



The Politics of Electronic Records

At long last, health care information technology takes the Washington stage. But will legislators cry 'Bravo' or leave at intermission?

By Joseph Goedert, News Editor

(February 2005) Four years ago, Associated Cardiovascular Consultants in Cherry Hill, N.J., implemented electronic medical records software. Since then, the six-office, 31-physician practice has spent \$30,000 a year replacing hardware that no longer does the job. The total tab for the electronic records project has hit \$800,000, says John Morris, executive director.

However, Morris believes patient care now is more efficient and of better quality than it was before the records software. What's more, the practice's transcription costs have dropped from \$250,000 a year to \$70,000. After a rough first year, patient visits now move just as fast as they did before electronic records, all prescriptions are legible and accurate, and clinical documentation has vastly improved, he says.

If President George W. Bush is to reach his goal of having a national health information network—including an interoperable electronic medical record for all Americans—by 2014, provider organizations across the nation will have to follow Associated Cardiovascular Consultants' lead and make substantial investments in information technology.

Nearly a year after Bush first proposed the project, however, it is not at all clear the level of help the government is willing to give, or whether the White House's commitment to the project will match its rhetoric.

The administration, for instance, proposed \$50 million in new funding in fiscal 2005 for demonstration programs to encourage creation of interoperable information systems, but didn't ensure the money was there when legislators finished the budget in late 2004.

And when Bush in December nominated Michael Leavitt to lead the Department of Health and Human Services, neither man mentioned information technology as a health care priority in the president's second term. Still, many industry observers agree that the next two years will see substantial political activity to flesh out the details of how to build and finance a national health information network. Further, the administration's point man on health care I.T. promises the president's commitment will become clear during 2005.

"By February, evidence of our commitment will be evident," says David Brailer, M.D., the HHS national coordinator for health information technology.

Dropped ball?

As 2005 began, the industry faced a bump in the road when Brailer's office did not secure the demonstration funding. Whether that bump is a big one will be determined during the next year.

"When Congress does something like that, you can't easily read its mind," says Lewis Redd, national practice leader at Capgemini, a New York-based consulting firm. "We won't know until deep into the next congressional session whether it was just a bump or something more."

While Brailer's office did not receive \$50 million in new funds for health care I.T. programs, Bush asked for and received continuation funding of \$50 million for demonstration programs managed by HHS' Agency for Health Research and Quality.

But the \$50 million in new spending out of Brailer's office was included in one sentence of a budget bill that eventually reached 1,400 pages.

"I don't think many congressional appropriators had a clear sense what the money was for," says Michael Zamore, policy advisor to Rep. Patrick Kennedy (D-R.I.), who has become a major advocate of health care I.T. "The most defining thing is the administration didn't appear to fight for it."

Brailer concedes the administration did not have a member on the congressional conference committee that put together the final budget to protect his office's funds; but that will change. "By February, the budget for 2006 will be out and Congress will know what the money is for," he contends. "And we'll be out selling our program for health care information technology adoption on Capitol Hill."

The White House and HHS will reprogram discretionary funds to give Brailer's office some level of funding for demonstration programs, says Newt Gingrich, former speaker of the U.S. House and now an advocate for health care I.T. He is founder of the Washington-based Center for Health Transformation. "They think it is a national security issue and a patient safety issue." It's only a matter of time, he adds, before the nation faces a natural or man-made biological or chemical disaster, and electronic medical records would offer real-time data to enable public health agencies to spot such an event early.

For now, the health care I.T. industry needs to give Brailer better support and step up its lobbying efforts, Zamore insists. "There's a real need for health care stakeholders to start ramping up their legislative efforts," he adds. "If a national health information network is to happen, it needs to be physically placed on the health care agenda of Congress. In the past, there has not been a strong lobbying effort."

Zamore is correct when he says the industry must learn to lobby better for its I.T. needs, says Dan Rode, vice president of policy and governmental relations at the American Health Information Management Association, Chicago. "That will change in 2005," he says. "There was a little bit of shock in not getting the funds."

