

ROUNDTABLE

THE AMERICAN RECOVERY AND REINVESTMENT ACT: WHAT HOSPITALS NEED TO DO NOW

Few industries depend on legislation and regulation as much as healthcare does. That's why the American Recovery and Reinvestment Act is so important for healthcare organizations of all sizes, from the smallest physician practice to the largest and most complex academic medical center. Why? Because they all stand to gain unprecedented reimbursement increases in return for meaningful use of information technology in their treatment of patients. Second, they all stand to be penalized if they don't comply with the technological specifications outlined in the act. How many healthcare organizations are currently ready to live with its provisions? What remediation do the vast majority of organizations need in order to be eligible for the rewards and disqualified from the penalties? HealthLeaders Media recently convened a panel of experts to seek answers to those questions and many more.

Panelist Profiles



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Roundtable Highlights

HEALTHLEADERS: *Over five years, the federal government will invest \$19 billion in incentives for meaningful use of IT. All of that additional reimbursement depends on whether the organization in question is meaningfully using technology in patient care. So what is meaningful use?*

BILL SHICKOLOVICH: The tenets of meaningful use include some level of certification, some level of interoperability, use of e-prescribing and some mechanism by which you can manage and report quality. Even without a formal definition, those are great foundational elements to guide decision-making. It's enough to get started.



Bill Shickolovich
Vice President and Chief
Information Officer
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HARRY GREENSPUN: It's interesting that the definition is circular. When you read it, it says, "A meaningful user demonstrates meaningful use." That's where the trouble begins. They use the word "meaningful" twice in there. One of the fears a lot of people have is what level of reporting and demonstration they're going to need in order to consistently show that they're complying. There may be a level of government oversight and interaction that many hospitals and providers have never experienced before.

HEALTHLEADERS: *In light of the fact that this is all about stimulus and IT reform and*

the goal of getting this thing going quickly suggests to me that the bar will be moderate.

GREENSPUN: The likelihood of the government having a significantly ramped-up enforcement mechanism, day one, is unlikely. When you have so many people starting from so many different places, the thought that you could actually have any sort of consistency in auditing is also unlikely.

MOLLY COYE: If there is a potential for audit, we need some idea of what providers are expected to do. It's easy to demonstrate whether you can report data, and whether you can accept data.

The hard thing will be for the government to make expectations clear regarding the future. I don't think they're going to have a great capability for auditing in the first couple of years. But at the same time, the purchasers of new systems or those who are adapting older systems are going to want to make sure they're heading in the right direction.

SHICKOLOVICH: Conversely, if we get too aggressive with it, we may get meaningful use but not necessarily meaningful value.

HEALTHLEADERS: *Let's talk about affiliated physicians. You're not sure if you're really going to meet a meaningful use definition with them or whether you really want to spend the money to integrate them into your EHR, for example.*

SHICKOLOVICH: On the community side, we're active in deploying some of this technology in pilots. The good news is we're well along our way and have already gone through all of the difficulty around planning and governance and selection and contracting and the infrastructure required to start up a big machine—to be able

deploy hundreds of physicians in small practices. The question becomes how much of an accelerant do we need to apply to that? Do we stay on our current trajectory?

JOHN WINFREY: At our facilities, the physicians who are paper-driven are all of a sudden getting very interested in electronic medical records, what can they do and how the hospital can help them. We have a system to provide them that will look and feel just like what they use inside the hospital facility itself. If we can mirror that in their offices I think they'll be well on their way to demonstrating meaningful use.

COYE: One of the important models for this will be setting up hospitals or multihospital systems as mini-RHIOs, connecting a set of referring physicians and, perhaps, providing an ASP model for the more loosely affiliated physicians. It gives hospitals the opportunity to collaborate with physicians in what hopefully can be a positive way.

