POLICY
PRESCRIPTIONS

EMBRACING THE ELECTRONIC ERA

Medicine lags behind many other industries in the transition to the electronic era. While high-tech advances like CAT scans and MRI machines take advantage of computerization, many physicians still rely on paper and pen to document patient conditions and treatment plans.

The American Recovery and Reinvestment Act has provided ample stimulus for doctors and hospitals to initiate the used of electronic health records. Prior surveys have demonstrated poor uptake of EHR among physician offices. Those most likely to use EHR systems are those in larger practices, those affiliated with residents or medical students, or those affiliated with hospital systems. Of those with electronic systems, most physicians (greater than 80 percent) are able to view lab results or document patient visits but less than half can order laboratory tests of transmit prescriptions to pharmacies electronically. A national survey of physicians conducted two years ago described far worse rates of EHR adoption among private practice doctors. In that survey, only 13 percent of physicians had a EHR; only 4 percent could claim to possess a "fully functional" electronic records system.

The current report in the NEJM describes efforts of a New York hospital system to entice local physicians to purchase and implement an electronic health record. Funds from the ARRA would allow for $44,000 in

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incentives from the federal government for physicians who have "meaningful use" of EHR. In addition to this, one hospital system in New York is offering up to an additional $40,000 for physicians who install an EHR which communicates with the hospital (50 percent match). If the EHR system allows for the sharing of quality data, the hospital will pay an 85 percent share of the cost.

The electronic incentives are specifically excluded from Stark Rules that otherwise prohibit hospitals from enticing physicians for referring patients to them. Historically, physicians have viewed the costs of installing and maintaining an EHR to be steep and often an unworthy investment. However, larger entities such as hospitals may find a broader information network as a means to expand their capture area and improve not only market share but also quality of care. The sharing of clinical information may reduce duplicative testing and will likely enable community physicians to be able to keep recently hospitalized patients from requiring readmission to the hospital.

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Commentary

Currently, patient information is scattered haphazardly in a mixture of illegibly-written paper notes and charts in millions of physicians offices. A small fraction of physicians have ready access to electronic health systems which permit rapid sharing of clinical information. Many of these clinicians are in academic institutions or large multi-specialty groups. The solo-practitioner and those practicing in small (less than 6 physician) groups are extremely unlikely to have access to electronic health records.

As financial incentives begin to appear in order to spur the adoption of electron health records, an emphasis must remain on interoperability and "meaningful use." However, regulators must be cautioned that to define "meaningful use" one must have an intimate view of the practice of medicine. The current push for electronic health records is not simply the digitization of doctors' notes but rather a streamlined process for all medical interactions and decision-making. From initial patient intake and medical record-keeping, EHRs must possess that capacity to allow for laboratory orders and data exchange, medication prescription, clinical decision support, and the transfer of patient specific data to other clinicians. On top of all this, electronic systems should promote the gathering of a robust, de-identified research data base to determine quality of care and a means by which to fairly compensate physicians delivering the "best" patient care.

Another important consideration is choice versus uniformity. We must not allow the typical American zeal for competition and choice trump the need for uniformity and interoperability; having practiced in an environment where several electronic systems reside in separate silos, the information might as well be locked in a vault. Ultimately, we need a universal patient record that is accessible to authorized clinicians in order to ensure efficient, safe, and effective patient care.