finding reliable information about many EHR products due to “gag clauses” that many of the biggest vendors include in their user contracts. “If you’re looking for an underlying problem causing a lot of these surface issues, that’s a biggie,” says Friedberg. “How is the industry supposed to evolve when you can’t talk about your EHR without violating the contract you signed with them? It would be like going to a restaurant and having to sign a document saying you can’t rate them on Yelp before you can get a meal.”
Population Health

Your EHR’s ability to use registries, sort patients into cohorts, and analyze data.

Slicing data to determine the needs of patients in your panel will be mandatory to meet payment initiatives based on quality metrics and value-based care. How do EHRs stack up in their ability to manage patient populations?

<table>
<thead>
<tr>
<th>Brand</th>
<th>Availability</th>
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HITECH, MU IMPACT

Underlying much of the discussion over EHR usability—or lack of it—is the impact of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and the Meaningful Use (MU) program and EHR certification requirements that it spawned, on the EHR industry and on doctors.

Few people on either side would dispute that the HITECH Act has achieved its goal of dramatically increasing EHR use. The question is whether that increased usage has come at the cost of stifling innovation in the industry and creating greater unhappiness among EHR users.

“Because of the timelines in place [for implementing MU] the vendors had to move very quickly because they knew they had to get certified or become irrelevant in the market,” says the AAFP’s Waldren. “And what we found [in the AmericanEHR consortium study, in which the AAFP participated] was a massive decrease in user satisfaction in the 2011-2014 MU time frame. And I think it’s because vendors were required to get the products out ASAP, and so the functionalities weren’t aligned with what physicians actually needed to take care of the patient in front of them.”

“Physicians, like most consumers, will go where the money is,” notes Rowley. And if you’re being rewarded for incorporating EHRs, you’ll get one, even though it may be the wrong one. It’s like saying ‘we’ll subsidize you for buying a suit,’ and it turns out it fits you all wrong.”

Data presented at a September meeting of ONC’s Health IT policy committee support Waldren’s and Rowley’s theory. It shows the percentage of MU participants, known as “eligible professionals” who changed their EHR vendor quadrupled from 2% to 8% between the 2013 and 2014 program years.

Schleyer says EHR vendor representatives have told him that “innovation came to a halt because they had to focus on all the stipulations of complying with Meaningful Use.”

“That wasn’t a bad thing per se. The adoption curve of EHRs speaks for itself,” he adds. “But usability was somewhat of an unintended casualty on the road to getting more people to use these systems.”

For his part, Reider scoffs.
Physicians face a wrenching transition over the next few years as Medicare and private payers begin paying them on the basis of “value” rather than volume. This move to value-based reimbursement requires a new approach to care delivery that emphasizes population health management, patient engagement, efficiency, and high-quality care, as defined by evidence-based medicine guidelines.

What many physicians don’t realize is that their electronic health records (EHRs) can help them achieve these goals. Although EHRs are not designed for population health management, the leading vendors are starting to add or improve components that enable aspects of population health management that would otherwise require significant manual effort.

Large groups and healthcare systems may be in a better position to adapt their current EHRs to value-based care, because they have information technology (IT) staff that can do the custom programming required. Small and medium-sized practices, however, can use the standard features and functions of their EHRs to prepare for this transition.

Regardless of practice size or setting, technology alone will not enable physicians to prepare for value-based care, notes John Kontor, MD, executive vice president of The Advisory Board Company, a Washington, DC-based consulting firm.

Practices must also reengineer their workflows, develop the competencies of support staff, and improve the knowledge and training of providers, he adds.

Still, if physicians and staff take the time to explore the more advanced features of their EHRs, observers say, they can greatly improve their chances of success with value-based care.

**Alerts and reports**

Most EHRs have health maintenance alerts that remind physicians when patients need preventive or chronic care for common conditions. These alerts pop up only when a chart is opened, usually during a visit, and so do not provide much help in identifying care gaps across a population. Some EHRs, however, can also generate reports or have dashboards showing which patients are overdue for particular types of care, regardless of whether they have visited the office recently.

Care teams can reach out to these patients—by phone, mail, or, in some EHRs, automated portal messaging—and urge them to make appointments with their providers.

The “canned” reports that come with conventional EHRs are generally related to meaningful use clinical quality measures and, in some cases, to metrics for the Physician Quality Reporting System (PQRS).

“The systems are preconfigured for the most common health maintenance items for the most common populations,” explains Michelle Holmes, a principal with ECG Management Consultants in Seattle. “If you’re looking at HbA1c tests for your diabetics or foot exams, or cholesterol checks, most systems can run those reports on demand without any customization.”

For less common problems and patients with comorbidities, someone on your staff would have to program custom reports. “If you’re a major health system with a sophisticated IT staff, it’s a lot easier to create the custom report that you need,” Kontor says. “If you’re a small to mid-sized practice, it’s significantly challenging.”

**Registries**

The basis of EHR reports are patient registries, which are lists of patients, their diagnoses, the services provided to them, the dates of service, their most recent lab results, and so forth. Until recently, Kontor notes, EHR registries were very limited, compared to the standalone registries available from third-party vendors. But in recent years, EHR registries have improved significantly. Not only do these classify patients by far more conditions than they used to but they also provide “integrated” functions that connect the registries with functions that make the data actionable.

Holmes agrees. “A lot of these EHRs have basic care management functions,” she says. “For example,
you can set up clinical protocols. In some systems, you can enroll patients in [disease-specific] programs. You can track patients with diabetes as part of a diabetes registry and set up items you’re tracking for that population. So your care manager can have a dashboard or a registry view of all the patients enrolled in that program and where they’re tracking in terms of compliance and outcomes.”

Taking it one step further, she notes, care coordinators can drill down into registries and “click through” to document phone calls to patients or activate automated phone calls, patient portal messages, or letters. Some EHRs, she says, even enable care managers to text reminders to patients on their smartphones.

EHRs can also help practices “close the loop” on referrals and orders. Let’s say that a diabetes report indicates that a patient with that condition requires an eye exam, and their doctor orders that test. To find out whether the patient received the test from an ophthalmologist, the practice can turn on the EHR feature that allows tracking of referrals, points out Rosemarie Nelson, a health IT consultant based in Syracuse, New York. Still, it’s not as simple as flipping a switch. Someone has to insert the parameters that the practice wants to use to monitor referrals.

Patient portals

Patient portals, which are now available with most EHRs, are an indispensable tool for patient engagement and can also increase practice efficiency. Nelson estimates that effective use of a portal can save a practice half a nurse’s workday per week.

Portals can be used not only to exchange secure messages with patients, but also for delivering lab results, and for appointment and prescription refill requests. The key to success is to change the practice workflow so that someone is assigned to triage portal messages to the appropriate staff person, whether that’s a scheduler, a nurse, or a doctor, says Cindy Dunn, a consultant for the Medical Group Management Association.

Appointment reminders and links to educational materials can be funneled to patients through the portal. Some portals even have smartphone apps or mobile versions that can be used in texting, Nelson observes.

Portals can also be used for entering medical histories, Nelson adds. Some EHRs come with “skeletal” history templates that can be expanded to elicit the desired information, she explains. Patients can input their history, and a nurse or medical assistant can edit and/or supplement it, reducing providers’ documentation time.

Documentation

Population health management requires nonvisit care. Care managers must help the sickest patients care for themselves to keep them out of the ER and the hospital, and patients with chronic diseases must receive continuous care to prevent those conditions from worsening. Even fairly healthy patients need preventive care and support for healthy lifestyles.

Because EHRs were developed with episodic, office-based care in mind, they don’t have good capabilities for documenting nonvisit care. Telephone calls and emails to and from patients can be documented in the communications area of the EHR. But the content of those phone calls and emails can be hard to find and is not always forwarded to consulting physicians or auditors along with other records, notes Dunn. She suggests documenting nonvisit care in the “care plan” section of traditional EHRs.

In some EHRs, Nelson observes, encounters can be documented only for a patient with a scheduled visit. So some practices create a fake care coordination “provider” and “schedule” an appointment in the system to document nonvisit encounters. Although this workaround is effective, it also highlights the shortcomings of many EHRs for dealing with population health management, she says.

