

**HIIAB EMR Adoption Panel 11/19/2008 Rick MacCornack, Ph.D.
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In the world of the community based clinic practices, the EMR adoption rate is low. This is attributed to the barriers which are summarized in the HIIAB documents. Our observation is that EMR adoption in smaller community based practices has occurred among the very early adopters who love electronic tools and among physicians and ARNPs who are young and building their practices. Among NPN's 102 PCPs, 10% are using an EMR, most at full capacity. Among the 334 specialists in the network, over 50% are using one. My comments pertain to EMR adoption in primary care practices. I would suggest that any discussion of EMR adoption should differentiate between primary care and specialty care. Specialties, by their very nature of being narrow and deep, are well suited to EMR use. The business case is easier to justify; and specialists have more money to spend on sophisticated tools. Adoption rates would generally support these assertions.

In responding to the Board's questions: as with most things in life, it's not so much the *what*, but understanding the *how* that creates a connection between recognition and understanding and subsequent behavior change.

To parse the logic and create a path in approaching and winning over paper based practices, I believe we should first be asking the following question of ourselves to illuminate *how* we should craft policy that fosters more rapid adoption of EMRs among primary care physicians who have chosen to make that decision for themselves. The question is:

Does an EMR improve the odds that a patient will receive better and more consistent medical care that leads to a more rapid or effective resolution or management of a problem, especially when more than one doctor is involved in treating the patient?

So when you ask the question this way, you're focused on the clinical importance – or lack of importance -- of an EMR in improving patient care. Every physician I have met in the last three years knows there are functions that an EMR performs which can improve the care process: like robust decision support; defined population management; and effective practice management tools. But there are also characteristics of any EMR that have no effect on assuring better care, and in some instances, can even be detrimental to it, such as the spewing of boilerplate progress notes which have the potential to eliminate clinical nuance, which many clinicians are looking for in a chart note. An unintended consequence of this can be otherwise unnecessary repeat testing.

In my experience in working with many, many well established paper-based practices since 2004, an EMR is seen as an unnecessary burden in primary care *if* it is viewed as an electronic library system with annoying templates that generate prefab descriptions and comments for charting purposes.

In this regard, I have heard many physicians voice the following questions and comments:

- Will an EMR support my clinical judgment in a way that actually makes a difference in the care process?
- If I am reading someone else's notes in an EMR, how do I get a sound clinical sense of what's going on with the patient outside of what I get from lab or other test data?
- How can you accurately discern between notes in an EMR that support a coding motive and notes that reflect astute clinical observation that provides insight into an underlying clinical process?
- When I see a note that is obviously driven from a template, I feel violated as a clinician with years of practice experience. It's an insult to everything I know as a physician.

We just completed an interview study with 38 PCPs in small practices, and we are reminded once again that there are four HIT priorities for *established* paper based practices if they are going to improve their medical effectiveness. An EMR may or may not provide some of these functions: These priorities are the use of...

- Registries for the management of prevalent medical conditions, with automated lab feeds.
(60% of PCPs in NPN are using one). Cost: Free. ROI: variable
- An automated referral system that assures efficient and complete communication and information provision between PCP and specialists and which also documents the care coordination process, documenting the who, what, when, where and why of referred care. As you may have read yesterday in national HIT news, effective, documented care coordination is now considered to be among the top few critical issues that must be resolved. It's important to underscore that no EMR supports this functionality outside its own platform.
(81% of PCPs in NPN are currently using an electronic, automated referral system for all their referrals). Cost: \$100/month. ROI: 2:1.
Our target is 100% adoption by 2nd quarter 09 and with a concurrent enlistment of all specialists in our broad network of providers by the end of 09.
- E Prescribing
(about 35% of PCPs in NPN are using an e Prescriber; our target is 50% by next June). Cost: Free - \$65/month. ROI: undetermined
- Communication tools via secure portals for providers and patients which are *NOT* EMR specific. Similar to an automated referral system supporting care coordination, a community practice *must* be able to communicate across EMR platforms. EMR-centric communication is just a 21st century silo.
(60% of PCPs in NPN are using the South Sound Health Communication Network). Cost: \$40/month. ROI: 8:1)

Total cost: \$140-205/month per physician who is working full time.

Each one of these functions is easy to implement, compared to implementing a complete EMR in an established practice. A practice can actually be an accountable, high performer with these four functions in place. Most importantly, we are finding that using these solutions in one combination or another actually begins to break down some of the resistance to EMR adoption. We have a few practices which are implementing an ASP-based EMR because they have whetted their appetite on the solutions I just described. They continue to use The South Sound Network for communication outside the electronic walls of the EMR and will do so until we built interfaces between the EMRs and The Network. They will use the automated referral system for care coordination forever, since most care coordination in the community occurs across a variety of EMR and paper based practice environments.

For the well established paper-based practice, the resistance to change is usually attributed to:

- initial conversion (time and cost);
- the initial and on-going service quality and responsiveness of the vendor support team;
- cost of support and product upgrades;
- fear of the dynamic (i.e. unstable) EMR industry and the concern about owning an orphan or assuming a new owner who has different priorities than the former owner.

But what really doesn't come out in this tick list is an ugly reality: most small primary care clinics have weak office staff support. Often they are the barrier to EMR conversion. Office staff attitudes are hard to change – often harder than changing physician attitudes. Office staff attitudes have been the biggest barrier to HIT adoption that we have identified so far. We have many examples in which the physician has arrived at the conclusion that an EMR would be a good idea, but he or she knows that to do so would blow up an already fragile office staff environment. This is much more complex an issue than having an EMR conversion crew come in and provide training and support to staff. Our counsel is therefore caution. We are already in short supply of primary care in this state. Ramming EMR adoption as an agenda on a timeline will be very unwise. The transition needs to be progressive, offering incremental options, as I have just described.

The most stable EMR vendors are the giants, which are also unaffordable and generally inappropriate for small clinic application. However, there are several smaller EMR vendors offering robust, affordable, reliable products for small practices, but physicians are understandably concerned about the survival of these vendors in the highly volatile EMR market.

The recent attempt to build a bridge to affordability, which allows hospital systems to purchase EMRs for community practices, is seen for what it is in many markets like ours -- a Trojan horse. Unless a physician has already decided to become a salaried employee, this is not an option.

In closing, I would suggest that this Board consider policy that includes an incremental approach to achieving the long term goal. At NPN, we are demonstrating the practical value of the incremental approach and would welcome a wider adoption of this tactic and the tools we are using so that there is greater success in converting all practices to full EMR adoption over the next few years across the state. To us who are based in the community, it's obvious, because we achieve the capacity to report from the practice on key clinical performance targets, manage chronic care and coordinate care, all of which push practices toward their eventual life with an EMR.