

## Volume 3 / Issue 5 / 2008 - Features

### Doing the Right Thing for the Wrong Reasons

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**The need to reduce errors, increase economies of scale in a fragmented system, and derive efficiencies in the delivery of medical services have been the key drivers of healthcare IT in the US in recent years. However, the pace of progress has been less than expected. Given below is an account of the evolving role of healthcare IT in the US, its challenges and promises – as well as the need to look at ‘soft’ issues such as patient empowerment. The author, currently a University Professor of Medicine, was previously an Under Secretary of Health at the Department of Veterans Affairs, widely credited with developing one of the first successful national electronic health record systems.**

#### To Err is Human

Over the past decade, the US has seen an accelerated effort to increase the use of health information technology (HIT) including electronic health records in the US healthcare system.

Much of this emphasis can arguably be traced to a pivotal report published by the prestigious Institute of Medicine (IoM) in the year 2000. The report, titled ‘To Err is Human’, estimated that as many as 98,000 people die in any given year from medical errors occurring in US hospitals.

A companion report published by the IoM the following year, titled ‘Crossing the Quality Chasm’, characterized the US healthcare system as “A highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities (and) results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays.” The report went on to recommend the use of HIT as a critical tool to address problems with both quality and cost in the US healthcare system.

#### The Department of Veteran Affairs: Making a Case for EHRs

Interestingly, during this same period, the US Department of Veterans Affairs (VA) deployed a robust electronic health record that had been developed internally over a number of years with extensive physician and staff involvement. The EHR was implemented throughout the extensive VA nationwide health care system. As portrayed in a 2004 feature in *The American Journal of Managed Care*, the VA’s EHR soon began recording benchmark results in a number of nationally recognized quality measures while dramatically increasing the number of veterans receiving care through the system. This experience in the VA, once considered a prime example of government bureaucracy and inefficiency, added further evidence to an increasingly popular belief that HIT was an essential strategy for improving quality and controlling costs in the US healthcare system.

#### The National HIT Plan 2004-2014

Then, in early 2004, President Bush announced his national HIT plan with the goal of assuring that most Americans have access to electronic health records (EHRs) within the next 10 years (by 2014), facilitated by the efforts of the newly created Office of the National Coordinator for Health Information Technology. More recently the US Centers for Medicare and Medicaid Services (CMS) implemented a pilot program to encourage adoption of EHRs through the use of enhanced payments to physicians who agree to implement these systems.

Yet despite this senior leadership emphasis, progress towards HIT implementation in the US has been relatively slow. In fact, a countrywide analysis ‘Electronic Health Records in Ambulatory Care - A National Survey of Physicians’, published by the prestigious *New England Journal of Medicine* found that only 4% of US physicians were utilizing a fully functional EHR in their practice.

#### Funding and Implementation

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However, the lagging HIT implementation effort by the US is not surprising when one examines how these efforts have been funded. In the predominantly fee-for-service US health care system, the implementation costs of electronic records systems are recouped very slowly, if at all, by the providers who have traditionally paid these costs, while payers, including commercial insurers and the CMS reap significant savings due to the elimination of adverse events, redundant care, and unnecessary services, with virtually no investment in HIT implementation.

Furthermore, while the US spends far more on health care per capita than any other Organization of Economic

Cooperation and Development (OECD) country, the US government spending on infrastructure and efforts to implement HIT is one of the lowest per capita compared to other major OECD countries, where significant investments have been made by both insurers and government instead of relying on providers to carry the brunt of implementation costs.

#### **Looking Beyond Quality and Cost**

However, before we write off the US lack of progress towards HIT implementation as a combination of misaligned incentives and a lack of government funding, we should examine the system in more depth. Are there more fundamental problems with the US healthcare system that HIT implementation efforts are failing to address? Quality and cost, though important, may be the wrong reasons for increased adoption of HIT. The average US life expectancy was only 47 years in 1900 prior to the availability of antibiotics, antihypertensive therapy, insulin, and effective cancer treatment. In this setting a hospital served as an effective place to treat patients who either survived, or succumbed to acute injury or illness.

A paternalistic, somewhat pedagogical style of medicine was practised in a system where patients did not question their physician and rarely understood the nature of their disease process. After all, if they survived it was no longer relevant, and if they succumbed it really didn't matter.

However, with the advent of effective pharmacotherapy for numerous once-fatal diseases and radically improved cancer management, Americans are now much more likely to survive and live for decades with chronic disease. In fact, in large part due to the huge post-war US "baby boom" population now entering their 60's, it is estimated that 75 to 80% of all US healthcare expenditures are for chronic conditions. Unfortunately most of this care is delivered in a hospital-centric health system that was never intended to provide these types of services.

Additionally, patients who must play an integral role in the care and management of their chronic conditions lack the expertise, means, and the cultural impetus to effectively interact with their providers. Thus, care for most chronic conditions is provided in a few brief minutes in the physician's office several times a year, interspersed with the occasional hospitalization that might have been avoided with effective chronic condition care.

An effective care model for management of chronic conditions might include improved patient education and access to health resources, enhanced screening and preventive care for chronic disease and associated complications, simplified selfmonitoring of physiological indicators of disease such as blood sugar, body weight, blood pressure, etc., improved communication between patient and provider, and most importantly direct involvement of the patient in the clinical decision making and care management process. Not surprisingly, each of these components is easily achieved with technology available today.

#### **Personal Health Records**

A particularly interesting approach to this need is the use of personal health records (PHRs), which have been debated extensively in the US. PHRs have been criticized because they may introduce commercial bias to patients, and physicians have expressed reservations about relying upon the accuracy and validity of patient-entered and maintained clinical information. However, at least as an interim measure, PHRs have the potential to educate and motivate patients, while creating pressure to develop greater availability of interfaces to allow the direct flow of clinical data into these records. Over time these interfaces will also facilitate other types of health information interchange (HIE) among providers as well as patients. Thus, it appears that increased use of PHRs could leverage efforts to adopt HIT in several possible ways.

#### **The VA and Low-Cost Telehealth**

Another interesting example of the use of HIT to address chronic condition management can once again be found in the US Department of Veterans Affairs (VA). Beginning with a pilot program in the state of Florida in 2001, the VA used low cost, in-home, interactive technology to monitor patients with chronic disease with remarkable results. Significant reductions in hospital admissions, nursing home admissions, and emergency department visits were achieved by early detection and intervention for complications associated with chronic conditions. The program was subsequently deployed nationally in the VA as the Care Coordination Home Telehealth program with similar results.

#### **From Error Reduction to Empowerment**

The greatest potential benefit of HIT adoption may not be the elimination of costly, unnecessary, ineffective, or duplicated care, or the avoidance of medical errors and adverse events. While these benefits are real and quite substantial, simply lowering costs and reducing errors would create greater efficiency in a health care system that still fails to meet the essential needs of the US population in the 21st century. The real value of HIT may lie in its ability to empower, educate, and motivate patients so that once paternalistic care models are replaced with a partnership model between physician and patient with a common goal of more effective disease screening and prevention and improved chronic condition

management, facilitated by technology, and utilizing evidence-based medicine.

Only after patients become knowledgeable health care consumers will they be able to discern and seek out true value in care and services. This increased healthcare "consumerism" will encourage providers to focus on quality, cost, access, and condition healthcare services increasingly sought by more informed and medically sophisticated patients desiring optimal management for their chronic conditions.

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