



Health information technology donations: A guide for physicians

**Readiness
survey
inside**



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Forward

Recent exceptions to the Physician's Self-Referral Law (Stark) and the Anti-Kickback Statute safe harbors create new opportunities for financing the transition to electronic health records (EHR) and electronic prescribing systems. Exceptions and safe harbors collectively may serve to alleviate the costly acquisition of HIT, but "donation" or subsidy agreements still raise many concerns for physician practices. The American Medical Association prepared this guide to assist physicians and practice administrators with their decision to accept a low cost donation of health information technology (HIT). While the Internal Revenue Service (IRS) views most of these arrangements as subsidies and not gifts, many people simply call them HIT donations. For convenience, the guide will do the same. Before accepting any HIT donation, physicians and practice administrators should know:

1. The consequences of accepting a donation and what to look for in a contract with the donating organization
2. The right questions to ask the donor and/or the system vendors
3. The readiness of the practice to successfully adopt HIT
4. The allowances included in the Stark law exceptions and the Anti-Kickback Statute safe harbors

Chapter 1:

Donation risks and benefits

I. Making the regulatory environment more flexible

In an effort to reduce the cost barrier to adoption of HIT, the Department of Health and Human Services (HHS), through its Centers for Medicare & Medicaid Services (CMS) and Office of the Inspector General (OIG), simultaneously established rules creating exceptions to the Physician's Self-Referral Law (Stark) and new safe harbors to the Anti-Kickback Statute.¹ The new exceptions and safe harbors provide rules for allowable donations of electronic prescribing and EHR technology. Additional relief appeared in a May 11, 2007, Internal Revenue Service (IRS) memorandum focused on physicians with staff privileges at tax-exempt hospitals. The IRS directive said that technology subsidies provided to staff physicians are not impermissible private benefits or inurements, provided the HHS regulations are followed by the 501(c)(3) hospital and all recipients.

II. Accepting donated HIT

Although the exceptions and safe harbors became effective in October 2006, many stakeholders—primarily hospitals, health systems and physicians—have delayed engaging in donation agreements. However, the IRS directive has sparked more donation activity, because tax-exempt hospitals have been assured HIT subsidies will not be treated as impermissible private benefits or inurements in violation of 501(c)(3)—though the following issues require additional clarification by the IRS:

1. Whether the donations will result in taxable income to the group or individual physician (based on whether a C or S corporation) or a gain or loss only upon disposition. While admitting there are income tax implications for the physicians who are the beneficiaries of the discount, the IRS has not yet issued guidance, except for exempt hospitals. HIT donations are not traditional “gifts” given from the heart without consideration and
2. Whether supplementary items or services may be donated and how the IRS will view them. For example, according to the exceptions and safe harbors, a donated EHR system may include an integrated practice management system (PMS) as part of the application (similar to an electronic prescribing component) as long as the primary purpose of the integrated application is to create, transmit and receive electronic records. Because the rules prohibit nonintegrated PMSs or other programs and services that may be used for personal or nonmedical purposes, it is likely that the IRS will treat PMSs separately from EHR donations, and PMS donations will not fall under the exception. In turn, most donors are concerned about violations and are more likely to subsidize the cost of the interface between the physician's current PMS and the donated EHR. Interface costs range between \$4,000 and \$15,000. It is worth noting that larger practices will likely have multiple interfaces to account for because each machine's software represents a different implementation.
3. Whether transfers within the exceptions and safe harbors for less than fair market value (FMV) result in an excess tax benefit transaction, among other reasons. Currently, the donating entity must define FMV and have physicians pay at least 15 percent. That 15 percent target rises as additional enhancements and contributions to the EHR software are made during installation and rollout. If the FMV is not increased and the recipient is not asked to

relinquishment of dominion and control. The words “gift” and “donation” do not appear in the IRS directive; these arrangements, under the IRS directive, are called “Health IT subsidies.” If property is acquired in part as a purchase and in part as a gift, the recipient's basis in the property should be determined at or before receipt. It is important to distinguish whether the recipient is the practice group or the individual physician because of the tax implications. Tax advisers should be consulted in advance, and the tax benefit or burden will vary considerably, depending upon whether the transfer document is a licensing agreement or a bill of sale.

increase their cost share, then the donation or subsidy becomes too rich, and the safe harbor provisions are violated, creating tax consequences for both the donor and recipient.