HEALTHLEADERS: *What do you see in terms of the potential for improved relations with physicians out of this, or how much is this going to be a bumpy process, because of inherent tensions and suspicions.*

WINFREY: Our main fear is that once we start offering the systems, I don't know if it'll improve the relationship or not, because anything that goes wrong will be our fault [laughs].

GREENSPUN: There's a new dynamic in which a lot of hospitals have been using these systems as a way to build their ambulatory strategy, and all of a sudden the community docs are thinking the hospital's going to be a good resource for them in this very challenging area. But I will be interested to see the actual advantage of being

linked up with an individual hospital just for an EHR and how hospitals will respond, in terms of providing better decision support or informatics support, to further differentiate and build that relationship.

SHICKOLOVICH: We see it as a significant strategy to create more cohesion within our community physicians ... If we can provide the right amount of support and structure around this, it'll create more infrastructure and more value to them, which will actually support our business model.

COYE: One of our members at Health-Tech is Peace Health; just a year ago, they installed their second EHR. They've been extending their original EHR out into the community, reaching community physicians, for the past five or six years and they've had exactly the impact that you were describing at Tufts. They've bonded with the physicians in the community, and it's been a terrific way to build this relationship ... The outcome of this is not just the immediate ability to collect information; it's establishing a platform that supports community health and also improves the business model for the sponsoring hospital systems.

HEALTHLEADERS: *Well, what about the demands on the hospital systems themselves to meet meaningful use targets?*

COYE: We go from a minimalist assumption about what is going to be required of affiliated physicians, who don't have an EHR in their offices now, to the question of what will be expected of hospital systems. The demands of hospital systems will develop much more rapidly. The government will become more stringent earlier for hospitals than for the unaffiliated or independent physicians. A good example of that is computerized physician order entry. Congress is aware of the fact that research shows that CPOE actually pays off for hospitals, including community

hospitals ... It would be a mistake to purchase systems now without planning to demonstrate CPOE capabilities within the next couple of years.

WINFREY: One of the issues we're facing right now with CPOE is we're ready to go, but the problem is to get these independent physicians to go along with us. You can't have half of them on CPOE and the other half refusing.

HEALTHLEADERS: *Let's talk about the workability of the stimulus payments to drive results. When have we seen the government threatening penalties and then, if something's not rolling out the way it expects, coming back and saying, "Well, looks like 50% of the hospitals are really not moving forward on this and these penalties are too severe." What danger do we have of that?*

GREENSPUN: When you look at how they expect the money to roll out, you see it peaking in 2014 and then the penalties start kicking in shortly thereafter. That's an incredible ramp-up, and if you think of the capacity of hospitals and doctors to respond to that, you think about the ability of vendors to even be available. So, for example, if they get many fewer hospitals and physicians doing it, a lot less money's going to go out and there'd be a lot more penalties on the back end. But meanwhile, that doesn't help anybody because down the road, they actually have to achieve the savings and improvements in quality to make this whole thing work. So you're going to have to retool it.

SHICKOLOVICH: We are inherently conflicted in this challenge. By definition, this is stimulus. This is all about moving money into the economy. But yet we are holding the line on outcomes and quality, which require thoughtful planning and effective execution.

GREENSPUN: We've gone from infancy straight to awkward adolescence. We may face a very stormy period of these various unintended consequences—

problems with productivity for example, and lots of other impacts that we hadn't really forecast. And the cost may be very high. That actually may suddenly put the brakes on at a lot of organizations.

HEALTHLEADERS: *To that point, let's talk about vendor bench strength, because as hospitals and physicians scramble to meet the targets, vendors—who don't carry a lot of extra weight in terms of staffing—will have to quickly meet that need. Are they capable?*

WINFREY: The answer is no [laughter].