Others contend the health care I.T. industry did not drop the lobbying ball. "The industry has done a very good job of lobbying," says Thomas Gilligan, executive director of the Washington-based Association for Electronic Health Care Transactions. "It's just a matter of where these issues will sit in the hierarchy of issues Congress will be dealing with."

Brailer's new office and the industry as a whole made dramatic accomplishments in 2004, the first year of pushing a project as large as a national health information network, Gilligan argues. "This issue didn't get this far without the health care industry pushing," he says. "And it won't get any further unless the industry continues to push and continues to bring information to the table."

Rode believes health care I.T. was not merely an election-year issue for the Bush White House. "It is an issue whose time has come," he says. "Someone in the administration knew that and put it on the president's agenda, and it immediately became part of the campaign. But it is a bipartisan issue."

Joining forces

During 2004, vendors, nurses and physicians formed new associations to bring unified voices to the health care I.T. debate.

For instance, 18 regional and national organizations established the Alliance for Nursing Informatics to represent nurse informaticists. Fourteen medical societies representing 50,000 physicians created the Physicians' Electronic Health Record Coalition. And 21 vendors of electronic medical records software formed the HIMSS EHR Vendor Association, which will operate as an organizational unit within the Healthcare Information and Management Systems Society, Chicago.

The new associations could make a positive contribution by further raising the awareness of health care I.T. among policymakers and the public, Gilligan says.

And more industry efforts to cooperate and raise the level of debate could be forthcoming, Rode believes. In late 2004, several groups were working together to reach consensus and jointly answer HHS' request for information on the structure and funding of a national health information network. Among the groups, there was talk of continuing cooperation past the RFI project to develop a uniform lobbying effort.

One of the most important tasks facing the industry in 2005 is educating new policymakers in Washington. That effort starts near the top with Bush's appointment of Michael Leavitt as HHS Secretary.

Former HHS Secretary Tommy Thompson was the driving force in getting health care I.T. on the Bush agenda. Leavitt, having spent one year as administrator of the Environmental Protection Agency and 11 years as governor of Utah, now will bring a new team to HHS.

Pole position safe ... probably

Many industry observers believe Brailer should be secure in his role as he is far enough down the leadership totem pole, but there are no guarantees.

"Brailer probably is safe, but everything is up for grabs," Gilligan says. "Leavitt will bring a cadre of new people to HHS. When you get a new boss, everyone he brings with him is on the A-team."

The departure of Thompson will not slow the Bush administration's plans for a national health information network, Gingrich contends. That's because Bush himself is a major driver of the plan. "This guy has clearly talked about health care I.T. more than all other presidents combined," he adds. "You should expect the administration to come back again and again to this topic."

Leavitt will need time to sort out priorities and get educated on health care I.T. issues, but he does have some experience with the subject. In Utah, he created a new program to increase Internet connectivity in rural areas to attract I.T. and related jobs, such as remote medical coding. Further, the state supported formation of the Utah Health Information Network, a cooperative venture between providers and payers to electronically exchange transactions.

But how much emphasis Leavitt gives to health care I.T. may depend on how high on the priority list the effort is for Bush, Gilligan says. "He'll probably follow the Bush agenda until it gets to health care I.T., but I don't know when that will be."

Congressional landscape

Changes also abound in Congress, and that could slow regulatory progress as the House and Senate reorganize following the 2004 elections.

Sen. Judd Gregg (R-N.H.) is stepping down as chair of the Senate Health, Education, Labor and Pensions Committee.

Gregg's likely successor is Sen. Michael Enzi (R-Wyo.), who has little experience in health care issues. However, Enzi's state has a fledgling regional health information organization and that could pique his interest in health care I.T., observers say.

President Bush envisions these regional networks as forming the foundation for a national network. However, with a new chair comes new committee staffers who will need to be educated on health care I.T. issues, Gilligan says.

