EHRs, the Doctor Will See You Now

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by Ruth Carol

EHR systems are costly to purchase, complex to evaluate, and require expertise to implement. So why are small physician practices buying more of them than ever before?

There are plenty of good reasons why EHRs have been scarce in small and medium-sized physician practices. Enormous cost is just one. But now a number of public and private agencies are nudging the EHR within reach.

While price tags may not be smaller, medical societies and the federal government are offering opportunities to purchase the technology at discounted prices. At the same time, EHRs are gaining more reach as standards develop, advancing interoperability among practices, hospitals, laboratories, pharmacies, and payers. And some healthcare payers are beginning to offer incentives to physicians who use EHRs. Conditions are becoming favorable for the EHR to take root in small physician practices.

For two out of five doctors, in fact, conditions are already good enough. Nearly 40 percent of respondents to a recent American Academy of Family Physicians (AAFP) survey are either completely converted to EHRs or in the process of doing so. The survey, conducted in summer 2004, reports that 24 percent of members with EHRs had purchased the system within the first half of that year.

"The growth rate in adoption among small practices is probably higher right now than it is in larger practices," says David C. Kibbe, MD, director of AAFP's Center for Health Information Technology. "This is a trend that we'll see accelerate over the next few years."

Costly and Complex

But in order for EHRs to achieve widespread adoption in smaller physician practices, the barriers to entry must drop lower. EHR systems must become cheaper, more interoperable, and return more on their investment. And physicians need better access to the IT and HIM expertise that will help them successfully implement EHR systems in their offices.

Cost remains the primary reason that physicians in small and medium-sized practices have not moved to EHRs. The median cost of implementing an EHR system is in the area of $30,000 per physician, notes independent consultant Barbara Drury, president of Pricare, a national consulting firm in Larkspur, CO. That figure doesn't include necessary hardware, training, network upgrades, and IT services, all of which can easily raise the cost to $50,000 per physician.

Challenges exist even before the purchase, and new ones appear after. Most practices lack expertise to help make informed purchase and implementation decisions, particularly in small and medium-sized practices. Many small practices lack HIM professionals, and few can afford to dedicate a staff member to the selection and implementation of an EHR. Moreover, hiring an IT consultant is beyond the budget of many practices. "If you get computer expertise, you're doing well," says Drury. "If you get health IT expertise, you're really lucky."

In addition, many technology standards are still lacking. To get the most out of an EHR, it should be compatible with other health IT systems in order to support exchange of patient data. And in a rapidly changing environment, physicians are also concerned that the software vendor they select may go out of business or be unable to provide adequate IT support.

Finally, there is a lack of financial incentives. While EHRs have the potential to help doctors provide higher quality and more cost-effective care, practices that deliver better care aren't rewarded for it. "We only have incentives for volume, with pay based on how many visits or procedures are done," says Mark Leavitt, MD, PhD, medical director of the Healthcare

Information and Management Systems Society. “We don’t measure the quality or effectiveness of the care physicians provide.”

These problems are no secret, however. With a focus on the benefits of health IT and the value of networking regional care providers, an array of associations, organizations, and government agencies are working to remove the barriers between EHRs and small physician practices.

The HIM Role

HIM professionals have a valuable role to play in helping small and medium-sized practices successfully implement EHR technology. Read how in the April 2005 *Journal of AHIMA* Professional Practice Solutions Column, "Outsourcing ROI: Does it Make Sense for You?".

Increasing Financial Opportunities

AAFP offers its members significant price reductions through group purchasing agreements with nine software, hardware, and ancillary equipment vendors. Similarly, the AAFP’s Partners for Patients initiative involves alliances the association forged with leading IT companies—78 to date—that have discounted the prices of their products and services between 15 and 50 percent for AAFP members.

“The intent is really to create a robust dialogue about the best uses of IT in the family physician medical practice, which isn’t simply a one-way street telling the vendors what to do,” says Kibbe. “It’s also engaging the physicians to understand how they may need to change what they do in order to take advantage of the IT that’s available.”