III. Other contracting concerns

In addition to the missing IRS clarification, the exceptions and safe harbors raise other contracting concerns for physicians considering HIT donations. Physicians must understand how to address these issues in a donation scenario and how to negotiate fair arrangements with the donor.

1. Vendor options

Donors will typically provide only one EHR option for all potential recipients. In turn, if physicians want to implement HIT, it is necessary to consider all donation and non-donation options.

2. Financing

Donations come with costs. According to the rules, the mandated minimum cost sharing for physicians receiving an EHR donation is 15 percent. The donor, however, determines the value of the donation. Thus, it may prove difficult for physicians to determine the true value of the software for which they are paying. Physicians should find out whether they can deduct or expense the investment in the year paid, or if it must be depreciated or amortized over the useful life of the software. This depends, in part, on the tax status or corporate structure of the recipient. Clearly, donors may incur significant costs during the initial implementation of systems in their data centers (i.e., costs of servers and related equipment, maintenance and software). What is not clear is whether physicians will be paying for those costs and when the payments might be due.

Physicians must inquire in detail about how the donor's costs are determined and how they are valued. Because donations are commonly valued either at base cost or at FMV, physicians should make note whether certain components are charged at cost and some at FMV, and whether their adjusted basis can or should be increased.

While neither the exceptions nor the safe harbors specify methodologies that donors should use to calculate cost, the OIG and the CMS are clear that regardless of the method used to determine cost, that method must be “reasonable and verifiable” and supported by contemporaneous and accurate documentation, as must the recipient's expected contribution. Physicians should have access to the donor's cost allocation documentation and an opportunity, if desired, to have their accountant or other financial expert review them. Access to this information should help the physician understand up front his or her financial obligations relative to the donation and any possible tax consequences.

The IRS has yet to clarify whether the value of donated EHR or electronic prescribing systems needs to be reported on a Form 1099. In the absence of clarification, in their written donation agreements, hospitals are reserving the right to report the cost on the Form 1099 in case the IRS makes it a reporting a requirement. Physicians should therefore be cognizant that they may be required to pay tax on the donation.

3. Implementation

When accepting a donation, physicians must consider interoperability (i.e., the software's capability to communicate and exchange data), data conversion and transmission, and training. Although there is an HHS-appointed organization, the Certification Commission for Healthcare Information Technology or CCHIT, charged with certifying EHR systems, interoperability issues are still a concern in every HIT acquisition. Physicians need to know that the donated software and hardware in electronic prescribing donations will interface or “talk to” their current PMS system. In many HIT donation agreements, donors are subsidizing the cost of the interface, which range between \$4,000 and \$15,000. If this is not the case, the practice must incur the cost of writing the interface(s), or they may install a new PMS, requiring additional cost and data migration.

Physicians must also consider whether the donated HIT arrangement will allow them to transport data from their office to pharmacies, other care providers, pay for performance administrators and other entities.

Lastly, training services may be included in donation packages. Physicians should know exactly who is conducting the training and how much is included in the agreement. This is one area where vendors may be able to offer more support than a donor. While a successful implementation is important to the donor, they often have limitations on the training services they can afford to support or staff. Vendor training packages often include multiple days, if not weeks, of training, so physicians should pay particular attention to the offered training services when considering the donation.

4. Maintenance

Ongoing training and support services and upgrades are essential to successful HIT maintenance. Without adequate training and ongoing support, HIT can be frustrating and may lead to deinstallation, costing physician practices additional time and money. Maintenance services such as software upgrades, new features, product offerings and customer service must be available to keep systems operating effectively. Donation agreements should explain how and when the recipient would receive the upgrades and other offerings. Upgrades included as part of the initial purchase price of technology do not trigger additional cost-sharing obligations by the recipient, but any upgrade not covered under the initial purchase price for the donated technology would be subject to separate cost-sharing obligations by the physician. In any case, donated upgrades must fulfill the “necessary” requirement, meaning they have to make the software more current or user friendly. The exceptions and safe harbors, therefore, do not apply if the physician already possesses equivalent software or services.