SHICKOLOVICH: I agree. Software and technology vendors, at their core, would readily admit that they are software and product companies. And they create a service offering to the extent to which it is required to be able to support the proliferation of their product. You've got an ecosystem around that—system implementers, integrators—to help align customer needs with product capabilities. If it's true that vendors are that way and if it's true that the likelihood of them changing their DNA overnight is low, we're stuck in the middle of trying to figure out are there enough integrators with skill sets who have the appropriate expertise to be able to manage all these balls in the air. The economy is creating a bunch of people from out of industry to come into healthcare. We're seeing a lot of financial folks. So the good news is there's plenty of IT talent. The bad news is it's not necessarily healthcare-specific.

WINFREY: I came out of the automobile industry years and years ago. Thank goodness I came out of it. But basically, you build a Ford, a Mercury, or a Lincoln and every one of them are really essentially the same. Whereas in healthcare your assembly line is patients, and every one is different.

GREENSPUN: When you have this influx of people from outside of healthcare working with healthcare, you can help them along. You can get them trained. I think that the difference and the gap in that expertise will become more and more apparent as they go farther out in the community. And it's going to be very challenging. This is going to be a time that will really separate who's able to better support them and what kind of models will do that. But at the end of the decade, we've got this huge cut coming to Medicare. And if we haven't achieved these savings by then, it's got to come out of something else.

COYE: A second related topic is the importance of creating health information exchange to link all of these systems together. The cost of health information exchange will decline as we begin to learn more about how to implement it. So we have to build a business model in which payment for services will be the responsibility of those stakeholders who are actually saving money as a result of health information exchange services. In California, for the first time in the country, we have a major national health plan agreeing to pay for state-wide health information exchange services. This is very good news for members of the Obama administration and for many states and communities around the country, because the stimulus funding for health information exchange is just enough to prime the pump—but it's not enough to make health information exchange sustainable without an ongoing method of financing it.

HEALTHLEADERS: *So where is the sustainable business model when the federal stimulus dollars are gone?*

GREENSPUN: Well, suddenly, we'll have a situation where the average doctor has an EHR; he or she has information available. And the quantity of information available for exchange will be so

much greater that the sustainability of these HIEs will be much more likely.

COYE: The advantages for health systems that are early investors in IT will rapidly become apparent because they can produce so much more information with a fairly sophisticated EHR. They will be able to deploy HIE much more rapidly and contribute more data to the exchanges.

HEALTHLEADERS: *Let's talk about the market freeze that we have going on right now as meaningful use is defined. We touched on it a little bit in our previous conversation, on vendors and their bench strength and things like that. At what point does the avalanche of implementation begin?*

SHICKOLOVICH: I don't think it's happening. People are getting incentive for use, not for purchase. So we're seeing lots of new models emerge, in terms of how software is sold, how these things are priced, how delivery is done. And I think it's causing everyone to rethink these models, such as software as a service and moving away from big up-front licensing fees and big hardware purchases. So it makes sense that we see alternative ways of financing. I don't think, given this economy, it's even possible for a typical organization to just write the check.

HEALTHLEADERS: *So are we talking about vendor financing then?*

SHICKOLOVICH: Vendor financing or partner financing. We've actually worked with some local banks to help some of the basic infrastructure that has to go into the practices, whether those be PCs or network. They're loaning the practices the money. For hardware alone, depending on the size of the practice and depending on how enabled they currently are, we've seen practices spend \$10,000 and \$25,000.

So software as a service is a great example of trying to lower the barrier of entry to get to the next discussion.

HEALTHLEADERS: *John, when you're building a financial model, say, for any kind of IT implementation, what kind of hard data do you have to plug in there and what part is making assumptions?*

WINFREY: You do have to build it on the assumptions. If we don't do it, then the cost to our system could be \$12 million, \$14 million. So we've already done a lot. We've got a lot in place. We're ready to go on CPOE. We have an electronic medical



John Winfrey
Chief Financial Officer
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record. We had physicians that are on paper and electronic, both within the hospital itself. So we had to keep progressing along on the path we're on right now. Can you build a payback model? I've always had problems with payback models when it comes to IT. Yet I think it's there. At least, unlike in the past, I've got hard dollars to point to.

