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WHITEC to provide technical resources for Wisconsin practices implementing EHRs

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Just the thought of implementing an electronic health record (EHR) system can be overwhelming. After all, we became physicians because we wanted to take care of people, right? For many of us, sitting in front of a computer wasn't part of the picture.

But EHRs are here, and a 2007 survey by the Medical Group Management Association revealed that most of those who had implemented EHRs wouldn't go back. In fact one respondent said, "After 3 years on EHR, I would never go back to paper charts. It's a daunting project, but well worth the time and effort."¹

Why? The benefits of going paperless can be significant, ultimately resulting in increased quality and efficiency and lower costs. At the same time, the process can be complex, costly, and time-consuming. It may take from 6 months to 2 years to move from the planning stage to becoming fully operational, and many practices don't have the necessary resources to work through that process. So over the past year, the Wisconsin Medical Society has offered programs and resources to assist practices with

the EHR selection and implementation process, as well as the use of data for quality improvement and patient outcomes.

Then in February, the Society was 1 of 5 members of a consortium awarded a 4-year, \$9.125 million federal grant, funded under the American Recovery and Reinvestment Act of 2009, for the operation of the Wisconsin Health Information Technology Extension Center (WHITEC). Other consortium members are the Wisconsin Primary Health Care Association, the Wisconsin Hospital Association, the Rural Wisconsin Health Cooperative and MetaStar, Inc.

WHITEC will provide an array of services designed to provide education, outreach and technical assistance to Wisconsin physicians, physician assistants and nurse practitioners to select, implement or improve the use of their EHR with the goal of becoming a "meaningful user" of their system. The general requirements of meaningful use include the following:

- using a "certified" system that allows for information exchange.
- the ability to report clinical quality data and other reporting measures.
- e-prescribing as appropriate.

Achieving these goals through EHRs will allow eligible providers to receive incentive payments from Medicare and Medicaid beginning

For more about WHITEC

WHITEC website:
www.whitec.org

Health IT website:
<http://healthit.hhs.gov>

in 2011. Although the definition of meaningful use won't be finalized until later this spring, it's already clear that if the criteria are met, incentives can add up, perhaps even offsetting the cost of the EHR as well as providing additional savings through increased efficiency. The maximum incentive available per provider is \$44,000 for Medicare and \$63,750 for Medicaid.

The time to begin a thoughtful selection process and implementation is now. Rushing can lead to poor decisions that won't work over the long-term; and starting in 2015, providers not actively using a certified EHR in compliance with the meaningful use definition will be subject to financial penalty.

WHITEC services will be available for a fee to all providers practicing in Wisconsin, and financial subsidies will be available the first 2 years to "priority primary care providers" who are defined as:

- physicians and other health care professionals with prescribing privileges in practices of 10 or less providers.

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cal staffs.² The medical staff conflict of interest policy should call for identifying physicians who have financial relationships with the hospital (such as employment or exclusive contracts) to guard against manipulation, while protecting them from retribution from the hospital when the physicians support the quality decision even when it does not advance the hospital's bottom line. Medical staff decision-making should be transparent and geared toward decisions that will promote quality patient care.

Code of Conduct

What is in the code of conduct that applies to the medical staff? If you don't know now, you might later find out the hard way that it prohibits conduct that would not occur to you as being "inappropriate" or "disruptive"³—such as conduct that competes with the hospital system. As most corporations and other organizations do, the hospital corporation has a code of conduct, which will apply to physicians unless the medical staff adopts a medical staff specific code of conduct governing its members' behavior. Hospital codes of conduct are designed for employees but often do not translate well to physicians who are not employees, directing complaints to the Human Resources Department instead of to peer review, or punishing violators who, for example, are automatically "disruptive" when they admit patients because a poorly written Code condemns "conduct that adds to the workload of the staff." Physician behavior should be addressed and controlled as warranted by the organized medical staff in the medical staff's code of conduct.⁴

Meetings

Medical staffs that have meeting requirements that do not work for

the medical staffs are medical staffs that do not work. Many medical staffs have outdated requirements for meetings that are either unenforced or unenforceable, so that the medical staff never takes an action because it never has a forum. If your medical staff does not meet, consider revising your structure to permit virtual meetings that can take place online, over an extended period during which physicians can log in and comment, vote, and otherwise participate.

Bylaws

The home for medical staff organization is its medical staff bylaws. Do your medical staff bylaws need some housecleaning? If the basic organizational problems described here are not resolved in your medical staff bylaws, the answer must be "yes." In Wisconsin, medical staffs have the benefit of a court ruling that medical staff bylaws are a contract.⁵ Medical staff bylaws are strengthened by this holding, but it is crucial that the medical staff bylaws are current and helpful for the medical staff. It's your contract with the hospital—make it a good one. And if your medical staff's hospital is accredited by the Joint Commission, know that changes in the accreditation requirements are pending and may be put into operation in 2011. Stay tuned for changes for your organized medical staff.

References

1. Joint Commission standard MS 08.01.03, Element of Performance 2.
2. American Medical Association. AMA Policy Compendium H-225.957.
3. Joint Commission standard LD 03.01.01, Element of Performance 4.
4. American Medical Association. AMA Council on Ethics and Judicial Opinion E-9.045.
5. *Austin v Mercy Health System*, 1995 WL 525250 (Wis. App.).

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- ambulatory clinics connected to a public or critical access hospital.
- community health centers or rural health clinics.
- other ambulatory settings predominantly serving uninsured, underinsured and medically underserved populations.

Each participating practice will complete an initial readiness assessment. Then, an individualized plan will be developed to provide a methodical process and needed services for achieving effective EHR implementation. For those practices that have already adopted and are striving for meaningful use, tailored assistance will be available.

Other WHITEC services include the following:

- workflow analysis and redesign tools.
- technology selection.
- contracting and purchasing tools.
- assistance with implementation.
- best practice information in privacy and security.
- assistance in interoperability and health information exchange.
- EHR optimization.

Practices interested in working with WHITEC are encouraged to complete an Application to Participate form, which is available on WHITEC's website: www.whitec.org. For more information, visit the website or e-mail QandE@wismed.org.

Reference

1. Margolis J. The great, the awful and the scary. What adopters have to say about implementing an EHR. *MGMA Connexion*. 2008; July: 24-27.

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