5. Termination

Physicians need to know their rights with respect to termination of contracts/agreements associated with donated HIT systems. They should be aware of the instances where termination is permissible or required on their behalf and the donor’s. If they do not have a property interest in the EHR that survives termination, that has an impact on the accounting and tax treatment of the software and should be determined upfront, not just before a departure. More importantly, physicians should inquire about and understand their rights to their records after termination.

6. Data access

Data access concerns can be categorized in two ways:

1) offsite data storage and 2) data sharing. First, physicians who enter a donation agreement may choose or be required to forgo maintaining their own data in-house, depending on the donation business model. Donations will likely be either donor-supported application service provider (ASP)² models, where the hospital provides specialty automation services or access under a service contract with the physician practice, or donor-supported non-ASP models, where the hardware, software, installation and support are provided based on fees determined in a collaborative agreement. Regardless of the model, according to the IRS memorandum, donors must have some access to the recipient’s data. Physicians, therefore, must carefully clarify all data access rights in the arrangement with the donor.

7. Obsolescence

With an evolving HIT market, obsolescence is a concern. As technology develops and new regulations and possible health plan and governmental HIT mandates pass, there is no fail-safe way to prevent obsolescence. Physicians can only make the best decision for their practice at the time. Donors, however, can and do negotiate obsolescence clauses with their vendors. In the contracts, they plan for buyouts and other instances where obsolescence would be an issue. For example, donors can require vendors to convert their data to a new platform, to pay a set fee, or to allow the donor to continue running the system for a set time. Physicians who have concerns about a prospective vendor should conduct their own research—asking for financial statements, reading industry reviews and inquiring about product upgrade plans.

IV. Conclusion

Although the regulations permitting HIT donations provide opportunities for HIT adoption, physicians should proceed with caution—just as they would in buying any information technology outright. A good starting point is to know what key questions to ask and to complete a readiness assessment. Physicians who study their practice needs, research options from donors and vendors, and seek legal counsel (if possible) will experience a more successful implementation.

There is no question that HIT is transforming health care and the physician office. As more improved products enter the market at reduced cost and more subsidizing programs, such as pay for performance, or more health plan or employer-sponsored initiatives appear, more physicians will enter the HIT community, lending to the larger goal of a national health information network. Until then, physician practices

should be mindful of the right time to make the transition to HIT. When the time is right for the practice, IT will be a resource to enhance the efficiency, quality and efficacy of care.

More information about the covered items and services in the Stark law exceptions and the Anti-Kickback Statute safe harbors is included in the next chapter.

Chapter 2: Regulatory compliance

I. The Stark law and Anti-Kickback Statute

In order to understand the exceptions and safe harbors, one must understand what the Stark law and the Anti-Kickback Statute prohibit, and how these statutes differ from one another.

The Stark statute prohibits a physician from referring Medicare patients for specific designated health services (DHSs) to entities with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies. A financial relationship includes any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity providing designated health services.

Remuneration can include anything of value, in kind or in cash.

The Anti-Kickback Statute prohibits the knowing or willful solicitation or acceptance of any type of remuneration to induce referrals for health services that are reimbursable by the federal government. While these prohibitions originally were limited to services reimbursed by the Medicare or Medicaid programs, the Anti-Kickback Statute has been extended to apply to most federal health care programs. Remuneration includes anything of value, in kind or in cash.

Exceptions and safe harbors

Although the Stark and Anti-Kickback statutes are worded broadly, they also describe a number of circumstances in which the statutes do not prohibit conduct that otherwise would violate the statutes. The Stark statute and regulations refer to these exempt circumstances as “exceptions,” and the Anti-Kickback Statute and its regulations use the term “safe harbors.”

Penalties under the statutes

The Stark statute is a civil statute, so the statute does not subject violators to the threat of imprisonment. Violations, however, could result in denial of payment for the prohibited referral, refunding of payments, monetary penalties ranging from \$15,000 to \$100,000 and exclusion from federal program participation.

Because the Anti-Kickback Statute is a criminal statute, violations constitute felonies, with criminal penalties of up to \$25,000 in fines and five years imprisonment. In addition, a person who violates the Anti-Kickback Statute can be subject to civil penalties of up to \$50,000 in fines and exclusion from federal program participation.