Only some EHRs provide a chronologic record of everything that was done for a patient, regardless of whether a provider or another clinician performed that service. If the messages involved in nonvisit care are kept in separate folders, Nelson says, it can be very difficult for doctors to dig up the details of care.

Analytics

Standard EHRs also fall short in the area of analytics, Kontor explains. Analytic software is required for risk stratification, predictive modeling, and other advanced functions used in population health management. EHRs have far fewer and less capable analytic tools than third-party solutions do, he points out. Moreover, healthcare organizations need data warehouses to aggregate clinical and claims data to have a comprehensive view of patient care.

Small and medium-sized practices, however, do not require such sophisticated solutions to get started down the road to value-based care, the experts say.

The utilization of EHRs for this purpose “is still back-to-basics stuff,” comments Holmes. If you look at it, there’s probably something you’re not using in the EHR.”

*athenahealth, sponsor of this article, helps health care providers take on the transition to value-based reimbursement with cloud-based EHR, practice management and care coordination services.

The athenahealth Full Value Program protects providers from program penalties while helping them take advantage of every quality care dollar, including those from new pay-for-service programs. For details, and to see how much money is at stake for practices, see athenahealth.com/fullvalue
40 at the notion of a tradeoff between speed of adoption and usability. “The automobile industry must meet certain regulatory requirements, but does that mean they can’t make heated seats and other cool things? It’s a question of resource allocation.

“There are many ways to skin a cat, and many HIT companies only looked at the surface of what the regulations required and didn’t think of creative ways of meeting them,” he adds. Reider cites the example of the requirement to capture smoking status. Many pre-MU versions of EHRs had templates that merely asked how long the patient had been smoking and how many packs per day. For MU, however, doctors had to classify patients according to one of eight Centers for Disease Control and Prevention-designated categories ranging from “never smoked” to “heavy tobacco smoker.”

“Companies that weren’t very thoughtful about this created a new workflow, pointed the finger at ONC and said ‘those bastards made us do it this way. Don’t blame us, blame them,’” Reider says. “Smart companies maintained their existing workflows, then mapped the concepts those captured to the concepts required for MU. The workflow wasn’t changed but the MU requirement was satisfied. Others said, ‘we’re just going to shovel this crap onto our customers and blame the government.’ Then the customers called us and said ‘you guys made my user experience miserable.’”

**REASONS FOR HOPE?**

So are doctors doomed to eternal unhappiness with their EHRs? Not necessarily. Experts say there is reason to believe that the technology’s usability will improve, and customer satisfaction along with it. But the process will be slow.

“The more that advocates for usability publish studies and get engaged in the industry, the more that awareness [of the importance of usability] takes hold,” says Schleyer of the Regenstrief Institute. “Of course, you also need a certain armamentarium, to know the methods. For a company just to say ‘starting tomorrow we care about usability’ is not going to fix the problem. You have to hire people who are trained in human-computer interaction.”

---

**Quality Metrics**

An EHR’s functionality for tracking performance on quality measures

Many physicians already are seeing their reimbursements based on hitting quality metrics, and it’s a trend that will only increase. A key aspect of succeeding with metrics is having an EHR that can enable you to track your performance.

<table>
<thead>
<tr>
<th>Brand</th>
<th>Final Score</th>
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<tbody>
<tr>
<td>Modernizing Medicine</td>
<td>8.5</td>
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<tr>
<td>Medent</td>
<td>7.8</td>
</tr>
<tr>
<td>Office Practicum</td>
<td>6.5</td>
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<tr>
<td>athenahealth</td>
<td>6.3</td>
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<tr>
<td>Epic</td>
<td>6.2</td>
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<tr>
<td>HealthFusion</td>
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<td>Amazing Charts</td>
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<td>eClinicalWorks</td>
<td>5.6</td>
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<td>Allscripts</td>
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<td>Greenway Health</td>
<td>4.1</td>
</tr>
<tr>
<td>Care360</td>
<td>4.0</td>
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</table>
and build user-centered design groups, and so on. And all that takes time."

The user experience committee of the Healthcare Information and Management Systems Society (HIMSS) includes "very passionate clinicians, who want systems they can trust and that make it easy for them to provide safe care," says Rod Piechowski, MA, senior director for health information systems at HIMSS. "I think you’ll see a lot more voices being raised about that in the coming years."

Reider says that before leaving ONC last year he had begun to see EHR vendors focusing more on user-centered design, but that the improvements haven’t yet shown up in the products themselves. "Their release cycles for upgrades to the products can be quite slow," he says. "So there may have been work done a year ago that hasn’t made it into the production version of a product. And even if it has gotten into the production version, it’s possible customers haven’t made that upgrade."

Usability is actually among the criteria for EHRs to attain 2014 Meaningful Use certification, Reider notes, albeit in an indirect fashion. For a subset of certification criteria, he says, vendors are required to demonstrate to ONC that they incorporated a user-centered design (UCD) process (as defined by the National Institute for Standards and Technology). ONC then would publish the results on its website. "Our hope was that by requiring the publication of usability testing that usability would improve," he explains.

A research letter in the Journal of the American Medical Association examined EHR adherence to the certification requirements for UCD among the 50 vendors with the largest number of providers attesting to MU certification with their products from April 2013 through November 2014. Of the 41 reports available for review, 34% had not stated their UCD process, 63% used fewer than the standard of 15 test participants, and only 22% used at least 15 participants with clinical backgrounds.

Asked to comment on the study, Reider replied by e-mail that "the key policy objective here was in fact reached: it’s very transparent which authorized certification bodies enforced..."
When should I use ICD-10?

- You must use ICD-9 on claims for services provided before October 1
- You must use ICD-10 on claims for services provided on or after October 1

Does ICD-10 affect my reimbursement?

- Payment for professional claims is not based on ICD-10 codes
- Payment continues to be based on CPT codes

Does ICD-10 apply to me?

- ICD-10 applies to all professionals and organizations covered by HIPAA, not just those who bill Medicare or Medicaid

For official resources, visit www.cms.gov/ICD10
Patient Portal

Usability of the patient portal from your EHR vendor

A functional and intuitive patient portal is key to lessening the administrative burdens faced by physicians and improving communication between providers and patients. It leads to more efficient workflow and boosts practice productivity, and results in healthier, more satisfied patients.

<table>
<thead>
<tr>
<th>Brand</th>
<th>Usability</th>
<th>Patient satisfaction</th>
<th>Final Score</th>
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<tr>
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<td>HealthFusion</td>
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<td>eClinicalWorks</td>
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<tr>
<td>Practice Fusion</td>
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<td>Cerner</td>
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<td>3.8</td>
<td>3.5</td>
<td>3.7</td>
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Our name is our mission.
More importantly, it compels us to continuously break down barriers and create innovative solutions to improve healthcare for everyone.

We provide specialty-specific EMR systems and practice solutions, but we are more than a healthcare technology company. At the core of what we do, it comes down to people. From patient to practice, every level of healthcare can benefit from our innovative approach to improving medical outcomes. We are Modernizing Medicine.
Survey respondents

More than 4,600 primary care physicians and specialists took part in this exclusive Medical Economics survey, conducted by Readex Research. The charts below provide a snapshot of the survey pool’s pertinent information, including practice type, size, and affiliation, and electronic health record (EHR) use and history.

