

WAFP Response to Questions for Stakeholders Regarding Accelerating EMR Adoption

Three key types of barriers to EMR adoption have been identified:

- 1) financial;
- 2) technical; and
- 3) practice (see attached presentation "Summary of EHR Adoption Information")

1. Are there are other key types of barriers that must be addressed other than those in the attached presentation?

Integration of information from diverse sources-hospitals, labs, imaging centers and pharmacies is a critical need, and extends the function of an EMR beyond the simple electronic version of the traditional paper record. The necessary interfaces and data warehousing exist only in limited settings/communities. The value of an EMR is in the ability to incorporate data electronically from multiple sources and to communicate with other medical providers to coordinate care efficiently.

2. What combination of barriers do you think need to be addressed to accelerate EMR adoption?

To be successful, the state must address the financial barriers. The estimated minimum adoption cost per physician is on the order of \$20,000 in up front hardware and software costs, plus the cost of training and the reduction in productivity expected with transition and start-up learning. Many practices will not realize a return on the investment in EMR for several years, with offsetting of transcription costs and costs of paper records. In addition, assistance in choosing an EMR that is well-supported, affordable and offering best value across multiple specialties in multiple settings is desirable. Although there are a wide variety of products available, web-based EMR's which have open architecture and ability to share data across HL7 compliant platforms allow for the integration of care across a spectrum of medical specialties and make the development of the medical home possible.

3. For each of the types of barriers addressed in #1 and #2 above, a. How can the barrier best be overcome?

One method of financing EMR adoption by rural and small practices, who may face larger challenges in realizing a return on investment in the short run, would be to divert Business and Occupation taxes on these practices into a state-subsidized web-braced EMR. The current B and O tax burden on a physician practice is 1.5% of gross revenues. For a Family Physician with MGMA median gross revenue of \$363,215, the estimated B and O tax burden is \$5448.21. Investing these tax revenues directly in EMR adoption would provide significant incentive for practices to implement an EMR, and with startup costs of EMR amortized over 4-5 years, a short-term deferral of B and O tax would have a positive long-term gain in productivity and efficiency, along with potential for real savings in reduced medication prescribing errors, duplication of services, and poor coordination of care.

b. Who should be responsible for the needed actions?

In order to provide for the greatest integration of medical information amongst a community of medical providers, there must be a systematic approach to the selection of EMR product(s) and the warehousing/dissemination of critical medical information. The concept of a Regional Health Information Organization requires development of architecture and structure to allow for the most appropriate availability of HIIPA complaint medical information at every point of care. It is critical that physician practices select EMR products that support integration; the creation of interfaces is extraordinarily expensive and for many small and rural practices, would be prohibitive unless a state-supported RHIO existed. Although there are models of privately-owned EMR companies currently operating in limited areas within the state who have created a RHIO-like integration of multiple practices, the functionality of the EMR product does not necessarily meet the needs of diverse medical and surgical specialties.

c. How should oversight be provided?

Develop a statewide consortium of RHIO/EMR providers coordinated by HCA/SHIAB

d. Who should bear the cost?

Some funding from State is necessary to create the infrastructure to support education and assistance with adoption, and the support of RHIO activities across the state. In settings where a community RHIO type of structure exists, the state's role would be to ensure that individual and group practices would be able to participate in the information-sharing tools of the RHIO without being limited to a single EMR platform.

The financing of EMR software and hardware needs should come from the practices themselves, using dollars that would have been paid to the state in B and O taxes, for a period of up to 5 years. By 5 years every practice should have been able to realize a net return on investment assuming that the physician(s) have made the optimal use of the platform and have eliminated transcription costs and significantly reduced administrative costs for continued use of paper records.

The state could play a significant role in negotiating with a limited number of high-value, best-of-breed EMR products for best possible pricing and regionalization of coverage and integration.

e. How can the proposed action avoid penalizing those who already have EMRs?

The wider adoption of EMR's by small practice and rural physicians and the more extensive development of shared data networks will allow for better coordination between the referral centers and specialty networks, reducing administrative burdens and costs for everyone. The larger groups who have already adopted EMR's will realize a benefit from the enhanced community integration possible with more widespread EMR adoption. Funding by the state for enhanced RHIO development would benefit these practices also. Most larger groups that have adopted EMR's will be able to achieve rapid ROI with reduced transcription and medical records staffing costs in a shorter period of time than the small offices.

**4. Please comment on the scale of action needed to accelerate EMR adoption:
a. Should it be statewide?**

There needs to be statewide support to integrate medical information across multiple venues (i.e Children's Medical Center/Harborview/UW with rural networks), and to negotiate pricing for a limited number of CCHIT-certified products, with communities and regions of networked physicians selecting products based on consensus reached after local, careful exploration and testing.

b. In communities?

Where integration of community primary and specialty care can improve efficiency, reduce duplication of services and streamline coordination of care (medical home), communities should be supported in reaching consensus in EMR selection and adoption, provided minimum interoperability is preserved (CCHIT)

c. By specialty?

Whenever possible, solutions that support a broad array of primary and specialty physicians utilizing an integrated EMR should be the goal. When technological barriers of a primary-care friendly foundational EMR do not support the efficient use for subspecialty care, like oncology, RHIO-style sharing of information across interfaces must be supported.

d. By practice size?

Larger practices by virtue of size and volume are more likely to be able to support EMR start-up and training costs and maintain productivity as an EMR is rolled out in stages across the group.

e. Other?

There needs to be enhanced technical support for hospitals, especially Critical Access Hospitals, to help them in turn provide IT support to small and rural practices.

5. What evaluation criteria should HIIAB and HCA use in assessing recommended actions for accelerating EMR adoption? (e.g., Practicality, Effectiveness, and/or Cost)

All factors are important.

6. What role could/would you and/or your organization/constituents play in helping to accelerate EMR adoption?

7. What other ideas or suggestions about EMR adoption would you like to share?