Strict liability versus intent

One other key difference between the Stark law and the Anti-Kickback Statute has to do with the role a person’s state of mind plays in determining violations. For example, if a physician makes a referral prohibited by the Stark statute (and an exception does not apply) that physician has violated the statute. For purposes of the violation, it makes no difference whether or not the physician knew the referral was prohibited. In this sense, the Stark statute is referred to as a “strict liability” statute, because violations do not depend on the physician’s knowledge or state of mind. If a physician makes a referral prohibited under the Stark statutes general language, the physician will be subject to Stark penalties *unless* the referral fits into one of the Stark statute exceptions.

The Anti-Kickback Statute is an intent-based statute. This means that even if a person violates the Anti-Kickback Statute only if the person acts “knowingly and willingly.” For example, a person might accept remuneration to induce referrals for federally reimbursable health services and not violate the Anti-Kickback Statute if they did not act knowingly and willingly. This intent requirement makes the Anti-Kickback Statute’s safe harbor clause apply differently than the Stark statute’s exceptions. The safe harbors describe circumstances in which conduct that otherwise might violate

the statute will not be subject to prosecution. However, conduct not falling under one of the safe harbors is also not necessarily an Anti-Kickback Statute violation. The government determines whether to prosecute conduct falling outside of the safe harbors on a case-by-case basis. Generally, however, FMV arrangements that are arm's-length and do not take into account in any manner the volume or value of federal health care program business, or arrangements that do not have as one purpose the generation of business payable by a federal health care program, should not raise concerns under the Anti-Kickback Statute. Fitting into a safe harbor is important, however, because doing so provides a sense of security that arrangements outside the safe harbors lack.

II. Recent Stark exceptions and Anti-Kickback safe harbors

Prior to August 2006, the Stark and Anti-Kickback statutes would have in some circumstances posed a barrier to physicians' adoption of HIT, even if the adoptions came via donation from hospitals and other potential HIT donors. More specifically, because donated HIT could constitute remuneration to the physician by the donor, such a donation could trigger a Stark law violation given the absence of a Stark HIT exception. An HIT donation could also lead to possible liability exposure under the Anti-Kickback Statute due to lack of a safe harbor. In order to lessen this barrier, the CMS created the Stark statute exceptions, and the OIG added its safe harbors to the Anti-Kickback Statute to protect donations of EHR and electronic prescribing technology in some situations.

The following table and subsequent information detail and compare the new Stark law exceptions and Anti-Kickback Statute safe harbors. It is important to keep in mind that although the exceptions and safe harbors provide protection under the federal Stark and Anti-Kickback statutes, a number of states have physician self-referral prohibitions and anti-kickback statutes. Consequently, prior to accepting HIT donations, physicians should consult with legal counsel to ensure that the donation also complies with any applicable state laws.

Stark law exception and Anti-Kickback Statute safe harbor structure

| Features | Electronic prescribing (e-prescribing) | Electronic health records (EHRs) |
|-----------------------------|--|---|
| Authority | Medicare Prescription Drug, Improvement and Modernization Act of 2003 §101 | Social Security Act §1128B(b)(3)(E) and 1877(b)(4) |
| Covered technology | Hardware, software and information technology and training services necessary and used solely to transmit and receive electronic prescription information. This includes wireless and broadband connectivity and interfaces. | <p>Software, information technology and training services necessary and used predominantly to create, maintain, transmit or receive EHRs.</p> <p>Hardware is excluded.</p> <p>Software must include an e-prescribing component.</p> <p>Practice management functionality (e.g., software to assist with patient administration, scheduling, billing, clinical support) may be permitted as long as it is interoperable, is used predominantly for health records, and meets other EHR rules.</p> |
| Compliance standards | <p>Must comply with final standards for e-prescribing as adopted by the Department of Health and Human Services (HHS) at the time the items and services are provided.</p> <p>Must be part of, or used to access, an electronic prescription drug program that meets applicable standards under Medicare Part D.</p> | <p>Software must be certified interoperable.</p> <p>Software is deemed interoperable if it has an up-to-date certification (by the Certification Commission for Healthcare Information Technology or CCHIT) at the time of the donation.</p> <p>e-prescribing component must comply with final standards for e-prescribing as adopted by HHS at the time the items and services are provided.</p> |