Still, many lawmakers who have shown an interest in health care I.T. in recent years will be around for the next session of Congress. In the Senate, these include Gregg, Hillary Clinton (D-N.Y.), Ted Kennedy (D-Mass.), Christopher Dodd (D-Conn.) and Senate leader William Frist, M.D. (R-Tenn.).

On the House side, Patrick Kennedy and Jim Murphy (R-Pa.) lead a health care I.T. caucus of about 20 members. But the key player, Patrick Kennedy advisor Zamore says, could be Rep. Nancy Johnson (R-Conn.). "She's not only chair of the health subcommittee of the Ways and Means Committee, but she was really out front in recognizing the importance of health care information technology, looking at it long before most folks around here."

Various pieces of legislation introduced in the last congressional session had a common theme of placing health care I.T. as a national priority, directing HHS to set and adopt data standards that foster interoperability and authorizing funds of from \$100 million to \$2.5 billion over many years.

It should be noted that authorizing funds in legislation is easy; getting the funds actually appropriated is the tough chore.

Absent the election and war in Iraq, a health care I.T. bill could have passed Congress in 2004, believes Rode of AHIMA. With that passage would have come lawmakers who had something to protect in the budget process. One passed bill can become a vehicle for other successes to come.

The lack of such a bill is one reason the White House didn't get demonstration funds for Brailer's office, Rode says. "There was no vehicle in Congress last year, so appropriations came along and saw a line item of \$50 million, and no one in appropriations had been working on this."

Right now, Brailer hasn't got the behind-the-scenes action in the White House and HHS that he needs to gain the necessary support in Congress, Rode contends. To get Congress on board, Brailer and Doug Badger, the White House health policy advisor, will have to sit down with congressional leaders and set a plan, he adds.

Even if that happens, the industry should expect to wait many months before a health care I.T. bill moves through Congress, Gilligan cautions. "Social Security and tax reform will go first and nothing else is going to get done before them."

Still, Brailer and legislative proponents of a national health information network laid out a "wonderful" set of I.T. goals for the health care community in 2004, Gilligan says.

But the challenge of interoperability at the data element level—where a piece of data means the same thing to the sender and receiver—should not be minimized. For instance, he notes, the transactions and code sets rule under the Health Insurance Portability and Accountability Act has not yet achieved this level of interoperability for common electronic administrative transactions. "It is important to the success

of a national network that goals be incremental and timelines be set with achievable expectations," Gilligan says.

Legal barriers

Today's health care climate is supportive of the effort to build interoperable electronic records and a national health information infrastructure, says John Hummel, senior vice president and CIO at 26-hospital Sutter Health, Sacramento, Calif.

"Five years ago, doctors said they'd retire before using an electronic medical records system," he recalls. "Now many accept it and so do their associations."

At Sutter, physicians and hospital leaders pushed for a dramatic acceleration of electronic records implementation throughout the delivery system. In 2004, Sutter's board approved boosting a \$1.2 billion, 10-year I.T. initiative by \$154 million to get electronic records enterprisewide by the end of 2006. But formidable obstacles loom for all providers moving to automate their clinical processes. The top barrier is money, but legal restraints also must be lifted to enable hospitals to assist smaller provider organizations, Hummel and others say.

Providers believe anti-kickback provisions in federal laws, particularly in a law known as Stark II that restricts physician referral practices, prevent large provider organizations from helping affiliated smaller ones to automate.

Large organizations should be able to implement and pay for clinical information systems on their own, Hummel says. But they also should be able to do such things as license electronic prescription or electronic records software, making them available to affiliated physicians and community hospitals. "We need to amend Stark II," Hummel says. "There should be a way for me to reach out to those who can't automate on their own."

The Stark II provisions will be corrected in 2005, Brailer pledges. Actually, Stark II should have been fixed in 2004, if not sooner, Gingrich says. "You are dealing with a federal bureaucracy that does not move at the speed of the modern world. It clearly is not acceptable, but it's a fact."