COYE: There's actually another way that hospital systems could face trouble if they have invested in an expensive hospital-based EHR. Many of those vendors' ambulatory EHRs are actually pretty expensive and elaborate. How free will the hospital systems be to move toward software-as-a-service models, perhaps from different vendors, serving as light ASP models that could get the capabilities into the hands of the physician more quickly and not carry

the cost and fixed upgrade costs of the more traditional hospital systems?

GREENSPUN: That's been precisely our approach when we work with some of the large systems, saying, "Let's give the physicians in the community options"—give them a low-price option, with or without practice management; you give them a medium-priced option; and you give them a higher-priced option, which is also very closely aligned with the hospital. So that the closer they're aligned, they can actually get an escalating type of relationship, based on more robust capabilities.

SHICKOLOVICH: In our network, we've struggled with this question. Does one size fit all? Do we take an enterprisewide model or structure, whether

going that they like. But I do want to push an offering that'll work with our system for physicians who do not have an EHR.

COYE: There's traditionally a lot of interest among hospital systems in extending their EHRs out into the community for the specialists that are referring into the hospital, for obvious reasons. And for them, it is arguably very important that they have a user interface that's familiar to them, whether they're in the hospital or in their office setting. But if you think about what's happening with the readmission reimbursement policy changes that are on the horizon now, it's going to become much more important to have a map that includes primary care physicians who almost never come into the hospital.

SHICKOLOVICH: We would need a systems integrator that can actually act as a trusted third party to help bridge some of those gaps, to try to leverage some of the intellect associated with some system integrators that are either in place or starting to come into place and yet not rip and replace the core HIS, which would be very expensive.

HEALTHLEADERS: *There's been a lot written lately about the open-source option. Basically, it comes down to the system that was created for VA.*

GREENSPUN: When people look at acquiring software, something that's free seems compelling. But the fact that the software is free doesn't present the total cost of ownership. So, for many places, the tradeoff is between return on investment or the acquisition cost. And it's smaller than most people think. Yet the government has spent billions of dollars on developing Vista and Alta for the Department of Defense. These are very sophisticated systems. We ought to be able to use them. But if someone needs a car, you

just can't take a Humvee and give it to him or her, because it might not fit in the garage. Vista and Alta were built for another user with other needs.

SHICKOLOVICH: The fact that it's free is great. It's a barrier that got knocked down a little bit. But as you stated, the acquisition cost of software is a fraction of the overall cost. And if you're already committed to a technology strategy or vendor, the likelihood of you throwing that out, unless you're significantly dissatisfied, is low.

COYE: In the past year or two, there has been more interest in open-source solutions. I think the government may extend its support for these systems as a commercial offering, by contracting for ambulatory and inpatient open-source vendors, so the vendors will put more support into development of applications and improving implementation. The price differential alone makes this worth exploring.

GREENSPUN: So now is there going to be a government vendor option? In trying to advance these things, does the government have to provide another option to make something affordable? And does that change the game for private industry? For instance, I'm not sure the problem is lack of choice in applications.

WINFREY: In fact, that might be a confusion point.

HEALTHLEADERS: *So are we looking at probable consolidation in the vendor space?*

SHICKOLOVICH: Absolutely.

WINFREY: Yes.

GREENSPUN: We sit above the fray since we're a vendor-neutral organization. We work with lots of different vendors. If you attend HIMSS and you see the thousands of booths, there are

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Chief Medical Officer
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it's an extension of an HIS or an ambulatory EHR vendor that has one set of choices, and all these independent physicians need to all get on board? We felt, in light of reality in our business and our related physicians, that we wanted to give them a little more independence and more of a lightweight solution.

WINFREY: My situation might be a little different as far as competition goes. But for those who do have EHR systems up and running right now, it's up to me, really, to find out how I can make that work. I don't want to change those that have already got something

certainly market leaders. And I think you're going to basically start boiling down. We talked earlier about the fact that people aren't writing checks right now. So you'll see a lot of consolidation, a lot of companies not being able to survive this time before the purchasing tidal wave. In the past, people were looking to these vendors to provide an interesting, differentiating application to fit specific needs. Now it's down to: What do I need to do to satisfy the requirements of meaningful use and fit my business needs?