| | | |
|---|---|---|
| <p>Permissible donors and recipients</p> | <p>Stark exception Hospitals may donate to physicians who are members of its medical staff.</p> <p>Group practices may donate to physicians who are prescribing members of the group.</p> <p>Prescription Drug Program (PDP) sponsors or Medicare Advantage (MA) organizations may donate to prescribing health care professionals.</p> <p>Anti-Kickback safe harbor Hospitals may donate to physicians who are members of its medical staff.</p> <p>Group practices may donate to prescribing physicians who are members of the group.</p> <p>PDP sponsors and MA organizations may donate to network pharmacists and pharmacies, and to prescribing health care professionals.</p> | <p>Stark exception Any entity that provides designated health services (DHSs) may donate to any physician.</p> <p>Anti-Kickback safe harbor Entities or individuals that provide services and submit claims or requests, either directly or through reassignment, to a federal health care program, or a health plan may donate to individuals or entities engaged in the delivery of health care (notable exclusions: pharmaceutical, device, or durable medical equipment manufacturers and other manufacturers or vendors that indirectly supply or furnish items or services used in the care of patients).</p> |
| <p>Selection of recipients</p> | <p>Donors may not select recipients using any method that takes into account the volume or value of referrals from the recipient or other business generated between the parties.</p> | <p>Donors may not select recipients using any method that takes into account directly the volume or value of referrals from the recipient or other business generated between the parties.</p> |
| <p>Costs</p> | <p>No limit on value of donations of e-prescribing technology.</p> | <p>No limit on value of donation; however, physicians must pay at least 15 percent of donor costs.</p> <p>Documentation of cost to donor and physician's contribution is required and must be specific.</p> <p>Donor (or any affiliate) must not finance the recipients payment or loan funds.</p> |
| <p>Expiration of safe harbor</p> | <p>None.</p> | <p>Sunsets Dec. 31, 2013.</p> |

The exceptions and safe harbors allow for the donation of both EHR and e-prescribing technology. However, there are important differences:

1. The electronic prescribing rules allow for the donation of equipment (or hardware); the EHR rules *do not*. The EHR rules only permit the donation of software and information technology and training services related to creation, maintenance, transmission and receipt of EHR information. Examples include interface and translation software; rights, licenses and intellectual property related to EHR software; connectivity services, including software to facilitate broadband and wireless Internet services; clinical support and information services related to patient care; maintenance services; secure messaging; patient portal software and access to help desk services. The EHR rules do not protect the donation of hardware of any kind (i.e., hardware—and operating software that makes the hardware function; network hardware, such as modems and routers; storage devices; or items or services used by a recipient primarily to conduct personal business or business unrelated to the recipient’s clinical practice or clinical operations).
2. The electronic prescribing rules permit donation of technology solely to transmit and receive electronic prescription information. The EHR rules permit the inclusion of multifunctional software and services, provided the predominant use of the donated software and information technology and training services are for EHR purposes, meaning the creation, maintenance, transmittal or receipt of electronic health records.
3. The electronic prescribing rules allow for a more limited list of eligible donors and recipients. The EHR rules permit donation by a broader range of donors to a broader range of recipients.
4. The electronic prescribing rules do not require cost sharing by recipients; EHR rules mandate at least 15 percent cost sharing, though a donor may request or insist on more.

III. Conditions of compliance

While the information in the table above explains electronic prescribing and EHR donation procedures, the CMS and the OIG have also put necessary conditions in place to ensure compliance with the new rules. Due to the complexity of the statutes, physicians should carefully note the following conditions before accepting an HIT donation.

Electronic prescribing

- The donated items and services must be part of, or used to access, an electronic prescribing drug program that meets the applicable standards under Medicare Part D.
- A donor cannot restrict or limit the ability of physicians to use technology for any patient, regardless of payer status.
- The recipient’s eligibility for (and the amount or nature of) the donation must not be determined in a way that takes into account the volume or value of referrals or business generated between parties.
- The arrangement must be set forth in a written agreement signed by both parties.
- Donations must not replicate technology the physician already possesses. Protected upgrades and equipment or software include those that significantly enhance the functionality of the item or service are protected under the new rules.

EHR

The following conditions, in addition to the aforementioned electronic prescribing conditions, apply to EHR donations.