Some physician organizations fear their hospital partners won't be willing to help as much as Sutter. Many hospitals want physician practices to foot the bill not just for information systems but for the links between the systems and their hospital-based counterparts, says Pam Coyle-Toerner, CEO of eight-office Queen City Physicians, a primary care group practice in Cincinnati.

Pay to play

"They want doctors to pay to play, but we're the ones generating the business," she says. "We're generating the revenue stream, but in order to get data back from the hospitals we have to pay for it."

President Bush's proposed 2006 budget, expected this month, will show the administration's commitment to health care I.T. and will start to answer the many questions surrounding the drive toward a national health information network, Brailer says.

"This is the launch year," he adds. "We spent eight months getting ready. We are moving to a new mode—an implementation mode—starting with the 2006 budget." Under former HHS Secretary Thompson, Brailer was given increased authority over reviewing and redirecting all federal health care I.T. spending, which accounts for about \$4 billion a year.

Now Brailer wants to leverage that spending to support the proposed national health information network. "One of our main tasks is to use the government's size to move the market," he notes.

The Department of Veterans Affairs, for example, is working to create a public domain version of its VistA clinical information system for physician practices. The practices would get the software for free, but would need to pay for implementation and integration work.

To push the industry toward quick development and adoption of standards that support interoperable systems, the government intends to purchase standards-based software and services to the extent that standards exist.

Further, at least 12 government programs are doing separate work on components of a national health information network. The government now is moving to coordinate the programs to ensure they are not redundant and directly support a national network, Brailer says.

'Skin in the game'

It remains too early to categorically state that providers should assume they will pay the majority of costs to implement standards-based, interoperable clinical systems, Brailer contends. "The government has not completed its analysis, and it is unclear the extent to which employers and payers will step up. Still, providers must have some skin in the game."

How much skin will be required remains a major question; its answer is largely dependent on the level of financial incentives given to providers that automate. There is no consensus, however, on where those incentives would come from and the degree to which they would help.

"The 2006 budget will make some statements on how the administration views its role in incenting adoption," Brailer says. "But the federal government will not pay all the bills. Providers, government, and private employers and payers must invest."

The reality is that huge deficits and the war in Iraq preclude massive government funding of a national health information network, says Jim Adams, executive vice president at Healthlink Inc., a Houston-based consulting firm. "We should expect more than seed money, but I don't think we'll get much more."

Meaningful incentives are important because many provider organizations, particularly physician practices, cannot be expected to absorb all the costs of implementing interoperable clinical systems, says Fred Hannett, managing principal at The Capital Alliance, a Washington-based consulting and lobbying firm.

"The reality is, when they make this investment they could be reducing their income," Hannett says. "We're asking providers to make an investment so they can have less money in their pockets."

The industry assumption, pending Bush's proposed 2006 budget, is that the Medicare program will pay some type of bonus reimbursement to providers that invest in clinical information systems and use new or existing systems to improve their data reporting to the Medicare program.

HHS will work with states to find other ways that governments can offer incentives, but Brailer can't promise that Medicaid programs will participate. "That's a very complicated issue, but it's being looked at."

Private sector incentives?

Whether private employers and nongovernmental insurers will pay incentives to any significant degree is very much an open question.

“Employers would like to see incentives, but I don’t know that they would like to spend more money,” says Helen Darling, president of the Washington-based National Business Group on Health. “They already feel they spend an awful lot on health care.”

Employers want to see a direct relationship between something positive resulting from I.T. implementation—such as better data reporting or improved safety and quality of care—and higher reimbursement, Darling says.

In 2004, the business group issued guidelines for corporate donations to health care organizations to promote I.T. “The National Business Group on Health and its 220 members would like to encourage corporate foundations to maximize the impact of their dollars by focusing on high value investments,” according to the guidelines. “At this stage in the evolution of the health care system, the greatest overall return on investment can be achieved through investments in health information technology.”

On the payer side, it is too early to say if private insurers, in large measure, will support incentives, according to a spokesperson for America’s Health Insurance Plans, a Washington-based trade association. The association is studying the issue of incentives that would not be tied to providers meeting certain performance measures, the spokesperson says. However, it is unclear if the association’s payer members will support incentives absent such measures.