**EHR use**

N=4,502
19% NO
81% YES

**Highest stage of meaningful use attested**

N=4,502
48% STAGE 2
30% STAGE 1
20% Has not attested with current EHR

**Planning to replace current EHR system**

N=3,655
13% YES
18% NOT SURE
69% NO

**Years with current EHR system**

N=3,655

<table>
<thead>
<tr>
<th>Years</th>
<th>Number of Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 year</td>
<td>13%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>27%</td>
</tr>
<tr>
<td>2-3 years</td>
<td>27%</td>
</tr>
<tr>
<td>3-4 years</td>
<td>18%</td>
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<tr>
<td>4-5 years</td>
<td>13%</td>
</tr>
<tr>
<td>5-9 years</td>
<td>6%</td>
</tr>
<tr>
<td>10-14 years</td>
<td>3%</td>
</tr>
<tr>
<td>≥15 years</td>
<td>9%</td>
</tr>
</tbody>
</table>

**Top 10 ambulatory EHR systems, by number of respondents**

<table>
<thead>
<tr>
<th>EHR</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epic</td>
<td>664</td>
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<tr>
<td>eClinicalWorks</td>
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<td>Allscripts</td>
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<td>GE</td>
<td>157</td>
</tr>
<tr>
<td>Amazing Charts</td>
<td>93</td>
</tr>
</tbody>
</table>

**Survey Methodology**

The findings cited in this report are based on a survey conducted by Readex Research on behalf of Medical Economics. Data was collected via online survey between June 23 and August 3, 2015. The survey received 4,657 responses from physicians. The majority of the survey’s results are based on the 3,655 physicians who indicated that their practice has an ambulatory EHR system.

As with any research, the results should be interpreted with the potential of non-response bias in mind. It is unknown how those who responded to the survey may be different from those who did not respond.

The margin of errors based on the responses is +/- 1.4 percentage points at the 95% confidence level.
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Clarissa Martinez, R.N.
Wichita Surgical Specialists

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Why you must avoid EHR note cloning

by BILL DACEY, Contributing author

I’ve read a lot about electronic health record (EHR) note cloning lately. How worried do I need to be about my EHR? How much “sameness” is OK?

A: Medicare carriers and contractors have said that documentation is considered cloned when each entry in the beneficiary’s medical record is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary.

Each part of the chart these days has elements that can be generated solely by the EHR, or with elements added by the physician. The chief complaints can be the “labels” or names of the template. If you use these, make sure they match the history of present illness (HPI) content that follows.

The HPI can consist of a series of queries covering the elements of location, duration, timing, quality, etc. If you use these, make sure they make sense. No one wants to see “duration: 2.” Two what? Days? Hours?

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The review of systems (ROS) is a routine offender. For instance, inadequate charting might occur if a physician includes a disclaimer such as, “complete 14-point review of systems negative except as noted in the HPI above,” and fails to include the ROS in the HPI; or it is a Level 3 visit and doesn’t require a full ROS; or there is a standard ROS blurb that conflicts with something in the HPI.

The physical exam is the second element most frequently cited as a cloning or cut and paste concern. Like the ROS, this information can be significantly out of proportion to the presenting problem(s). The ROS and exam proportion issue ties directly to the payer position that cloned documentation does not meet medical necessity criteria.

Payers will tell you that cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. They would rather see patient-specific details than generic documentation to cover a given topic or element of an encounter.

Physicians also need to consider whether the assessment and plan (A/P) overstates the number of problems addressed. A long list of codes with no visible management does not meet medical necessity criteria.

Medicare has said repeatedly that it wants to see the number, acuity, and severity/duration of problems addressed through the history, physical, and medical decision-making, rather than just seeing it in the A/P section of the chart.

The increased frequency of medical records with identical documentation across services appears to be a concern of the federal government. This is not idle chatter: There is concern that current EHR misuse results in significant over-payments.

Q: Do we have to code an established patient visit if an exam is not done on a new patient?

A: If you code the visit by time you don’t need the exam to meet the new patient visit requirements; if you code by the components of history, exam, and medical decision-making you do need the exam. Essentially, without the exam, and coding by components, you could still code an established visit.

Most often, when there is no exam there is some amount of counseling going on and the time rules apply. For instance, you must state something like, “Greater than 50 percent of the encounter spent counseling on ‘X.’”

Bill Dacey, CPC, MBA, MHA, is principal in the Dacey Group, a consulting firm dedicated to coding, billing, documentation, and compliance concerns. This article was first published in Physicians Practice. Send your coding and billing questions to medec@advanstar.com.
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- Chart Summaries

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MEDENT Named One of the Best EHR Systems for 2014

Medical Economics asked thousands of physicians to rate their EHR systems in 5 key areas: quality of care, meaningful use, patient portal, technical support and clinical decision support.

Medent scored in the top ten of every area, including #1 in three of the categories.
Increasing patient portal use: Lessons from my practice

by TIM DUDLEY, MD Contributing author

I work with a patient who is on several medications, can’t always come in to see me, and needs a little more help than your average patient. At 85 years old, she is one of my vulnerable patients. Yet what if I told you that this 85-year-old patient, though not particularly tech-savvy, has embraced my practice’s patient portal?

THIS PATIENT uses our portal to stay in touch, get alerts about medications, and other needed information and take control of her care. It may be hard to believe that we convinced an 85-year-old to use our portal, but we also managed to convince the majority of our patients; 80% of the patient population at my practice are on our portal.

This journey began eight years ago, when I adopted a portal to help manage phone calls and messages. I found that although many patients were tech-savvy, it wasn’t as easy as I thought to get them onto the portal, and while I saw some success, it was limited.

Then a few years ago, I decided to go with a new vendor, who partnered with me to drive higher portal adoption. Having so many of my patients on the portal has provided numerous benefits, including:

- Freeing up my time to spend with other patients—you may think that more communication would eat up more of my time, but in fact many of the questions that come through can be answered by other staff members.
- Allowing patients to schedule appointments and check test results online, empowering them to take more control of their care.
- Providing a quick and streamlined way to reach at-risk patients to remind them to make appointments, take their medications, schedule their flu shot or follow other medical counsel.

So how can a medical practice maximize portal adoption and reap these benefits?

The most important thing is to make sure patients have a compelling reason to use a portal. It may seem obvious, but if your practice aspires to achieve high rates of portal use it needs to ensure that patients derive value from the portal.

Nothing is worse for long-term adoption than urging patients to register for a portal and then providing them with a disappointing experience. A practice should try to ensure that it provides three major portal resources: lab results delivered online, secure messages with timely provider responses, and general support for portal questions or requests.

Then, follow these six steps for maximizing portal adoption:

1/ Develop a portal adoption policy
The policy should outline expectations for patient portal usage; part of my success stemmed from making portal registration mandatory for patients.

2/ Offer online-only lab results delivery
After collecting patient email addresses, this service provides easier access to results, encourages patients to use the portal, and reduces administrative overhead.

3/ Implement a streamlined portal training program
For both providers and non-clinical staff, a training program that emphasizes the major portal functionalities that the practice believes patients should use can go a long way to achieving patient buy-in.

4/ Craft a strong message
You need a compelling portal marketing message...
that explains the major benefits of using a portal, tailored to a practice’s service and patient mix. Your vendor may be able to help you do this—my technology partner in fact, even did it on my behalf.

5/ Support in-office registration
The ideal way to do this is by installing kiosks in the office or allowing patients to register for the portal from a registrar’s computer; these registrations produce vastly higher yields than automated e-mails sent to patients outside the office.

6/ Train or hire on-premises support
These staff members can handle complicated technical questions or assuage concerns of reluctant patients, relieving registrars of the burden of handling these issues. This can be someone’s full-time responsibility, or assigned to an administrator with other duties.

I recognize that these six steps may be burdensome for your practice and you may not be in a position to implement all of them. If you’re not able to do all of them, I recommend focusing on three best practices—electronic lab results delivery, streamlined portal adoption training, and designation of a staff portal expert— these alone can lead to portal adoption well above average and may even help you convince some of your least tech savvy patients to get on board.

Tim Dudley, MD has more than 30 years of experience delivering medical care in both in-patient and out-patient settings. He practices at DTC Family Health practice in Greenwood Village, Colorado. Send your practice management questions to medec@advanstar.com.

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ALWAYS (AMT)
Physicians are frustrated with their current electronic health record (EHR) system—58% of doctors surveyed described their EHR as “hard to use,” according to a 2015 Accenture report. With the evolving marketplace, switching EHRs may become increasingly commonplace as some systems are discontinued and others prove unable to meet future needs for information exchange, patient engagement, and data analytics. At the same time, providers must understand their role in an EHR’s success or failure and be willing to take steps to ensure the best possible outcome.