- The software must be CCHIT-certified interoperable at the time it is provided. At the time of donation, the software must be able to (1) communicate and exchange data accurately, effectively, securely and consistently with different information technology systems, software applications and networks, in various settings, and

(2) exchange data such that the clinical or operational purpose and meaning of the data are preserved and unaltered.

- The donor must not limit or restrict the use, compatibility or interoperability of the terms or services with other electronic prescribing or EHR systems.
- The EHR software must include electronic prescribing capability that meets the Medicare Drug Benefit Standards at the time it is provided.
- Before receipt of items and services, the recipient must pay at least 15 percent of the donor's costs.
- The donor must not shift the cost of the items or services to any federal health care program.
- The transfer of items and/or services must occur on or before Dec. 31, 2013.

Chapter 3:

Preparing for a donation

I. Donation agreement questions

Although the Stark law exceptions and the Anti-Kickback Statute safe harbors enable adoption of electronic prescribing and EHR technology through donations, there are still many things to consider before accepting donated technology.

Because of the complex legal environment, potential donation arrangements require additional scrutiny.

Begin by asking yourself and the donor key questions.

Readiness

- Does the vendor system have appropriate functionality for your practice? Will the new software impose limitations not currently present in your practice? If so, are these changes good? Are they manageable?
- How will the new software and technology interface with key systems you use regularly? If the interfacing capability is not there, what are the future consequences for your practice?
- What is the vendor's track record in providing HIT services to physician practices?

Cost

- Are all of your costs well understood and documented? Will fees be raised over the term of the contract/agreement? Are there significant costs beyond the mandated 15 percent? What are the upgrades and maintenance costs?

Implementation

- How will your data be transferred or converted to the new system(s)? What protections are required, or should you implement beforehand, to preserve your data?

- Will you lose certain aspects of your data in the transfer?
- Who will be responsible for training you on the new technology? How much training is included? Will you be able to consult with these parties when future problems arise?
- Will you have the opportunity to test the donated software? How long is the testing period?

Termination/maintenance

- According to the donation agreement, who is provided access to your data? How will you maintain your data if the contractual relationship is terminated? What are your rights with regard to termination of the contract/agreement?
- Will upgrades, customer service and new quality services be available to you when they arrive? How will these developments be communicated to you?
- What are the security measures and protocol followed by the donor? What security features are unique to the donated software? Where will the data reside?

II. Readiness assessment and survey

The process of evaluating, selecting and implementing an EHR system is a significant undertaking. To determine whether a practice is ready to implement any HIT, physicians must understand the entire operation of the practice. This includes knowing how willing and able the practice is to adopt HIT. Documenting certain personnel perceptions and characteristics will determine whether the practice is positioned to succeed in implementing and maximizing the benefit of an EHR system. Physician practices considering the transition to HIT should complete a survey like the one included here or a similar form of readiness assessment prior to any HIT acquisition. The scores will determine whether a practice is ready to move on to more advanced planning activities such as analyzing workflow and costs and quantifying potential return on investment.

Health information technology readiness survey³

This survey is intended to assess the readiness of your practice to successfully implement health information technology (HIT) and the readiness of personnel to accept and productively use it. Your responses will help you determine the present state of technology adoption, prerequisites for change, potential barriers, user needs, time-sensitive factors and appropriate action steps.

The following questions relate to critical success factors and potential barriers to the implementation and use of clinical information systems and other HIT. Please indicate the degree to which you agree with each statement from the perspective of your practice as a whole.

| | | Strongly disagree | Somewhat disagree | Neutral | Somewhat agree | Strongly agree |
|----|--|-------------------|-------------------|---------|----------------|----------------|
| | Statement (please circle one response for each) | | | | | |
| 1. | Most physicians and clinical staff in your practice believe that there is an urgent need to improve health care through clinical computing and HIT. | SD | D | N | A | SA |
| 2. | Most physicians and clinical staff in your practice see electronic health record (EHR) systems as critically important to their future success. | SD | D | N | A | SA |
| 3. | Most physicians and clinical staff in your practice are willing to put forth the extra time and effort required to learn how to use an EHR system. | SD | D | N | A | SA |
| 4. | Physicians in your practice will regularly use an EHR or other automated system to retrieve patient information. | SD | D | N | A | SA |
| 5. | Physicians in your practice will regularly use an electronic health record system to document patient care during clinical encounters. | SD | D | N | A | SA |
| 6. | The executive leadership of your practice is visionary and supportive of efforts to improve health care through clinical computing and HIT. | SD | D | N | A | SA |
| 7. | Your practice has a guiding coalition of influential leaders committed to successful implementation and continued use of HIT. | SD | D | N | A | SA |
| 8. | Formal and informal leaders in your practice are willing and able to serve as HIT champions, pushing or pulling as needed during various times of success or failure to promote use of clinical information systems. | SD | D | N | A | SA |
| 9. | Your practice has a clear plan for how it will use HIT to meet its overall practice goals, with strong executive support. | SD | D | N | A | SA |