It is too early to know if private payers and employers really understand the role they must play in the formation of a national health information network, says Hannett of The Capital Alliance. But without major encouragement from the private sector, the timeline for Bush’s vision could stretch to 20 years.

“This is a long process that will require significant investment,” Hannett says. “If we want to speed that up, it will take an alignment of incentives, primarily by payers.”

Incentive programs work, argues Coyle-Toerner of Queen City Physicians. In November, the practice received its first payment under an early stage employer/insurer pay-for-performance program called Bridges to Excellence. Queen City Physicians got \$14,000 after 11 of its physicians were certified as delivering quality care to diabetics. “It’s not huge money, but it is new money for us,” Coyle-Toerner says. “And it’s just one program.”

Where are the rewards?

But Queen City Physicians, which in 2002 completed implementation of electronic medical records in its eight offices, does not yet receive incentive payments for its I.T. investments. “I don’t get a tax break, higher reimbursement or a break in malpractice insurance,” Coyle-Toerner says. “But our doctors conducting electronic prescriptions are less a threat to patient safety than those using paper.”

In Boston, the Bridges to Excellence program has started offering annual bonus payments to physician practices that have implemented I.T. to track and educate patients, maintain medical records, prescribe medications, and ensure appropriate follow-up care. In December 2004, 35 practices in the Boston area shared a total of \$800,000 in bonuses. The Bridges to Excellence program also is starting up in upstate New York.

On another front, some payers are literally giving away information technology. WellPoint Health Networks, which recently merged with Anthem Inc. to form WellPoint Inc., has offered thousands of physicians a personal digital assistant or desktop PC and printer loaded with electronic prescription software. The program has met with limited success. Elsewhere, three major payers in Massachusetts—Blue Cross and Blue Shield, Tufts Health Plan, and Neighborhood Health Plan—offer physicians electronic prescription software and a PDA. BlueCross BlueShield of Tennessee offers free e-prescription software to physicians, who must purchase their own PDA.

Such bonus payment or technology giveaway incentive programs could be the final push some physicians need to automate, says James Fisher, a director in the health care practice of the New York-based consulting firm PricewaterhouseCoopers LLP.

“But not enough payers will provide these incentives, so government will have to provide most of them through Medicare and help providers make the initial capital investment.”

The cost of incentives, at least early on, could be offset through lower reimbursement to provider organizations that won't automate, says Jonathan Bush, CEO of athenahealth Inc., a Waltham, Mass.-based software and services vendor. “The government should increase reimbursement for people who can provide access to certain clinical data elements to measure quality and other factors, and take it out of the hide of those who don't.”

He and others warn, however, that incentives likely would last for only two to four years, which could be sooner than provider organizations see a substantial return on their clinical I.T. investment.

Many private payers are willing to offer incentives and wait for their return on investment, believes Paul Brient, CEO of PatientKeeper Inc., a Brighton, Mass.-based vendor of software for mobile computers. “Employers are the real problem, even though they have the most incentive,” he adds. “But the ‘quarter-to-quarter’ myopia prevents them from realizing this.”

Teaspoon of commitment?

Whether or not private payers and employers embrace incentives, Medicare must lead, Brient insists. “Medicare alone can drive this.”

However, President Bush's vision of an electronic medical record for every citizen lacks the funding commitment to make it happen, according to a recent report from PricewaterhouseCoopers.

The level of spending the White House has so far proposed “is a teaspoon of the funding needed to digitize a \$1.6 trillion industry,” according to the report. The report cites research from The Lewin Group, Falls Church, Va., that estimates the cost of implementing electronic records nationwide at \$27 billion to \$50 billion.

The bottom line, Fisher says, is that the vision is realistic and doable only with enough incentives, and it still will take 10 to 15 years.