Moving to a new EHR also is fraught with stresses ranging from the cost of implementation and transferring data to the learning curve associated with a replacement system. Still, many practices are making the switch successfully. If you believe it is time for your practice to make a move, here’s what to consider to ensure your next EHR is a worthwhile investment.

Why do you want to switch? Answering that question is the first step in determining whether you will be happy with your new EHR system.

Once you’ve determined the finalists in your selection process, see the products in action in another physician’s practice.

Physicians who consider changing EHRs can take steps to ensure the next system meets their needs.
TRAILBLAZER

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Technology

Switching EHRs

54

money. It’s worth some extra financial investment to have a more robust product that is efficient for your staff.”

Because her new vendor guarantees MU2 attestation and ICD-10 transition, Lucarelli says she is confident the company places the same priority on successful compliance with federal government mandates as she does.

“Part of the reason why most of us went ahead and made the leap and converted to an EHR is the need to meet these metrics,” she says. “We initially had incentives. Now we’re past the carrot and moving onto the stick. You need to make sure you’re compliant with ongoing regulations.”

When considering switching EHRs, Peter Kilbridge, MD, senior research director at The Advisory Board Company, says physicians have to recognize that some inherent problems with EHRs won’t disappear when a new system is installed.

“There are common things people complain about with EHRs but they tend to be common across EHRs,” he says. “It takes more time to document things than it did using paper, but going to another EHR isn’t going to eliminate that problem. Maybe the tools you had in the first one aren’t as good as you hoped and you want to try a different one, but saying documentation is taking longer is a common complaint, not necessarily a reason to switch.”

Joseph Scherger, MD, vice president of Primary Care at Eisenhower George and Julia Argyros Health Center in La Quinta, California, and a member of the Medical Economics editorial advisory board has been using an EHR since 1994. Now he is helping to select a new EHR for Eisenhower Health Center, a change brought about by the scheduled phase-out of Eisenhower’s current system as well as its inability to keep up with reporting requirements.

Having used numerous EHRs during his career, Scherger has words of hope for physicians whose frustration levels with their current systems have reached a tipping point. “Your first conversion to an EHR is your most difficult conversion,” Scherger says. “Professionally, it is one of the most difficult things you will do in your career, and one of the last things you want to do is go through it again. But the second and third times are a lot easier.

“It’s kind of like a bad marriage,” Scherger adds. “Do you want to spend the rest of your life in a bad marriage? If it is really that bad, you should make the change and get in a better situation.”

For physicians looking for a fresh start with a new EHR, here are “lessons learned” from your peers:

Consider only meaningful use 2 EHRs. Kilbridge maintains that physicians should begin their search for a new EHR by looking only at ambulatory EHRs that have been certified to meet MU2 criteria. “That’s not a terribly high bar, but it is an absolute minimum,” he says. “If it is not meaningful use certified, you can’t be sure it is going to do a lot of basic things that are going to become required in the near future.”

Don’t rush to judgment. Research and review multiple EHRs before deciding on a new system. “If you don’t like product A, just don’t see one demo of product B and buy it,” Kilbridge says. “If you are unhappy the first time, make sure you look at a bunch of possibilities the second time.”

Know which functions you must have. Is patient information stored simultaneously in multiple places? Does the EHR include a search function to aid in reporting Physician Quality Reporting System metrics? “We’re moving away for payment for service to payment for value,” Scherger says. “Your record needs to be robust in telling you how you’re doing managing the patients and populations you’re serving.”

Evaluate clinical decision support. Not all EHRs are created equal in terms of clinical decision support. Scherger suggests finding one that “helps you do a better job.” “Does it give you a good patient history?” he says. “Does it take that patient history and give you suggestions on what diagnoses should be considered and what tests probably should be done? This is the digital brain that has the potential of enhancing our practice of medicine.”

Incorporate your staff in the decision. While one physician ultimately may decide which EHR to select for your practice, many voices should influence the decision. “It is important not only to get physician buy-in, but to get input...
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Switching EHRs

When selecting an EHR, says Derek Kosiorek, CPEHR, CPHIT, a principal with Medical Group Management Association (MGMA) Health Care Consulting, “You want to bring in a representative from the front desk staff, nursing staff, billing staff, if you’re including practice management, and have them all give input on their own area because this is defining how the practice works.”

Go beyond a product demonstration. Once you’ve determined the finalists in your selection process, see the products in action in another physician’s practice. “Talk to other physicians and do a site visit,” suggests Faith Protsman, MD, a family practice physician in Gilroy, Calif. “Look at their workflow. Look at how easy or difficult it is to work with the system on a day-to-day basis.”

Consider integrated systems. When replacing a “bare bones” EHR, Protsman opted for an integrated, “robust” system that included EHR, medical billing and practice management and communication services, “I talked to folks in my local area, many of whom are solo docs. Many had smaller, cheaper systems that just offered the EHR or they had one system for the EHR and one system for practice management, and everybody had complaints. Nobody was happy,” Protsman says.

EHR SWITCHING: WHAT PHYSICIANS SAY

Proportion whose practice is planning to replace EHR

- Yes: 13%
- No: 69%
- Not Sure: 18%

N=3,655

Likelihood of recommending EHR system

- Very likely: 21%
- Likely: 30%
- Not sure: 9%
- Not likely: 16%
- Not at all likely: 21%
- No answer: 3%

N=3,655

Reasons for plans to replace EHR system

- Improved ability to customize: 63%
- Better technical support: 52%
- Better customer support: 48%
- Better billing capabilities: 37%
- More cost-efficient option: 36%

N=468

Reasons for not recommending their current EHR system to a colleague

- Not meeting practice’s needs: 60%
- Poor technical support: 50%
- Little or no ability to customize: 48%
- Inadequate training: 40%
- Inadequate communication: 40%

N=1,716

Source: 2015 Medical Economics Physician EHR Survey
Recognize the importance of training.

“You’re not going to get trained on a complicated product that does all your billing for you and all of your meaningful use in two days. That’s never going to happen,” says Lucarelli, who was impressed by her replacement EHR’s 13-week training program that included weekly meetings, online webinars, and training modules.

Understand the upgrade process.

“What is it going to cost when there is a new, upgraded version of the record?” Scherger asks. “How much is it going to cost me and how much pain am I going to go through? Those are important considerations.”

Partner with your vendor.

“You not only are purchasing a product but you are purchasing a partnership with that company. Your livelihood depends on how well that software does or doesn’t perform over the next 10, 15, 20 years or longer if it becomes a true, meaningful partnership,” says Erik Bermudez, KLAS Report Research director.

Look to the cloud.

“Small practices are notoriously poorly resourced in terms of IT support,” Kilbridge says. “You don’t have an IT staff in a three-physician practice. You need products that are designed for that environment and don’t require a lot of support. Cloud-based solutions can be a good bet for exactly that reason. You don’t have to maintain the system on your own computers.

“People worry a lot about security and privacy,” he says. “I think security and privacy capabilities of the cloud are at a point where they really shouldn’t be an issue.” In addition, a good Internet connection is a must with a cloud-based system, as is a strong service level agreement that states how much downtime is acceptable.

Select a “scalable” EHR.

In addition to knowing what functions you want to retain from your current EHR, it is important to consider what features you may want to add in the future. “Make sure the tools are available that you want to grow into,” Kosiorek says. “The scalability of the system should be there. You should have a solution for a patient portal right off the bat.

Any tools like that need to be available, evaluated and looked at early on.”

Insist on strong customer support.

EHR customer support and service can range from dedicated support personnel to outsourced support departments, which often lead to unresolved technical problems and poor on-going training. “We see the account manager, who has the customer’s back, to be a very successful model,” Bermudez says. “A lot of vendors don’t have that. They have a support desk and you get a random person each and every time you call. Push your vendor. Ask them: ‘Is there someone willing to give me their name and phone number and I stick with that person to make sure I am successful as your customer?’”

Negotiate with the vendor.

Review your original vendor contract and determine what worked or didn’t work. When presented with a contract from a new vendor, know that all terms are negotiable. “The purchase agreements are written 100% sided toward the vendor,” Kosiorek says. “If you sign it, you are giving away a lot. Anything in the contract is negotiable.”