SHICKOLOVICH: And now that their reimbursement is dependent on this, people are going to want to make sure they're working with a solid vendor that's going to be around to support them. And which vendors have the vision and capability to actually make you better over time and which have that base of customers to be able to spur that innovation and not be a laggard relative to competitors?

GREENSPUN: We'll be curious to see if the hospitals and docs say to the government, "Hey, we did what you told us. We bought a certified system. We've got everyone becoming meaningful users. And the application that we bought now no longer meets your evolving definition, and the software company's out of business. Is it our fault?"

HEALTHLEADERS: *Let's talk about whether these decisions should be made outside the fact that the stimulus bill is rewarding meaningful use. There are other reasons to do this, yes?*

SHICKOLOVICH: Well, forget vendor selection and product and cost and contracting. Those are all mechanics that have to get done. So you've got to understand the business drivers that are making you make the decision. We didn't have the stimulus a year ago. So are the business keys enough to carry the adoption curve? What's the business case and why are you doing it? And that has to be developed, under-

stood, and sold every day. That's work. That's effort.

WINFREY: We've been doing that all along. But really, the difference is now physicians are coming to us and saying, "Help!"

HEALTHLEADERS: *John, talk about the conversations you have with your board about these issues. Do you feel like they're plugged in and understand where the docs are coming from and do they give you any direction on how to implement this?*

WINFREY: Well, this piece is all brand new to them. But I think the board has always been interested in tying the docs in closer to us to be able to share information back and forth. Have they really been pushing it? No, not at this point. And quite frankly, they've also been a little reluctant for us to spend money and resources on the docs without some type of payback to do that. So in the past, it wasn't a hot issue. It's going to be hotter as we move forward. As a leadership team, we are working on how we're going to roll it out before we bring it up to the board because we're all still trying to figure out what meaningful use is. Do we have a system that's going to be certified? I think we do. But we're not sure of that at this point. The board wants a specific case made for what you plan on doing. And right now, we don't have that specific case.

GREENSPUN: Going back to the time frame that it actually takes to get these things implemented, I think people often dramatically underestimate that. What's been a challenge is that I'm not sure the government has articulated what the long-term vision is.


COYE: We are seeing the outlines of some of the answers that we will need to take to our boards for discussion, and that will shape our strategies. For example, if federal policy moves to bundled payments, that's going to reinforce the need for integrated systems,

including the primaries in the community and the hospital systems, and that will drive the shape of future systems.

HEALTHLEADERS: *We've left out one important part of this equation. The ultimate responsibility for driving the value in all this is patients doing what they're supposed to.*

WINFREY: That was the issue I wanted to raise. In 2020, the vision may not be for a patient to walk in to any doctor anywhere in the country and get all their health information. Maybe it's not having a patient walk into a doctor's office at all.

COYE: We've got a great deal of evidence that we can change consumer and patient behavior, making both their quality of life better and driving down costs due to the utilization of emergency departments and hospitalizations, with 85% satisfaction among the consumers participating in it. The problem is we don't have aligned incentives. So beyond the VA and some of the integrated provider-based plans, hospital systems experimenting with these solutions have basically shut down very successful experiments because they stripped out volume—the potential savings were all losses for the hospitals. So if health reform bundles payments or uses other approaches to align incentives, we'll rapidly see traction on this. The barrier is not the willingness of consumers to participate in these kinds of programs. The barrier has been a system that rewards all the wrong behaviors for institutions as well as consumers.

GREENSPUN: For example, the VA has done some great things with home health, but it's a closed system. And so, again, it's the issue of alignment of incentives and the fact that, if I'm a physician, that I would get paid more for keeping my patients out of my office and out of the hospital. That would be a very different model. 

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