



**2009 New York Healthcare Information Management Systems Society
Legislative Action Day:**

Physicians Get 'IT'

**Physician Practice Adoption of Health Information Technology: Current
Trends, Barriers & Policy Considerations**

**This document was developed through the efforts of the following co-
sponsoring organizations:**

- **Greater New York Hospital Association (GNYHA)**
- **Healthcare Association of New York (HANYs)**
- **Medical Informatics New York (MINY)**
- **New York Chapter, American College of Physicians**
- **New York eHealth Collaborative (NYeC)**
- **The Adirondak Area Health Information Management Association (AHIMA)**
- **The College of Healthcare Information Management Executives (CHIME)**
- **The Medical Society of the State of New York (MSSNY)**
- **The New York Health Plan Association (NYHPA)**

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Healthcare Challenges

- Health spend as percentage of GDP is 16%; more than any other nation
- \$2.3 Trillion; \$7,600/person; rising 6.9%/year (2X inflation)
- 14% of U.S. population is uninsured
- \$44 B in wasted dollars is recoverable from ambulatory computerized provider order entry (CPOE) systems
- \$3.5 B from inpatient adverse drug events (ADE)
- 44,000-98,000 preventable inpatient deaths/year; 7,000 from drug errors
- 500K preventable ADE injuries and deaths in outpatient/year
- 1 medication error/inpatient/day
- 17 years before effective treatment is routine
- Only 55% chance of patients getting appropriate care

Source: Jerome A. Osheroff, MD, HIMSS09

Electronic Health Records (EHRs) Improve The Quality Of Care

The system wide adoption of Health Information Technology including the implementation of office Electronic Health Records (EHRs), participation in Health Information Exchanges and use of Personal Health Records by physician practices is critical to transforming the care delivery process. Quality of care is improved by:

- Ensuring that life-saving information is available to treat you in an emergency.
- Making sure that your doctors get a complete picture of your health so they can give you the best care possible everyday.
- Reducing the risk of mistakes caused by poor handwriting, hard-to-read faxes, and other challenges of paper-based information.
- Avoiding duplicate tests because doctors can quickly access the results of tests performed at other locations.
- No longer having to fill out clipboards for every doctor and carrying around your medical information in paper—it's all online.
- Better understanding and taking charge of your own health and the health of your family.
- Knowing that your information is secure in a system that can only be accessed by authorized medical personnel, and that everyone who views your records can be identified.
- Automated assistance in choosing care protocols, identifying cost effective treatments and delivering alerts at time of prescription that can be corrected quickly and with far less risk to the patient

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Federal Level: The American Recovery and Reinvestment Act (ARRA) / The Health Information Technology for Economic and Clinical Health Act (HITECH) - February 2009

The American Recovery and Reinvestment Act of 2009 (ARRA), enacted on February 17, 2009, includes provisions aimed at promoting the widespread adoption of health information technology (HIT). The Health Information Technology for Economic and Clinical Health Act (HITECH), which is incorporated into the ARRA, provides a total of \$19 billion in Federal investments for HIT adoption and implementation. HITECH also codifies the Office of the National Coordinator for Health Information Technology (ONCHIT) within the U.S. Department of Health and Human Services. ONCHIT will be responsible for creating a nationwide health information network and will oversee the development of HIT standards and policy, as well as the testing of HIT products to ensure secure electronic storage and exchange of information.

HITECH provides \$2 billion in funding for various HIT-related activities including planning and implementation grants to states and state-designated entities for implementing health information exchange networks, education, and dissemination of best practices. The \$2 billion also includes funding for states to develop low-interest loan programs for HIT adoption.

Most notably, HITECH includes \$17 billion in financial incentives for provider adoption of HIT through Medicare and Medicaid payment add-ons. Under this provision, eligible hospitals would receive payments—over a four-year period beginning in FY 2011—for the “meaningful use” of electronic health record (EHR) technology. These payments would be phased out over four years. Penalties would apply thereafter for hospitals that fail to demonstrate “meaningful use” of an EHR.