Understand your “escape clause.”

Similar to a prenuptial agreement, an escape clause outlines the terms of the dissolution of your marriage to your EHR vendor, so know the potential costs involved. “There should be a clear explanation of what the process is for conversion to another system,” Lucarelli says. “What happens to the data? How does it get converted? How much is it going to cost to get your data into a format that will go somewhere else?”

Reward your staff.

Switching EHRs typically adds to a staff’s workload, so reward them for their extra work. At the end of her practice’s “go live” day using their new EHR, Lucarelli personally thanked each staff member and told them they would be receiving a raise. “That little bit says I understand this is battle pay for going above and beyond,” she explains. “Appreciate your staff. It would be awful to have staff members jump ship because you are making a conversion. All of the sudden you’re training someone new at the same time you’re starting with a new product.”
Interoperability: How close are we?

If interoperability is to become a reality, the government and private sector must overcome existing obstacles. But how should the industry proceed? Our experts explain.

by KEITH L. MARTIN, content channel director

To date, the concept of exchanging patient health data—interoperability—is more vision than reality. While existing in pockets across the healthcare landscape, there is still no true electronic information highway for enabling physicians to share patient data efficiently.

Recently, Medical Economics convened a panel of experts to discuss the current state of interoperability and how to move closer to a goal of truly connected patient data. The panel consisted of:

- Russell P. Branzell, FCHIME, president and CEO, College of Healthcare Information Executives (CHIME);
- Leigh C. Burchell, chair, HIMSS EHR Association (EHRA) and vice president, government affairs & public policy for health IT vendor Allscripts;
- John D. Halamka, MD, a professor of medicine at Harvard Medical School, chief information officer of Beth Israel Deaconess Medical Center (Boston, Massachusetts);
- Michael J. McCoy, MD, chief health information officer (CHIO) in the Office of the National Coordinator for Health Information Technology (ONC); and
- Robert Rowley, MD, a practicing family physician, health IT consultant, and entrepreneur.

Q: Is interoperability a feasible goal?

Michael J. McCoy: Well, I think first of all the question has to be “what is the definition of interoperability?” I think that, as in many other industries, there are pockets of what would be considered interoperability now. But if you put the focus [on a definition as] the movement of data that’s relevant and important for patients, so that it’s usable by clinicians wherever they may reside and whatever the setting is, that to me is the most important definition of interoperability. And you get beyond the general, technical framework of what is interoperability, to the “what does it really mean?” in use. Yes, I think interoperability is a reasonable goal when you focus it on the movement of data that’s required for taking care of patients.

If you broaden that to research, to population health, again, I think that there are still some priority data elements that ONC and our federal advisory committees have pointed out as the crux of the most important information that needs to be moved around. We’re making great progress in that area as well.

John D. Halamka: I think Mike is exactly right, the definition of interoperability is so key. I was editing an article last night where an author was lamenting that if they in their practice referred to another practice, a pa-
tient for say, cardiac care, but they in the future, had no idea if that patient ever went or was treated, that that is an interoperability problem. So of course, if we describe this as a closed loop referral workflow, is that interoperability?

Or I was testifying to a group and I said exactly what Mike said, “Interoperability is the exchange of defined elements, such as problems, meds, allergies, notes, labs, diet, care plan, [etc.].” They said, “No it is everything, for every purpose, for everyone!” And I said, “Well, if you define interoperability that way, you are never going to achieve your goal.” Because you want hair color and toenail length? ... So let us cleanly define interoperability.

Leigh C. Burchell: It’s true that healthcare is arguably the most complex industry in which to create an interoperable data exchange environment. But other industries have done it and they’ve done it well. I think there are some parties who sometimes let their impatience for the end goal get the best of them and have some urgency to figure this out. But we’re well on our way.

There are a number of metrics that provide encouraging news in this area. From the percent of healthcare organizations that now use robust electronic health records and I think that matters in the context of interoperability, because it’s a fundamental requirement for electronic data exchange.

The number of hospitals exchanging data with providers outside of their walls has increased rapidly. There has been exponential growth in the utilization of Direct protocols

“"I think interoperability is a reasonable goal when you focus it on the movement of data that’s required for taking care of patients.”

—MICHAEL J. MCCOY, MD, CHIEF HEALTH INFORMATION OFFICER, OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.
for example, [and] the rapidly increasing volume of primary care physicians who are submitting electronic immunization to local public health agencies. All of those have increased very rapidly in the last several years.

Robert Rowley: Let me take a different tack on this. Because I think we’ve all been talking about how we can get the current systems that exist in the marketplace to exchange data, and I like the point of defining what kinds of data need to be exchanged. To me that is a fairly organization- and physician-focused way of looking at interoperability.

I’m going to throw in a somewhat different, somewhat radical perspective, which is that if we are trying to achieve interoperability between data silos, but we leave the silos intact, then we are asking the wrong question. I think the goal is universal longitudinal patient center data; something that follows a patient through their lifetime, as they move through different health plans, different providers—in and out of different systems.

I don’t believe this can be achieved, so long as patient data remains locked within the EHRs that we see on the landscape or on the horizon today.

“I don’t believe [interoperability] can be achieved, so long as patient data remains locked within the EHRs that we see on the landscape or on the horizon today.”

— ROBERT ROWLEY, MD, A PRACTICING FAMILY MEDICINE PHYSICIAN, HEALTH IT CONSULTANT, AND ENTREPRENEUR

with the same data source.

John D. Halamka: If we look at our millennials and their involvement in say multi-player online role playing games, here we have a cohort of 20 team members interacting in real time virtual reality from their iPhones and laptops. It puts medicine to shame. And one asks “Does Wikipedia and Facebook do a better job at creating shared care plans, and the idea of teams working together [better] than an EHR?” [It’s] probably true.

Russell P. Branzell: The reality is we have interoperability today. It’s just small amount and it’s only occurring usually in fairly small silos. So the concept of whether it’s realistic, well, it’s already here. Is the end state, as John stated earlier, everything, everywhere for all time? Well, that’s going to take a really, really long time. Well beyond any of our tenures in our jobs, or even in the workplace.

But the realistic view of this is, what needs to be exchanged and what time frame? And if we need to get it done in a short period of time, 18 to 24 months, that’s a much different prospect than say a 10-year road map. So the question is: “How fast can we go at a reasonable pace of adoption to accelerate the exchange?”

Michael J. McCoy: But I think overall, the federal government has done a good job in helping guide to the point where we are. I think we still have a lot of work to be done. ONC is not the doer in this regard. It is again, the coordinator and the collaborator with a variety of other people represented on this call that can help further the goals of what we need for better healthcare for the country.

Q: Let’s discuss the process of “information blocking” when it comes to sharing data via EHR. ONC, in its report to Congress, said it had received approximately 60 unsolicited reports of the practice, mostly directed at IT developers. What is the current level of information blocking in healthcare today?

Michael J. McCoy: As we did indicate to Congress, we think that there are some vendors blocking, which may be either intentional or unintentional. I think some are
indeed from vendors and their business practices; some are from health systems and their business practices.

I find that in my experience in dealing with individual physicians, most physicians are less problematic in intentionally having data blocking though they may be unintentionally doing so, by not participating in portals, not participating in other kinds of exchange that are possible. It may be financial reasons that they are not participating in some of those areas.

So when we look at a large landscape of things that can lead to the data not moving, again, my personal view is that not necessarily data blocking, but the data moves very, very slowly, and perhaps in an intentional fashion to move slowly. Because as been discussed many times, how many hospital CEOs wake up saying, “Oh, how can I make it easier for my patients to go to another hospital?”

Leigh C. Burchell: There are a lot of anecdotal stories. And that could be about software developers, it could be about providers, it could be about anybody. So there’s a lot of anecdotal information flying around, but not a great deal of quantifiable data or real research. So the acknowledgement of that [from ONC] was something we really appreciated...

The business model for information exchange right now isn’t fully baked, shall we say. In fact, the market drivers, the payment models that we have in place right now, don’t really encourage providers to exchange information for fear of losing a patient to somebody else, and losing that revenue source.

