Any analysis of the current American healthcare system must acknowledge the role of the Affordable Care Act ("ACA") as the predominant legislative and regulatory catalyst in our health services system. However, perhaps the earliest area of provider adaptation has come not as a response to the regulatory scheme of the Affordable Care Act, but rather as an effort to satisfy "Meaningful Use" requirements of its precursor, the American Recovery and Reinvestment Act of 2009 ("ARRA").

**THE ACT**

ARRA is known in common parlance as “the Stimulus.” As a response to the Great Recession, Congress passed ARRA to address a number of economic issues, including healthcare. Title XIII of ARRA is referred to as the Health Information Technology for Economic and Clinical Health Act ("HITECH") and was intended to address myriad healthcare issues including quality, information technology, and privacy. In fact, HITECH establishes an office within the Department of Health and Human Services ("DHHS") to coordinate nationwide health technology, ensure improvement of quality, and to generally increase efficiency. Indeed, in response to the efficiency requirements of the ARRA and ACA, burgeoning topics such as population health management, accountable care organizations, and the network of patient-centered medical homes have been regular topics of discussion in healthcare media and at conferences on effective governance and management.

Perhaps HITECH’s most notable efficiency requirement is the implementation of the Electronic Health Record ("EHR"). At first mention, EHR is often viewed simply as medical record digitization. However, HITECH empowers the DHHS National Coordinator, in conjunction with a standards committee, to answer the question: “What should a viable EHR system look like?” Practically, the EHR systems implemented by providers throughout the country will not only digitize health records but will do much more. HITECH calls for the following: collection of population health data for internal
and external quality reporting, standardization of certain treatment with order sets for physicians, assistance in determining preventative health care treatment for at-risk patients, reduction of fragmented treatment for patients who visit multiple providers for chronic conditions, and reduction of the paperwork patients must complete at every visit to their providers.

To encourage EHR implementation, ARRA creates “incentives for adoption and meaningful use of certified EHR technology.” Hospital based physicians who satisfactorily demonstrate meaningful use of EHR technology are eligible for these incentives, as are hospitals for inpatient services. Implementation of a viable EHR system occurs in stages. The Center for Medicare and Medicaid Services (“CMS”) has established objectives for each of these stages, including the use of computerized entry of orders, maintenance of active medication and allergy lists for patients, inclusion of demographic data, and notations on vital signs and smoking status. Implementation of the EHR, plus its meaningful use, will result in incentive payments.

IMPLEMENTATION PROCESSES

The first step toward CMS incentive payments is the implementation of an EHR program at the provider level. Again, because EHR is more than simply scanning and digitizing patient medical records, implementation is easier said than done. EHR implementation involves drastic – and expensive – changes to provider software to ensure that the EHR complies with the objectives of the health information technology regulatory scheme. CMS has even established an approved list of vendors whose products meet the EHR requirements. Writing in February 2013 for the Healthcare Financial Management Association in “The Total Cost of EHR Ownership,” Steven Easteagh observed that EHR operation costs will exceed $2 million for the average 350-bed hospital. Original contract prices can be in the tens of millions of dollars. Of course these costs are related not only to software licensing and upgrading, but also to installation and troubleshooting.

EHR installation has proved to be both financially overwhelming and operationally daunting. In an August 2014 piece for Healthcare IT News, Erin McCann profiles seven EHR implementation disasters which resulted in medication errors, delays in treatment, budget deficits and resignations of high-level hospital executives.

MEANINGFUL USE PAYMENTS

HealthIT.gov reminds EHR participants that early participation leads to maximum incentive payments, and failure to participate will even result in financial penalties beginning in 2015. CMS indicates that it will make up to $27 billion in EHR incentive payments, allowing thousands of dollars in payments to eligible medical professionals and $2 million or more to hospitals. In its October 2014 report, the Office of the National Coordinator of the DHHS reported that as of June 2014, 75% of professionals and 92% of hospitals had received incentive payments for implementation.

IMPLICATIONS ON HEALTHCARE

The nascent spread of EHR raises the question of its full potential. As technology improves and providers pass the learning curve associated with a paperless system, the opportunity for new uses of EHR is boundless. The use of EHR for data collection presents new opportunities for analysis and better outcomes. Internally, this data mining will provide suggestions on how to improve procedural breakdowns. Practically, these analytics may help identify waste in supplies or pinpoint lags in emergency room response time. Data collection will also help to pinpoint the frequency of Serious Reportable Events, defined in the National Quality Forum’s 2011 report as “unambiguous, largely preventable, and serious, as well as adverse, indicative of a problem in a healthcare setting’s safety systems, or important for public credibility or public accountability.” This data will also improve patient care. At the macro level, providers will have a clearer picture of population health, which may direct growth in certain practice areas or help to reduce readmissions. At the micro level, holistic data on an individual patient may help to predict or identify certain risks.

Once providers adapt to the significant technological changes which characterize EHR, healthcare delivery is expected to change further. EHR software allows practitioners to create “order sets” or import those already developed by other professionals. Order sets establish a pre-determined method for specific procedures or even basic, but frequent, tasks. For instance, one order set may prompt the administration of one drug with the identification of a specific condition. Another order set may provide suggested responses after entry of a certain symptom. The use of order sets standardizes medicine and helps to reduce error.

Of course, the arrival of this new technology has the potential for many unintended consequences. For example, this standardization may remove a practitioner’s prior inclination to analyze the single patient before him or her and treat the unique health concerns presented. This can be remedied with discipline and a flexible software that permits modification of order sets by each provider and the preservation of such order sets in a bank available to the user.

Perhaps the greatest, and yet unformalized, of these consequences is the impact order set usage will have on malpractice standards of care. For instance, if physicians in a certain community are more likely to use Order Set A for an appendectomy and defendant-doctor used Order Set B, has he or she breached the standard of care? These are questions that courts will likely answer in an EHR-dominated world.

From a patient perspective, the advent of EHR increases the accessibility of medical records. Providers and EHR software producers have created “patient portals,” which allow patients to directly access records via online websites or handheld device applications. A key aim of a viable EHR system, as stated by the Office of National Coordinator in its October 2014 report, is the integration of a patient’s medical record between providers. The transferability and accessibility of a patient’s record despite geographical and organizational limitations appears to end an era of hectic coordination between patients, past providers, and current providers.

CONCLUSION

While the present-day healthcare debate revolves around the ACA – both its requirements and its uncertain future – providers have already begun complying with earlier regulations from HITECH. Despite the cost of implementation, a complete EHR system presents unique opportunities to monitor quality of care, improve treatment, and involve patients. More than just record digitization, EHR presents a radical change to the healthcare industry and time alone will tell its real impact.

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