Guest Essay

2011: Showtime for the Meaningful Use of Health IT

by Robert Gladd, ASQ member and ASQ Healthcare Division member

After more than a year of concerted groundwork effort led by the Office of the National Coordinator (ONC) within the U.S. Department of Health and Human Services (HHS), on Jan. 3, 2011, Title XIII of the American Recovery and Reinvestment Act (ARRA), the Health Information Technology for Economic and Clinical Health Act (HITECH) launched into high gear.

This year, 2011, is the first year in which eligible outpatient medical providers and hospitals can apply for incentive reimbursement funding in the wake of attestation that they have complied with the Stage One Criteria by which to demonstrate Meaningful Use of health IT (HIT) as defined by the HITECH and its subsequent operationalizing federal regulations. These regulations include National Institute for Standards and Technology-derived functional certification of electronic health record (EHR) systems.

Funding for this initiative, as noted by the American Health Informatics Association, is as follows:[1]

- $20.819 billion in incentives through the Medicare and Medicaid reimbursement systems to assist providers and organizations in the adoption of EHRs.
- $4.7 billion for National Telecommunications and Information Administration's Broadband Technology Opportunities Program.
- $2.5 billion for the U.S. Department of Agriculture's Distance Learning, Telemedicine, and Broadband Program.
- $2 billion for the ONC.
- $1.5 billion for construction, renovation and equipment for health centers through the Health Resources and Services Administration.
- $1.1 billion for comparative effectiveness research within the Agency for Healthcare Research and Quality, National Institutes of Health and the HSS.
- $500 million for the Social Security Administration.

- $85 million for HIT, including telemedicine services, within Indian Health Services.
- $50 million for IT within the Veteran's Administration.

Individual outpatient Medicare providers can generally obtain up to $44,000 in incentive reimbursements (as well as a 10% bonus for physicians practicing in certain health resources shortage areas) across a five-year period—$18,000 of that in their first year of participation. Medicaid providers can obtain $21,250 during their first year of engagement—and a total of $63,750 over the six-year life of the Medicaid incentive program. The incentive reimbursement allocation for qualifying inpatient facilities is rather complex, but can be lucrative for participating facilities complying with the criteria.

The goal of this ambitious and important initiative is to help improve healthcare quality and eventually lower the cost of care through the accelerated and significantly more widespread use of IT—a core ONC goal is to sign up at least 100,000 primary care providers during the first two years of the program. The principal long-term thrust is twofold:

1. Provide patients and their doctors with 24/7 anytime/anywhere secure authorized access to their health information at any point of care.
2. Provide from-the-trenches data for more timely comparative effectiveness research via which to improve the quality of clinical outcomes.

The U.S. National Health Expenditure is expected to consume about 18% of gross domestic product this year, and healthcare costs have been increasing at roughly four times the rate of inflation. Policymakers and citizens alike know such a path is unsustainable and significant improvement in the way the United States delivers care is long overdue.

While much controversy continues to roil with regard to the Patient Protection and Affordable Care Act, there appears to be much broader national support for the ends comprising the HITECH Act—albeit with some pointed dubiety.

Effective means to these improvement ends require widespread Meaningful Use of digital HIT. Simply put, Meaningful Use involves consistently capturing, coding, storing, retrieving and transmitting health encounter data in a standard digital alphanumeric—

and queryable—manner. It is anticipated that, within a decade, handwritten paper medical records will largely be the relics they need to become.

About making these changes, Mark Smith, M.D.,[2] president and CEO of the California Healthcare Foundation,[3] said:

> "If you think about it, we don't do anything the way we did 20 years ago. We don't shop the way we did 20 years ago, we don't make airline reservations the way we did 20 years ago, we don't get our news or information, we don't bank, don't communicate with our friends—about the only thing we do pretty much as we did 20 years ago, is healthcare."

With a now significant and concerted federal nudge, that is about to change on a large scale.

High-tech regional extension centers

Within the ONC portion of the HITECH Act expenditure was the provision of roughly two thirds of a billion dollars' worth of funding for 62 not-for-profit Regional Extension Centers (RECs) tasked with providing technical assistance for providers seeking to comply with the Meaningful Use criteria and garner the incentive reimbursements.

I now work for one of them: the HealthInsight REC.[4] The new RECs are not universally applauded within the industry, by any means. Some health HIT vendors see RECs as obstacles to closing deals, and many commercial HIT consultants similarly view RECs as competition. Others express skepticism that the RECs can adequately staff up and deploy in a timely manner to comprise an effective resource nationally.

There is indeed much to do in a relatively compressed time frame. The provider-level REC technical assistance mandate for adoption and Meaningful Use of electronic health records (EHRs) covers the following comprehensive services:

- Initial readiness assessment.
- Workflow analysis aimed at redesign for optimal alignment with HIT.
- Tailored EHR selection tools.
- Referrals to mentor clinics.
- EHR contract-negotiation tools.

- Project management for EHR implementation.
- Privacy and security best practices.
- Health information exchange assistance.
- Getting to Meaningful Use and the incentive reimbursements.

RECs are federally funded via incremental, four-year milestone-based performance grants geared toward assuring that providers participate and reach the ONC goal of Meaningful Use. I should note that engaging with RECs is not required for incentive funding eligibility.

'Clicking for cash?'

This skeptical phrase recently emerged amid HIT industry news during the Health Information and Management Systems Society 2011 conference in Orlando. It concisely expresses the concern that the Meaningful Use initiative will not amount to much more than a transient money chase—one principally benefitting HIT vendors—with quality improvement principles relegated to a faint lip-service afterthought if even considered at all.

The reservation is one that has been with me since day one of my REC tenure (as I have noted in ongoing detail on my independent REC blog). I made contact early last year with ASQ Healthcare Division Chair Joseph Fortuna, M.D, and was delighted to find him an enthusiastic supporter of the RECs and the Meaningful Use effort. Fortuna shares my unease regarding the possibility in failing to seize the moment for the inclusion of durable, tested quality improvement tactics and strategies into the REC program. He has been in discussions with top ONC officials regarding how ASQ could support the effort, modeled perhaps in line with the concepts expressed in the ASQ Healthcare Division's "Marshall Plan for Healthcare."[5]

It's now show time, act I for Meaningful Use. We all need to do whatever it takes to ensure that it's a long and successful run. It's difficult to overstate the importance of the effort, and we are all stakeholders in the outcome, whether we realize it or not. ASQ brings considerable expertise to the table and is uniquely positioned to help the industry move forward. I would hope we are accorded the opportunity to serve.

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