So I think, from that perspective, it raises questions about information blocking. For example, if a hospital receives two requests for connectivity from two physicians, one is in a local area, where there’s a strong referral pattern, and the other is 200 miles away in a frequent retirement area for their patients, but clearly the information volume would be less. The question would be, if the hospital prioritizes connectivity with the local person and the work on the more distant one takes longer, is that information blocking? I don’t think so. I think that you have to look at the business model environment and be realistic and pragmatic about the work that is going into this.

John D. Halamka: Do our vendors have chief information blocking officers, who wake up every morning, figuring out how to reduce interoperability? Of course they don’t. The challenge, of course, is exactly as was described by the others, if interoperability is exchanging every byte of data with every person for every purpose. Oh, well the lack of that could be information blocking.

I will tell you in Massachusetts, we have a very strong business case for sharing data because we have so much global capitated risk. We have been very early adopters of this idea of pay for quality, pay for outcomes

“I really think we are on the cusp of success. ... that combination of some government, some private sector and the business cases will push us over the finish line.”

—JOHN D. HALAMKA, MD, PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL, CHIEF INFORMATION OFFICER, BETH ISRAEL DEACONESS MEDICAL CENTER
“It’s true that healthcare is arguably the most complex industry in which to create an interoperable data exchange environment. But other industries have done it and they’ve done it well.”

—LEIGH C. BURCHELL, CHAIR, HIMSS EHR ASSOCIATION, VICE PRESIDENT, GOVERNMENT AFFAIRS & PUBLIC POLICY, ALLSCRIPTS

and not fee-for-service. It is a business imperative throughout the state to share data. So where there is a business driver, I will tell you I have never seen in the state of Massachusetts, any issue with sharing data from any vendor or any provider. I just have not seen it. And it’s because there’s a business driver.

Russell P. Branzell: I think what’s occurred here is we are in the middle of a journey as we’ve headed down this acceleration of adoption of electronic records and we’re in the middle of the journey.

The way I try to compare it, is we all start in Seattle, we’re all heading to Miami, but none of us took the same path to get there. So we are in the middle of a period of pretty serious dysfunctional adoption, which I think accelerates the perception of people not willing to exchange data or in some cases even the concept of the information blocking. And I agree with everything that’s been said relative to, it’s very difficult to find examples of true information blocking and I’ve spent quite a bit of time with our vendor partners, as part of CHIME and just like John, have never found the office of information blocking in any of their headquarters, maybe it’s hidden in a dark secret place but by their words and their actions they’re working very hard.

Robert Rowley: I think [information blocking is] something that sort of happens, more than he matter of corporate priority. I think that the problems, though they are a challenge ... are primarily technical. I think they are mainly about organizations wanting to share information.

The barrier is a political barrier. I think so long as there are multiple organizations competing for the same market, there is going to be a resistance to share data with your competitors. And that drives more reluctance. It’s not refusal to share data because the patient can ask for their data. They just make it more difficult...

I don’t think it’s willful but I think it’s just a reality that a lot of organizations are really tapped out, they’re trying to deal with things like ICD-10, they’re trying to deal with software upgrades, and things that they’ve purchased in the 90s that are no longer functional and they just can’t get around to dealing with new ways of looking at interoperability.

Michael J. McCoy: I would echo and one of the things that the Medicare Access and CHIP Reauthorization Act legislation is trying to do is and what HHS is trying to do is align so that we are making those drivers a reality. It is about data sharing and overall health with payments being tied to outcomes. It’s going to require physicians and hospitals and others in the community to understand the need for sharing data so that it’s relevant and timely and effective in reducing costs and improving outcomes.

Q: Who should take the lead on interoperability, the government or the private sector?

Robert Rowley: I think the government will set standards. They’ll create or specify standard vocabularies, standard message types, standard [human-computer interaction] functionality needed for certification of products. But I think the marketplace will determine the particulars.

An analogy I like use is the auto industry. There are thousands of different kinds of cars, but the government has set specific safety and functionality standards that ev-
“The reality is we have interoperability today. It’s a just small amount and it’s only occurring usually in fairly small silos.”

—RUSSELL P. BRANZELL, FCHIME, PRESIDENT AND CHIEF EXECUTIVE OFFICER, COLLEGE OF HEALTHCARE INFORMATION EXECUTIVES

Everybody must meet. I think the EHR industry will evolve in that way. Everything that comes to market and is certified needs to have certain capabilities to be able to exchange data easily. And I think the previous state of EHRs was to facilitate workflows within an organization, but wasn’t really thought of as exchanging data with others.

Now the rules of the road are that exchanging data with others is the most important thing. And I think that will come from the government. But I think the marketplace will determine the particulars.

Michael J. McCoy: Well, I think as stated, the role of the government is to help facilitate, not so much to regulate. I think when you look at our opportunity, it is to help convene those stakeholders—vendors, developers, large hospital systems, those representing small physicians and clinicians, and again, don’t forget the consumer or patient involved in all of this. And looking at balancing the requirements, making it happen in an expedient fashion, is a challenge that we all have to take on in order to achieve the ultimate best outcome that we can.

Leigh C. Burchell: We hear from our clients regularly that they just want some breathing room to work all of this into the new way that they do business. But I do think that there are some areas that we think government support is probably still necessary. Privacy and security being one; that’s certainly something we all need to stay on top of.

We need to be thinking through cybersecurity threats and also looking at variation in interstate laws and regulations around opt-in and opt-out—those types of topics is certainly something that still needs some attention, promotion in an appropriate way, and mapping out the best opportunities for telemedicine. I think this obviously still requires some effort because there’s such variation from state to state.

Russell P. Branzell: I think this is definitely an area where we can take a more aggressive approach. There are so many equivalent solutions where we are able to cross this country in different ways, whether that be the transportation system or financial system. We’ve figured out fairly quickly how to cross this country in an electronic format and/or even manual format.

We need to learn from those other industries and come up with a way to do this. If our Federal Reserve system worked like what we are trying to exchange [health data] on, we’d have different currencies for every state and we’d all be having to exchange currency when we travel every single day. There’s got to be a better solution to this in which we can look on fairly quickly.

John D. Halamka: I think it is unlikely we’re going to end up with a giant database in the basement of the White House, run by President Trump. I think in fact, we are going to have government working on standards, frameworks for governance, and to ensure that as a country we have regional solutions that solve the business problems of each locality.

I really think we are on the cusp of success. The private sector is taking a new role, with such things as the Argonaut Project and new standards are getting balloted every day. So that combination of some government, some private sector and the business cases will push us over the finish line.

MORE ONLINE
To hear the complete roundtable discussion, visit: bit.ly/interoperable-talk
Avoiding an EHR-related malpractice suit

As electronic health record use grows, physicians must take steps to protect themselves from liability

by SUSAN KREIMER, Contributing author

HIGHLIGHTS
• Research indicates that the number of malpractice lawsuits associated with EHRs has increased. Awareness of potential problems stemming from the ins and outs of new technology can help physician practices avoid legal repercussions.
• Incorrect data input and other user errors rank as the leading reasons for EHR-related malpractice claims.

Long gone are the days when most physicians carried patient charts into exam rooms and jotted down their findings by hand. In some ways, electronic health records (EHRs) have simplified the record-keeping process, but they also may have rendered it more complex and risky.

Research indicates that malpractice lawsuits associated with EHRs have edged upwards, intensifying the need to heed red flags. Awareness of potential problems stemming from the ins and outs of new technology can help physician practices avoid legal repercussions.

Although EHRs were cited in only 1% of a sample of lawsuits closing between 2007 and 2013, the number of EHR-related lawsuits doubled between 2013 and 2014, according to a recent analysis by The Doctors Company, a physician-owned national medical malpractice insurer in Napa, California. The insurer predicts this issue will become even more pronounced in the next few years.

“This is due in part to the reluctance of some major vendors to openly discuss design flaws and work with users to make improvements that facilitate workflow and minimize disruptive drug alerts,” says David Troxel, MD, medical director of The Doctors Company.

