Informing Clinical Practice Subcommittee Breakout Session 4/18/2006:

Issues:

Financial:

The single most important barrier to physicians' use of EHRs is financial. Although physicians must make the investment in EHR systems, they accrued only 11 percent of the benefit in one study of the economic benefits of computerized ordering, which results in much of the savings[1]. Most of the benefit goes instead to payers and purchasers. Research by Robert Miller, Ph.D. finds that for small group practices with EHRs, initial costs average $44,000 per clinician, with ongoing costs averaging $8,400 per clinician per year.[2] These costs include initial software, hardware and loss of revenue in addition to ongoing maintenance and upgrades when hiring health information technology specialists. Although some data suggest that the return to providers will be good over a five-year period, the timing of benefit is less certain, and few data are available comparing the benefit among different vendor products.

Another key financial issue relates to capital and risk. Most U.S. primary care is delivered in small practices, and many of these are doing poorly financially. Increases in expenses outpaced the increase in physician compensation in primary care for three straight years, according to the Medical Group Management Association.[3]
As a result, primary care providers appear to be finding it particularly hard to justify the risk in making any investment, especially in a new technology that they perceive as risky with uncertain returns for them, such as an EHR. In rural areas, EHR adoption is even lower with an estimates 5-15% of offices utilizing electronic health records.

The early adopters should not be penalized for investing so much time in electronic records. These early adopters should be given support if improved and standardized systems become the end result of the ONCHIT process (Ellen Brull)

1) The cost of electronic records needs to be spread among those who benefit: patients, clinicians, and insurance companies. (Craig Backs)

2) Cost of Electronic Health Records needs to come down as the supply for these services increases. Constant upgrades costs will be tolerable only if the cost for Electronic Health Records goes down. (Craig Backs)

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[1] Physicians And Ambulatory Electronic Health Records, David Bates, MD *Health Affairs*, September/October 2005, 24 (5): 1180–89

[2] The Value of Electronic Health Records in Solo or Small Group Practices, Robert H. Miller, Ph.D., Christopher West, Tiffany Martin Brown et al., *Health Affairs*, September/October 2005, 24 (5): 1127–37

[3] Medical Group Management Association, "MGMA Reports Nominal Increases in Physician Compensation in 2003, Medical Group Practice Managers' Compensation Keeping Pace," Press Release, 11 August 2004, www.mgina.com/press/phymgmtcomp.cfm (28 May 2005).

Some low cost alternatives include Vista Health (Veterans Administration's record system)[4] and the Continuity of Care Record[5]. However, both of these systems still require technical support to fully implement.

There need to be incentives for physicians use electronic records. Claims data will not be adequate for the eventual interoperable systems (Craig Backs)

Privacy:

Ensuring patient privacy and security is paramount to a successful health information exchange. Patients need to be reassured that their information is confidential and that any/all persons that have viewed their records can be audited. While some control over what information will be accessible is necessary (especially with mental health data), a system where each and every data point is to be controlled is not feasible. Since we firmly believe that increasing the use of EHRs will improve care, an opt-out option is preferable to an opt-in. This system has been shown to be successful in other states (New York City's surveillance and resources for patients with elevated HgbA1cs[6])

Compatibility:

Record compatibility is integral for fully operational EHRs. Having clinicians view laboratory, pharmacy and specialist data in a standardized manner should be the gold standard for all EHR systems. (Ellen Brull)

The need for a standard and certified record must come from HIMSS and/or the Federal government. While EHRs are a more complex system than other electronic data systems we have used in the past, we are hopeful that software systems can be compatible in less than 10 years.

Vendor Reliance:

There needs to be an organization to supervise vendors, and ensure their compatibility.

The current state of medical records is fairly heterogeneous and it is important that the software packages out there tend to physician needs. Interfaces need to improve and software packages need to be tailored to the clinician offices where they will be used.

CCHIT information needs to be readily available to clinicians in all 50 states:

In September 2005, HHS awarded CCHIT a three-year contract to develop and evaluate certification criteria and create an inspection process for HIT in three areas:

- Ambulatory EHRs for the office-based physician or provider
- Inpatient EHRs for hospitals and health systems

[4] http://www.vista-office.org
[5] http://www.medrecinst.com/pages/about.asp?id=54
[6] http://www.nyc.gov/html/doh/html/diabetes/diabetes-nycar.shtml

- The Network components through which they interoperate and share information[7]

Duplication of information:

Currently there are over 20 databases collecting information on patients in Illinois. Most are specific to certain users and are difficult to navigate. For long term care there is a "Minimum Data Set" but this information probably exists elsewhere. We need a path to decrease duplication of information (Bill Kempiners)

Physicians would like to know more about the information on MDS and how it relates to their patient's care (Dan Litoff)

Physician Adaptation:

The extent of EHRs may not be fully realized by all clinicians. Many providers do not use the products that they have effectively. Assistance from vendors, payers and provider organizations may be needed for providers to realize the full extent of EHR capabilities.

Rural Health:

Data needs to be collected to understand the scope of EHR penetration in the rural Illinois. Surveys may be needed to determine what factors are limiting their capabilities. Some thoughts of barriers include financial and lack of internet access.

[7] http://www.cchit.org/about/