| | | Strongly disagree | Somewhat disagree | Neutral | Somewhat agree | Strongly agree |
|-----|---|-------------------|-------------------|---------|----------------|----------------|
| | Statement (please circle one response for each) | | | | | |
| 10. | Leaders and managers in your practice believe that continuing efforts to advance organizational culture will be required for effective clinician use of HIT. | SD | D | N | A | SA |
| 11. | Your practice has a strong track record of successfully implementing information technology for use in clinical care. | SD | D | N | A | SA |
| 12. | In your practice, physicians and staff trust each other, work well together in teams, and are willing to be accountable for using HIT to improve patient care. | SD | D | N | A | SA |
| 13. | Physicians and clinical staff in your practice are willing to change how they work if needed to improve patient care. | SD | D | N | A | SA |
| 14. | Your practice will provide meaningful incentives to reward appropriate clinician use of HIT. | SD | D | N | A | SA |
| 15. | Your practice will set clear expectations for use of EHR systems and other HIT. | SD | D | N | A | SA |
| 16. | Your practice has the necessary technology, training, and support resources needed to implement new clinical information systems. | SD | D | N | A | SA |
| 17. | Leadership in your practice ensures that important processes and outcomes are regularly measured, with information communicated to physicians and clinical staff in a timely manner. | SD | D | N | A | SA |
| 18. | HIT vendors doing business with your practice consistently provide functional, sustainable products and timely, high-quality support services. | SD | D | N | A | SA |
| 19. | IT professionals in your practice effectively adapt software to support appropriate clinical workflows. | SD | D | N | A | SA |
| 20. | People who will be using new computer information systems in your practice have a realistic understanding of what the systems are capable of doing. | SD | D | N | A | SA |
| 21. | Your practice has an effective mechanism in place to ensure that people who will be using the new computer information systems have meaningful roles in deliberations, decision-making and communications regarding clinical information system planning, selection, implementation and modification. | SD | D | N | A | SA |
| 22. | Your practice has an effective mechanism in place to ensure that comments and concerns shared by people who will be using new clinical information systems are received, acknowledged and responded to in a timely manner. | SD | D | N | A | SA |

Readiness scale

| Response | Numeric score |
|----------|---------------|
| SA | 5 |
| A | 4 |
| N | 3 |
| D | 2 |
| SD | 1 |

Maximum score = # of items x 5 = 22 x 5 = **110 points**

| Estimated [†] overall readiness* | Not ready | Probably not ready | Possibly ready | Probably ready | Ready |
|--|-----------|--------------------|----------------|----------------|---------|
| Average total score | 0–76 | 77–87 | 78–88 | 89–99 | 100–110 |
| Percent of single item scores <3 | ≥20 | 15–19 | 10–14 | 5–9 | ≤5 |

[†] Draft estimate—not yet empirically tested.

* Overall readiness is determined by the lowest readiness classification in any category.

Examples:

- Average total score = 94
 - Percent single item scores <3 = 7% —> **Probably ready**
 - Percent single item scores <3 = 12% —> **Possibly ready**
 - Percent single item scores <3 = 17% —> **Probably not ready**
- Percent single item scores <3 = 2%
 - Average total score = 104 —> **Ready**
 - Average total score = 94 —> **Probably ready**
 - Average total score = 84 —> **Possibly ready**

References

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¹ 71 Fed. Reg. 45109-45171 (Aug. 8, 2006).

² A company that contracts with a health plan and/or physician practice to supply software-related services over the Internet via a browser. In this case, a donor hospital or health plan may serve as the ASP.

³ Prepared by Michael H. Zaroukian, MD, PhD