PIAA, the trade association that represents medical liability insurers, suggests that clinicians exercise greater caution with vendor agreements. “Vendor contracts may shift liability resulting from less than ideal software design from the vendor onto the user, so we recommend that healthcare professionals read all contracts carefully,” says P. Divya Parikh, MPH, vice president of research and risk management at PIAA, formerly known as the Physician Insurers Association of America, in Rockville, Maryland.

In navigating EHR systems, physicians often encounter drop-down menus that address the most common scenarios and omit less frequent ones, while some autocorrect features and auto-population of data fields—intended to speed up the process—adversely lead to incorrect information input, she says.

Incorrect data input and other user errors rank as the leading reason for EHR-related malpractice claims, according to The Doctors Company. From January 2007 to June 2014, 64% of the insurer’s 97 closed EHR-related malpractice claims involved user errors, while 42% were attributed to system factors. (Some claims had more than one contributing element, accounting for why the two categories do not add up to 100%.)

The most frequent user mistakes stemmed from inaccurate data, hybrid health records (existing in both paper and electronic form), EHR conversion, and issues pertaining to copying and pasting information. Less common issues in this cat-
category could be traced to user error, training and education, EHR alert fatigue, and workarounds, according to the report.

A busy physician may be inclined to forego rewriting a patient’s pertinent medical history and current physical findings. “It’s a real temptation to copy the prior note and paste it into the current visit, and then hopefully, go through the newly pasted version and delete things that are no longer relevant, and add what’s new,” Troxel says.

Too often, however, disruptions impede a physician’s intentions to delete extraneous information, resulting in longer notes that bury significant new details and increase their likelihood of being overlooked. “If you have any erroneous or dated information in there, it gets perpetuated and takes on a life of its own,” he says.

Diagnosis failures and medication errors were the top allegations among all EHR-related claims in The Doctors Company’s report. Medication mishaps involved allegedly prescribing incorrect medications, ordering an inappropriate dosage, or improperly managing the patient on the medication.

**PREPARING FOR UNEXPECTED RISKS**

Of the system-related EHR claims, 10% were associated with technology and design issues, such as the formulary and templates not being up-to-date. Electronic systems/technology failures—which occur, for example, when lab or radiology computers are unable to communicate with the main EHR—contributed to 9% of cases.

An additional 7% of cases involved lack of an EHR alert or an alarm/decision support tool. Other complaints spanned the spectrum from faulty data routing to inadequate scope or area for documentation, to fragmentation of similar information (lab and imaging test results) being stored in different areas, according to the report. Some claims contained more than one contributing factor.

Specific internal medicine subspecialists—cardiologists, hospitalists, oncologists and gastroenterologists—were most likely to face EHR-related claims, representing 20% percent of cases all together. Family physicians and general internists were accused in 16% of cases, while obstetricians/gynecologists incurred claims in 15% of cases.
The rapidity of EHR adoption has resulted in major and often unanticipated risks. For example, without proper backup of files, losing the entire electronic copy of all medical records is within the realm of possibility. Ideally, a physician should back up data to an off-site server at least once every day, says Dean F. Sittig, PhD, co-editor of the 2015 book, "SAFER Electronic Health Records: Safety Assurance Factors for EHR Resilience."

"The more reliant you are on your computer and all the data it contains, the more precautions you have to take," says Sittig, a professor in the School of Biomedical Informatics at the University of Texas Health Science Center in Houston. Also, in performing a self-assessment of your system, "you have to be really be honest with yourself" and perhaps admit, for instance, that weekly backups are inadequate.

Information overload often results from the sheer volume of important messages a physician receives about patient care. There is also an increase in mandatory clinical documentation tasks. Adhering to Meaningful Use requirements, physicians need to indicate the smoking status—using a checkbox or some other form of structured documentation—for all patients. "The rules have changed, and there's a lot more to record now," Sittig says.

Extensive data-keeping has elevated the level of responsibility and accountability for physicians as a result of extensive EHR adoption.

There is "a lot more transparency of information that wasn't there before," says Hardeep Singh, MD, MPH, chief of the health policy, quality and informatics program at Michael E. DeBakey Veterans Affairs Medical Center and Baylor College of Medicine in Houston, and the other coauthor of SAFER Electronic Health Records. "With electronic records, physicians have to realize that now we have a window into a black box that can show who has done what and who has seen what."

An EHR can track the length of time a physician spends on various tasks, such as meeting with a patient, based on starting and signing off on a computerized note. In a situation where both the primary care physician and the specialist miss abnormal test results, the EHR can audit if one or both had reviewed the findings, Singh says.

When used correctly, EHRs actually can help physicians defend their care by documenting decisions and the rationale for making them, says Mariel Taylor, JD, a healthcare litigation attorney at Greensfelder, Hemker & Gale PC in St. Louis and a member of the American Bar Association's Medicine and Law Committee of the Torts, Trial, and Insurance Practice Section.

For example, some EHR systems prompt physicians to fill out templates or forms explaining why they are overriding each particular drug interaction alert. "That could be very helpful in their defense" if a malpractice lawsuit ensues over a patient’s allergic reaction, Taylor says. Conversely, simply ignoring alerts without proper written explanation "can look bad before a jury."

Establishing guidelines for email correspondence with patients also would be a prudent measure. Taylor suggests asking patients to sign a consent form stating that e-mails don’t replace office visits and are not to be used in emergencies because physi-
EHR-related lawsuits

Physicians may not see the messages in time. This lets patients know what to expect. “A patient is more likely to file a malpractice suit if they feel like their doctor ignored them or wasn’t communicating with them,” she says.

In making the transition from paper to electronic records, quality assurance procedures should be put in place. During the transitional period, Taylor recommends cross-checking paper and electronic records to ensure there aren’t any gaps.

Physicians should select an EHR program with templates that are useful to them in accurately documenting a patient’s care, rather than a system with numerous data fields that don’t serve their needs. In addition, Taylor notes that “there has to be a way for the program to highlight critical findings, so they don’t get lost in a big, lengthy document that contains a lot of irrelevant information.”

Other useful features in some EHR systems allow for tracking a primary care physician’s referrals to specialists and documenting informed patients’ consent before procedures. The options vary considerably, says Adam Wright, PhD, an associate professor of medicine at Harvard Medical School who specializes in electronic health records and clinical decision support systems.

“Some have a lot of decision support built into them; others are blank canvases or blank slates,” he says. “You have to decide which things you care about.” For example, an EHR system can be tailored to notify patients when they are due or overdue for colonoscopies, mammograms, Pap smears, or flu shots.

EHRs have a ways to go in making modifications. “EHR is on a continuum, and the maturity of the electronic medical record is definitely in its infancy,” says Luke Sato, MD, senior vice president and chief medical officer at CRICO/Risk Management Foundation in Cambridge, Massachusetts.

Vendors should consider building some sort of intelligence into their systems that would help a physician “identify what’s critical, what’s important, and what needs to be acted upon,” he says. “Currently, the physician has to do all that work.”

“EHR is on a continuum, and the maturity of the electronic medical record is definitely in its infancy,” says Luke Sato, MD, senior vice president and chief medical officer at CRICO/Risk Management Foundation in Cambridge, Massachusetts.

Detrimental Design?

Differences in design among EHR systems also can create conundrums. As vendors try to iron out the kinks, “there’s a lot of effort being put forth to keep EHRs from becoming complicated and overwhelming for healthcare professionals. Ideally, they should be more streamlined and universal,” says Parikh, who also notes a growing consensus to limit the number of intrusive and distracting pop-up messages that physicians receive.

Upgrading to a newer and more user-friendly platform is fraught with challenges as well. Andrew Carroll, MD, FAAFP, of Renaissance Medical Group LLC in Chandler, Arizona, is converting to a third EHR system since opening his solo family medicine practice in 2003. Back then, there were few EHR options. Nine years later, the range of choices had greatly increased, and he switched to a new program. This summer, he changed once again.

“There’s a learning curve, obviously,” says Carroll, immediate past president of the Arizona chapter of the American Academy of Family Physicians. “We don’t want things to fall through the cracks, so we’re trying very hard to make sure that the transition to the new software is inclusive of the data we had previously.” This transition has entailed paying a vendor to perform the data migration from the old system.