The government is also exploring financial incentives. The Office of the National Coordinator for Health Information Technology is considering the use of grants, loans, or loan guarantees to encourage physicians to adopt EHRs.

Calling in the Experts

AAFP wants half of its 65,000 members using EHRs by the end of this year. To that end, the association is creating a learning community within its membership that includes physicians, vendors, and supporting companies that have expertise in IT applications for small businesses. “These physicians are taking time off from their work to become competent consumers of this technology,” says Kibbe. “So we want to help them learn very rapidly from their peers and help them to make rational choices.”

One way AAFP is fostering and sharing knowledge is through a pilot project in which six small and medium-sized family medicine practices were recruited to implement EHRs. Another means is the online EHR product reviews started last October. To date, approximately 60 products and services have been reviewed by nearly 300 family physicians. Kibbe hopes to engage specialists in the review process in the future.

AAFP is also partnering with the federal government. AAFP’s Center for Health Information Technology serves as a lead quality improvement organization for the Doctors’ Office Quality-Information Technology project funded by the Centers for Medicare and Medicaid Services. The two-year demonstration project promotes the adoption of EHR systems by helping physicians conduct needs assessments and identify appropriate EHR systems for their practices in the hope of improving care to Medicare beneficiaries.

Seventeen medical associations have teamed up to form the Physicians Electronic Health Record Coalition (PEHRC). The coalition assists physicians, primarily those in small and medium-sized practices, in selecting EHR systems. “The PERHC coalition doesn’t see itself as coming up with new technology solutions,” says Peter Basch, MD, PEHRC cochair, “but rather using the power of its member organizations to coordinate efforts.” Many of these organizations have already established efforts to help physicians match technology to their needs.

Smoothing the Way with Standards

While some organizations focus on price and selection, others are focused on the more technical aspects of EHRs—common standards that will allow disparate EHR systems to exchange data.

Formed in 2004, the Certification Commission for Healthcare Information Technology (CCHIT) seeks to accelerate the adoption of robust, interoperable health IT products by establishing a voluntary product certification process, starting with EHRs. Founded by AHIMA, the Healthcare Information and Management Systems Society, and the National Alliance for Health Information Technology, the commission consists primarily of providers, vendors, and payers willing to offer incentives, as well as some government health IT leaders, standards development organizations, and healthcare consumer advocates.

CCHIT will rate products on a pass-fail basis, explains Leavitt, who also serves as the organization's chair. The test certification process is expected to get under way this summer. Each year, the commission will refine its set of standards and the certification process. It will also publish a "road map" to help vendors prepare to meet future expectations.

"Certification is a way to ensure that manufacturers are complying with standards so the products really do plug and play," says Leavitt, who further explains that payers can't offer incentives to providers unless they get assurance that the products are interoperative and are actually capable of delivering higher quality care. Certification, Leavitt says, can reduce the providers' risk because physicians will know that the products meet CCHIT criteria.

Standardization also helps lay the foundation for regional and, eventually, national health data exchange networks by providing common language parameters. In July 2004 Health Level Seven, the international health standards-setting organization, approved a model and standards for EHRs, moving one step closer to establishing national guidelines.

The Centers for Medicare and Medicaid Services is close to the promulgation of standards for e-prescribing required by the Medicare Modernization Act of 2003. These standards will help smooth the electronic transfer of prescriptions between physicians and pharmacies.

Rewarding Performance

The last piece of the puzzle is financial incentives to physicians who provide higher-quality care through the use of health IT. Probably the most well-known of the pay-for-performance efforts is Bridges to Excellence, which evaluates and rewards physicians for providing exemplary cardiovascular and diabetes care and for reducing medical errors. Last December the program awarded its largest bonus payout to date: $800,000 to 35 medical groups in the Boston area.

The government also has initiated a pay-for-performance pilot project for physicians who adopt IT to improve quality of care and reduce avoidable hospitalizations for chronically ill patients. Doctors participating in the three-year Care Management Performance Demonstration program who meet or exceed performance standards will receive a bonus payment for managing the care of eligible Medicare beneficiaries.