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HITECH also includes a series of privacy provisions that clarify and expand current HIPAA privacy and security requirements and will have an impact on HIPAA privacy enforcement. Among other provisions, HITECH specifically applies HIPAA security standards and privacy rules, and the related civil and criminal penalties, to business associates. It requires investigations and imposition of penalties in certain instances for HIPAA violations and allows for increased enforcement and oversight activities. "Covered entities" (including hospitals) are required to notify patients in the event of breaches of "unsecured protected health information." Patients also have a right to an electronic copy of their protected health information if it is maintained in an EHR, and HITECH further permits patients to receive an accounting of disclosures of their health records. HITECH also includes language stating that all written fundraising communications that make use of a patient's protected health information must provide an opportunity for patients to opt out of further fundraising communications. While this provision represents no change from existing requirements, it definitely reinforces the importance of informing patients of their right to opt out of receiving additional communications of this sort. *All this constitutes a substantial down payment on the financial and human resources needed to wire the U.S. health care system. Still, major hurdles remain. First, the DHHS and ONCHIT are operating on a very tight schedule. The infrastructure to support HIT adoption should be in place well before 2011 if physicians and hospitals are to be prepared to benefit from the most generous Medicare and Medicaid bonuses. Meeting this deadline will be challenging. It takes time to develop and implement innovative federal programs, and it will take even more time to create the local institutions needed to support HIT implementation.*

"Second, much will depend on the federal government's skill in defining two critical terms: "certified EHR" and "meaningful use." ONCHIT currently contracts with a private organization, the Certification Commission for Health Information Technology, to certify EHRs as having the basic capabilities the federal government believes they need. But many certified EHRs are neither user-friendly nor designed to meet HITECH's ambitious goal of improving quality and efficiency in the health care system. Tightening the certification process is a critical early challenge for ONCHIT. Similarly, if EHRs are to catalyze quality improvement and cost control, physicians and hospitals will have to use them effectively. That means taking advantage of embedded clinical decision supports that help physicians take better care of their patients."

"By tying Medicare and Medicaid financial incentives to "meaningful use," Congress has given the administration an important tool for motivating providers to take full advantage of EHRs, but if the requirements are set too high, many physicians and hospitals may rebel — petitioning Congress to change the law or just resigning themselves to forgoing incentives and accepting penalties."

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“Finally, realizing the full potential of HIT depends in no small measure on changing the health care system’s overall payment incentives so that providers benefit from improving the quality and efficiency of the services they provide. Only then will they be motivated to take full advantage of the power of EHRs.”

Dr. David Blumenthal, National Coordinator of Health Information Technology

State Level: HEAL NY Program

New York is in a strong position to take advantage of these monies, having already begun efforts to develop its own statewide network.

New York has been a national leader in its investments in health IT. Thus far New York’s principal vehicle for providing health IT funding has been the Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program (HEAL NY) Program. Through the HEAL Program, the Department of Health (DOH) has awarded over \$150 million to projects across the state to advance New York’s health IT infrastructure. The purpose of the funding is to transform NY’s health care delivery from a paper-based system to an electronic, interconnected system.

Roughly half of this investment has gone to community initiatives which are implementing EHRs in doctors’ offices and providing the necessary support to ensure successful adoption and use. The other half of the investment has gone towards regional health information organizations (RHIOs). These RHIOs are developing community health information exchange networks through which a patient’s health information can be securely accessed and exchanged between clinicians and patients. Collectively, the RHIOs are developing the *Statewide Health Information Network for New York (SHIN-NY)*. The SHIN-NY will serve as a public good that benefits all.

Barriers to EHR Adoption

However, physician adoption of EHR is still lagging

“Few U.S. doctors or hospitals — perhaps 17% and 10%, respectively — have even basic EHRs, and there are significant barriers to their adoption and use: their substantial cost, the perceived lack of financial return from investing in them, the technical and logistic challenges involved in installing, maintaining, and updating them, and consumers’ and physicians’ concerns about the privacy and security of electronic health information. HITECH addresses these obstacles head on, but huge challenges await efforts to implement the law and fulfill President Barack Obama’s promise that every American will have the benefit of an EHR by 2014.”

Dr. David Blumenthal, National Coordinator of Health Information Technology

Financial barriers:

Although policies that offer financial incentives for HIT adoption take several forms, all aim to reduce HITs costs and increase the return to providers on their technology investments. Changing payment policies to reward good healthcare performance, for example, creates a non-specific incentive for providers to improve their quality and reduce costs of care. A sustainable financial model for implementing EHRs and other system wide technologies is needed. The ARRA, which includes incentives and penalties related to EHR adoption is an important step in that direction.