In Carroll’s experience, “it’s very important to shop as many products as you possibly can” before selecting the right one for your physician practice. “Do not make a decision based on the cost, or what your friend is using, or what the healthcare system wants you to pick,” he cautions. “Make sure you pick the software that best integrates with your mode of care. Don’t look for the software that you need to adapt to; look for software that adapts to you.”

The EHR system in Carroll’s practice includes a robust patient portal. By entering encrypted passwords, patients are able to access their own medical records at home and review his notes from their office visits. They can update their medication lists for him to approve or correct as necessary. This way, he says, “the patient is fully invested in the medical record,” and any discrepancies are caught soon after they occur.

“It’s a real temptation to copy the prior note and paste it into the current visit ... If you have any erroneous or dated information in there, it gets perpetuated and takes on a life of its own.”

— DAVID TROXEL, MD, MEDICAL DIRECTOR, THE DOCTORS COMPANY
Top apps for medical practices

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by MEDICAL ECONOMICS STAFF

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I recommend this app for patients to track weight loss and diet. It's a great tool.
—Deborah Winiger, MD, family physician, Vernon Hills, Illinois

Canopy Medical Translator
This app has multiple languages and medical contexts to enable conversations with patients facing a language barrier.
—Stephen Rockower, MD, orthopedic surgeon, North Bethesda, Maryland

Facebook
I belong to a couple of physician groups and we ask each other questions—in a HIPAA-compliant manner, of course—as well as brainstorm about work-related problems and discuss our careers. Through the app, I can check these posts without being distracted by invitations to play FarmVille or other games like I get on my computer.
—Melissa Young, MD, endocrinologist, Freehold, New Jersey

QxCalculate
This clinical calculator and decision support tool features various cardiology risk scores, like the CHADS2 score for atrial fibrillation stroke risk, revised cardiac risk score for preoperative assessments and many more.
—Georgia L. Newman, MD, FACP, internist/geriatrician, Oberlin, Ohio

NarcCalc
This app allows me to convert easily between one narcotic or opioid to another.
—Georgia L. Newman, MD, FACP, internist/geriatrician, Oberlin, Ohio

YouTube
I use the YouTube app to calm patients’ nerves about a specific procedure that I may offer. As opposed to dissuading them from the barrage of too much information online, I will show them the video on my iPhone in the office or share the links with them to watch on their own device.
—Mark Birmingham, DPM, podiatric surgeon, Boulder, Colorado

Epocrates
I do not know how I got along without Epocrates on my belt [via smartphone]. You can check drug interactions of up to 40 different medications in seconds. Checking formulary coverage and tier for medications is also quick and there are many helpful clinical calculators. I still receive a hard copy version of the “Physician’s Desk Reference”, but the only thing I have used if for in recent years is to prop up my PC monitor higher at home to avoid neck pains from the long hours spent on the computer at night catching up all my EHR workload.
—Jeffrey Kagan, MD, internist, Newington, Connecticut

Fitbit
When people monitor their activity and set goals, they continue to be physically active. Walking 10,000 or more steps a day helps people be fit and avoid being overweight. A Fitbit measures this and other things like calories burned. One day we found an overweight patient walking circles in our waiting room. When we asked what he was doing he said he and his wife are in competition for the most steps daily and he uses every spare minute to walk. His Fitbit has him at more than 20,000 steps daily.
—Joseph Scherger, MD, family physician, La Quinta, California

Sleepbot
This free app allows you to track your sleep and wake times, as well as dreams and other sleep-related info. Most impressively, though, it has the ability to track motion and sound during your sleep, and produce a graph indicating sleep interruptions and issues. This app has potential to be used by doctors to help patients’ with sleep problems since patients can easily show their physicians their data logs. In addition, I can envision the app offering...
Skyscape
I use this medical library app’s reference material for all the things I’ve forgotten since medical school.

—David J. Norris, MD, MBA, CPE, anesthesiologist, Wichita, Kansas

GoodReader
I use this app to store and read documents on my iPad. It can read Word files, Excel spreadsheets, PDF files, and others. It has functionality for annotating and highlighting, which makes it easy to find things in meeting agendas. It also syncs with Dropbox.

—Yul D. Ejnes, MD, MACP, internist, Cranston, Rhode Island

TouchCare
This app provides secure telemedicine visits with patients. I often use it to enhance my ability to follow up with patients even if it is not possible or necessary for them to see me in the office. Since it does not require in-app documentation, I can document my visits in my EHR without duplication of efforts.

—Brian Forrest, MD, family physician, Apex, North Carolina

VOCRE
Although my medical Spanish is OK, and I have picked up a little Korean and Swahili, occasionally a patient will come in without a family member to help translate. When this happens, I have found VOCRE to be incredibly reliable in acting as a live voice to voice translator. I talk into my iPhone and it speaks the phrase to the patient in their native language. They speak back to me and my iPhone turns it into English. It’s very handy.

—Brian Forrest, MD, family physician, Apex, North Carolina

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uch like “Meaningful Use” itself, the Flex-IT 2 Act may work better in theory than in reality.

The bill, proposed by U. S. Rep. Renee Ellmers (R-N.C.) in July, likely won’t make it through Congress, but it’s seen as significant for doctors because it sends a message to the Centers for Medicare & Medicaid Services (CMS) to slow the pace of adopting meaningful use (MU) standards for electronic health records (EHRs), say those involved with the legislation.

Key provisions of the proposed bill include delaying MU stage 3 rulemaking until at least 2017 and instituting a 90-day reporting period for each year’s compliance regardless of the stage involved. CMS is scheduled to finalize Stage 3 rules by year’s end.

Only about 10% of the members of the American Academy of Family Physicians (AAFP) have met stage 2 requirements, according to AAFP President Robert Wergin, MD.

Complying with MU requirements to date has hindered many doctors’ abilities to see patients, he contends. In his own rural Nebraska practice, Wergin estimates he’s seeing 10% to 15% fewer patients now than four years ago, when he started meeting the requirements, because of the administrative burdens the efforts have imposed.

**BILL A ‘CONVERSATION STARTER’**

Ellmers’ bill has 17 cosponsors, a number that could get CMS’s attention and lead it to reconsider its Stage 3 timetable, those close to the debate say. “This is the first piece of legislation that takes a comprehensive look at meaningful use,” says Leslie Krigstein, vice president of Congressional affairs with the College of Healthcare Information Management Executives, a health IT organization that supports the legislation. The chances of the bill passing are slim, she adds, but “using it as a conversation starter is likely just as valuable.”

A Congressional battle to defund Planned Parenthood is putting all other healthcare-related measures on the back burner, says a spokesperson for Ellmers’ office. But even without the Planned Parenthood fight, it’s doubtful Congress could agree on the Flex-IT 2 Act, given the highly charged political atmosphere in Washington today, notes Krigstein. No hearings for the bill had been set as of late-September.

**FATE OF STAGE 3**

“The goal of the legislation is to add flexibility to the Meaningful Use program in the areas that have been the source of continued frustrations for clinicians,” Krigstein says. The 90-day reporting area in particular is one doctors would like to see as part of Stage 3.

In January, CMS announced it was considering a 90-day reporting period for 2015. Proponents of the Ellmers bill hope that will be extended into future years as well.

EHR vendors have raised doubts about Flex-IT 2 or any effort to slow the pace of EHR adoption. “Generally we would suggest that delaying the release of the final regulatory language around meaningful use stage 3 would not necessarily get us to the place where we are all collectively trying to go,” says Leigh Burchell, vice president of government affairs for EHR vendor Allscripts.

Burchell adds that it would be more useful for doctors and software vendors to see first what requirements CMS proposes for Stage 3 before seeking to delay anything. Knowing the CMS plan would offer a useful guide for all parties to begin their Stage 3 planning, she says.

Even at the current pace, which has included a delay in CMS issuing final rules for Stage 3, it’s unlikely that Stage 3 would start before 2018, Burchell cautions. That’s enough time for vendors to have their products ready.

John N. Frank has more than 39 years experience as a professional journalist, including coverage of the complex and changing world of healthcare. He is a contributing author for *Medical Economics*. 

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