Neither the Bush White House nor Congress yet understand the true cost of a national health information network, Gingrich contends. “Sometime this year or next, Bush will have to confront the reality that the government must adequately fund electronic medical records adoption.” •

Sidebar

Will vendors cooperate on interoperability?

A major barrier to the vision of an electronic medical record for all U.S. citizens is the lack of interoperability among information systems. However, during this month's 2005 Healthcare Information and Management Systems Society Annual Conference and Exhibition in Dallas, several I.T. vendors will demonstrate an array of interoperable functions among disparate information systems.

Still, even these progressive vendors have not made all of the functions in all of their products interoperable. Overall, the concept remains in the earliest stages.

But without interoperability, the vision of President George W. Bush will fall apart. So the burning question is: Are vendors committed to interoperable information systems?

“Interoperability between health care I.T. vendors will be the biggest obstacle to electronic records adoption,” says Keith Bolton, vice president of marketing for Amicore Inc., an Andover, Mass.-based vendor of software for physicians. “There is nothing in the Bush plan to encourage vendors to open up their systems and share data.”

The obstacles to interoperability are not technological, says Robert Seliger, president and CEO of Sentillion Inc., an Andover, Mass.-based systems integration firm. He also serves as chair of the HIMSS steering committee on integration and interoperability.

Asking vendors to drop their proprietary systems and create new ones based on open standards is not realistic without good business incentives, he argues. “What’s in it for vendors to interoperate? That’s not a selfish question, but a very good business question. There’s got to be really good business reasons to do all of this. We need to create opportunities for vendors to move away from closed systems.”

Many vendors are not ready to embrace interoperability for a host of reasons, says Paul Brient, CEO of PatientKeeper Inc., a Brighton, Mass.-based mobile health software vendor. For one thing, vendors routinely charge tens of thousands of dollars for interfacing to link their closed legacy systems with other closed systems.

But there are other reasons as well, Brient says. “Large incumbent vendors have explicit internal policies about not being open because it scares them,” he contends. “If truly open, they have to be ‘best of breed’ for every application and they clearly are not.”

How interoperable information systems need to be, and what interoperability really means, are issues yet to be resolved.

Vendors integrate their information systems with those of other vendors all the time, notes Tom Skelton, CEO of Misys Healthcare Systems Inc., Raleigh, N.C. “Virtually anytime you place a system somewhere, you are integrating with other systems.”

What is just as important, Skelton says, is that critical data be standardized and captured in a uniform manner within disparate information systems.

For example, what is considered a normal blood pressure for a 40-year-old male may differ from one hospital to another, based on their clinical decision support software. •

Sidebars

Finding a common ground on pricing

How much should an affordable, standards-based, interoperable electronic medical records system cost? That’s an issue that soon could have battle lines being drawn as the nation figures out how to automate small physician practices.

David Brailer, M.D., the government’s national coordinator for health information technology, believes vendors should be able to offer a system to practices of one to four physicians for \$100 per physician per month.

Many software vendors are large enough that they can offer a product with some features “turned off” at this price, he argues. It means a smaller profit, but in a high-volume market. “Markets are created by people going after a mass market with cheap costs.”

“I think \$100 per month is unrealistic,” responds Andrew Ury, M.D., president of Physician Micro Systems Inc. of Seattle, a vendor catering to physician practices. “That was tried by the old MedicaLogic company and they couldn’t make it work.” Physicians have to get real value from an electronic records system, limiting the ability of vendors to strip a system down for a small practice, Ury says.

His company is a founding member of the American Academy of Family Physicians’ Partners for Patients program to develop information technologies that meet certain performance standards yet are affordable to virtually any physician practice. Right now, the lowest price Physician Micro Systems can charge for a functional electronic records package is about \$250 per physician per month, Ury says.

Doctors are ready to give business to records vendors who can sell affordable systems, says David Kibbe, M.D., director of the Leawood, Kan.-based academy’s Center for Health Information Technology.

“We’ve gone from about 8% of our members using electronic records 18 months ago to 15% today,” Kibbe says. “And we expect to reach 30% to 35% by the end of 2006.” •