Technology barriers:

High cost of HIT acquisition combined with market uncertainties for software and hardware providers and already cash strapped physician practices, creates an inability to take decisive action. There are efforts underway at the State and Federal level to develop functional requirements, technical standards and certification criteria which will help to alleviate some of these barriers, but much work still needs to be done.

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Legal/Regulatory barriers:

Legal issues fall into three categories:

1. Concern about newly created legal exposures: adoption of HIT may violate certain legal standards or expose the practice organization to liability;
2. Concern over the actual or perceived legal burden of compliance: adoption of HIT may increase perceived burden of compliance with HIPAA privacy and security; and
3. Concerns regarding actual or perceived legal exposures associated with disclosure of information: as accessibility of data is expanded to personal health records and information exchanges the extent to which these produce new sources of liability on physicians and practice organizations remains to be seen.

Efforts are under way at the State level to develop strong common HIT privacy and security policies. This will be important to ensure consumers' trust in the use of these important technologies to benefit patient care.

Organizational barriers:

There is a number of dynamic factors that combine to form barriers, these include:

- size of the organization;
- payer-mix; and
- leadership.

Larger physician organizations are generally better able to fund the investments necessary for HIT adoption, while smaller practices must bear a larger cost per physician. Practices where payer mix suggests a larger proportion of uncompensated care generally have limited ability to generate other sources of revenue. Finally, leadership in any of these types of practices can make a significant difference in vision, constancy of purpose and ability to make necessary sacrifices along the way.

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Recommendations:

Many of these challenges are being addressed at national as well as state levels; however, there are still many sectors which lag in terms of their adoption and use of HIT. For example, the independent physician practice, whether large or small, continues to require careful policy attention driven by specific research to identify a sustainable financial model for implementing HIT. We recommend the following:

1. Additional consideration be given to current state budget gaps as exist for health care organizations versus increased mandate to implement EHR technology and compliance reporting, requiring human and capital investments;
2. Assurance that State and Federal revenue streams are complimentary to each other and not substituted, thus serving to accelerate adoption;
3. Continued assurance that New York provide strong voice and guidance to the Federal government given our current leadership in state health information exchanges, EHR adoption and informed consumer consent;
4. Development of consistency in pay-for-performance programs so that reporting requirements can easily be adopted into EHR systems and appropriate workflow processes can be incorporated into vendor product, service development and training programs;
5. Increased study and publication of information on costs (and benefits) related to on-going HIT usage, including benchmarks and methodologies for optimal adoption; and
6. On-going financial support of provider EHR usage by all parties that benefit from EHR usage, including employers, ancillary service providers (such as labs) and payers.

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Appendix

What Is an Electronic Health Record?

- Clinical documentation
 - Demographic characteristics of patients
 - Physicians' notes
 - Nursing assessments
 - Problem lists
 - Medication lists
 - Discharge summaries
 - Advanced directives
- Test and imaging results
 - Laboratory reports
 - Radiologic reports
 - Radiologic images
 - Diagnostic-test results
 - Diagnostic-test images
 - Consultant reports
- Computerized provider-order entry
 - Laboratory tests
 - Radiologic tests
 - Medications
 - Consultation requests
 - Nursing orders
- Decision support
 - Clinical guidelines
 - Clinical reminders
 - Drug-allergy alerts
 - Drug–drug interaction alerts
 - Drug–laboratory interaction alerts (e.g., digoxin and low level of serum potassium)
 - Drug-dose support (e.g., renal dose guidance)

Source: Use of Electronic Health Records in U.S. Hospitals. Ashish K. Jha, M.D., M.P.H., Catherine M. DesRoches, Dr.Ph., Eric G. Campbell, Ph.D., Karen Donelan, Sc.D., Sowmya R. Rao, Ph.D., Timothy G. Ferris, M.D., M.P.H., Alexandra Shields, Ph.D., Sara Rosenbaum, J.D., and David Blumenthal, M.D., M.P.P. N Engl J Med 2009;360.