$22b for health information technology, but not quite so much for dentistry

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When the Health Information Technology for Economic and Clinical Health Act (HITECH) was signed into law in 2009, $22 billion was set aside to improve patient outcomes through increased use of electronic health records (EHR) by clinicians during the next five years (2011–2015).

The proportion expected to go to dentistry: negligible. Prorating dentistry’s share of the health-care market (approximately 3 percent) would yield over $1 billion of the allocated amount, but we will be lucky if we receive a fraction of that.

You may ask why. After all, dentistry, with its more than 150,000 practitioners in the United States, is an important primary care discipline that cares for almost 200 million Americans in any given year.

The main reason we are pretty much left out is because the legislation was written with the interests of physicians and hospitals, not with those of other health-care providers, in mind. The consequence is a huge missed opportunity for dentistry.

The federal government requires providers to fulfill three criteria to become eligible for Health Information Technology (HIT) stimulus funds from the HITECH Act. They must use certified EHRs, demonstrate the capability to measure meaningful use of EHRs based on a pre-defined framework and have a patient population that includes at least 50 percent Medicaid or Medicare beneficiaries for oral health care procedures.

Unfortunately, these criteria make it very difficult for any dentist to qualify. At this time, not one dental EHR has been certified by the Certification Commission for Health Information Technology (CCHIT).

Meaningful use criteria have been developed mainly based on general, not dental, health needs. In addition, few dentists have patient pools that include a large share of Medicaid/Medicare beneficiaries.

Electronic health records, the use of which can be supported by the HITECH Act, are certified by CCHIT. CCHIT is an independent, 501(c)3 nonprofit organization that has been recognized by the U.S. Department of Health and Human Services (HHS) as the official certification body for EHRs since 2006.

CCHIT conducts the certification process by following industry standards for EHRs and checking how suitable EHRs are in achieving the meaningful use requirements specified by the HHS. As of today, no dental EHR has undergone this certification process.

Another stumbling block is the way meaningful use has been defined by the Office of National Coordinator for Health Information Technology (ONC).

The idea of meaningful use is to define a set of process measures that reflect good health care practices, for instance, periodically checking the blood pressure for hypertensive patients and monitoring glucose levels of diabetics.

While some meaningful use measures, such as generating problem lists for oral health conditions, maintaining lists of active medications and allergies, and recording primary language, insurance type, gender, vital signs and other patient-specific variables are certainly appropriate for dentistry, many measures only apply to physician or hospital settings.

Unfortunately, the meaningful use measures, as currently defined, include very few criteria that are relevant to oral health. Dentists are unlikely to demonstrate the capability to enter orders through an EHR, perform medication reconciliation, submit information to immunization registries and electronically submit lab reports to public health agencies.

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Thus, in general, meaningful use does not work for dentistry. Dentists and dental schools also need to have at least 30 percent of their patient population qualify for Medicaid reimbursement or Medicare services. Very few dentists will qualify based on this criterion. Most likely, it will be those who provide dental care in federally qualified health centers or some dental schools. So, why would all this matter to us? As our studies have shown, more and more dental practitioners are adopting electronic patient records for a variety of reasons. Some see them as a more efficient way to manage patient information and their practice. Others use them to keep track of individual, group and population health outcomes. (What is the average survival time of a veneer for all your patients? A difficult question to answer without an electronic patient record.)

Down the road, more widespread adoption of EHRs in dentistry will enable us to track incidence and prevalence of various dental diseases; identify patients at risk for developing disease; systematically follow up on patients with certain conditions; and expand research through practice-based research networks. This is indeed a missed opportunity.

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