Meanwhile, eyes are turned toward the payer community as a central driver to encourage widespread adoption. Some insurers are beginning to provide financial incentives to physicians, such as those who use e-prescribing and review clinical results and reports electronically.

Like many others, Leavitt maintains that when these incentives move into the mainstream the use of EHRs will soar. "Paying for quality will naturally drive physicians to adopt this technology," he says.

For many physicians, 2005 may be the year.

Worth the Investment

Is an EHR worth the money and time required to implement it?

Absolutely, says John Morrow, MD, of North Fulton Family Medicine in Alpharetta, GA. The practice implemented an EHR in 1998, when there were only four doctors making the decision. The practice now consists of eight doctors and eight physician assistants.

The initial cost to implement the EHR was approximately $30,000 per provider. “But by the time we added the hardware and training, [the total] was in the $180,000 range,” says Morrow, who noted that hardware costs were boosted because the practice purchased higher-quality computers and installed one in every examination room. “We looked at it as a long-term investment and felt it would pay us in the long-run,” he says, adding, “We still have a few of those computers.”

The practice also opted to pay for training above and beyond what the contract provided. Morrow calls this a “worthy investment.” The vendor provided an implementation specialist who visited the site for a week prior to implementation and stayed a few days afterward. The vendor also helped the doctors create templates and short lists.

“It’s unfathomable to me that a physician would try to implement an EHR without hours of training from someone who knows the system inside and out,” says Morrow. “It’s not like learning Microsoft Word. These things are so detailed and robust that there’s no way you can get what you need out of it and get the savings you deserve without the kind of training we’re talking about.”

The savings totaled $253,000 in the first year alone. The practice no longer had to pull and create charts, pay for transcriptions and dictation, use paper lab results, and buy chart supplies. Prior to implementing the EHR, the practice calculated that it cost $112 to see each patient, says Morrow. After implementing it, the cost dropped to $79.

North Fulton Family Medicine didn’t experience too much down time during implementation, either. The night before going live, it held a dress rehearsal. On the first day the physicians saw 110 patients. “Every chart went into the EHR, every prescription was done electronically,” Morrow recalls. “We finished probably 30 minutes later than we did any other day.”

There was some overtime for the first few weeks, and the workflow required redesigning to incorporate the EHR. “You do have to change some of the work processes,” says Morrow. “There’s no longer a chart in the rack in the business office. There’s a difference in how you order lab tests and x-rays and provide education to patients.”

“Don’t Wait”

Evans Medical Group in Evans, GA, was another early adopter of EHRs. The four-physician primary care practice implemented a system in 1996.

One of the best changes to the workflow was the addition of computers in the exam rooms, says Robert Lamberts, MD, who often uses them to educate patients during consultations. If a patient claims that his blood pressure is fine, for example, Lamberts can show him his actual risk by calculating the Framingham cardiac risk on the computer. “I can show a patient if we reduce his or her blood pressure what the risk is then. The patient can see the actual difference,” he says. “I treat cystolic blood pressure way more aggressively than I ever have because I have the Framingham calculations right there.” Lamberts is also monitoring his diabetes patients much more closely and can show how their levels of blood sugar and low-density lipoprotein cholesterol have decreased as a result.

Like Morrow, Lamberts’ practice didn’t experience much down time when implementing the EHR. He does still spend time customizing charts and developing templates. In fact, he’s known around the office for his charts. “If I develop a new form, I will try it out for a while. The other doctors see that my notes are better, and they’ll want to use my form,” he says. Implementing the EHR well will cause other physicians to be converted, he adds.

Lamberts believes in paying for ongoing IT support. Not only does the practice pay a monthly fee for additional support from the vendor, but it uses a local IT consultant to address network issues. “It’s worth every dime because they’re both very good and there are always issues you have to deal with.

If your charts go down, you don't work. So you have to have somebody you can call anytime for any problems."

Morrow concludes, "The main thing is, you don't wait to do this. Every day you wait, you're waiting on providing better healthcare and waiting on saving money. Do your due diligence and make your choice. You'll never regret it."

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