From the Editor's Desk: Legislating Change

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Seismic changes in medical practice typically have come from discovery (such as DNA or penicillin) or new innovation (for example, new imaging devices such as MRI scanners), but rarely as the result of legislation. However, the American Reinvestment and Renew Act (ARRA), passed by Congress in February 2009, may do just that. The ARRA, which allocates $19 billion specifically to incentivize the use of electronic health records (EHR), is poised to dramatically change medical practice in the US. This money would be paid directly to physician's practices, with early non-hospital-based adopters of EHRs receiving up to $63,000 per physician ($42,500 for pediatricians) over 6 years through add-ons to Medicare payments.

The majority of US physicians still practice in solo, small (2–10) or medium (11–50) size group practices. Currently, these physicians face serious financial obstacles to implementing even limited (non-enterprise) EHRs. Behavioral change can be fueled by financial incentives/disincentives that are over 10–20% of base salary, when the downsides of the change are just moderately onerous. Under ARRA, the adoption incentive is quite high, while the non-adoption disincentive is quite low (1–5% Medicare cuts starting 2015), especially for mid-sized group practices. While non-adopters would eventually be penalized, the incentive's magnitude is probably sufficient to entice smaller practices to re-consider the costs and workflow changes necessary for EHR adoption.

In this issue of JGIM, O'Malley and colleagues report on the results of 60 telephone interviews with small and medium group practice US physicians, highlighting six sentinel issues around EHR-related care coordination and provision. O'Malley demonstrates a need for additional integration of decision-support and inter-office communication into existing platforms. Additionally, her group identifies specific payment reforms that could help drive better communication between physicians (paying for intergroup care coordination, not just direct patient care), to further improve patient care.

What will EHR adoption mean for the average patient? As is so often the case in health care, the answer is, "it all depends." If the promise of seamless medical data capture and transmission is realized, with simultaneous creation of patient portals for open healthcare access, the seismic transformation of medicine would be underway. In this idyllic health care environment, informed and activated patients would partner with health care providers longitudinally to improve their health. Patients and physicians would have access to decision-support tools tied to emerging evidence. Patients would be able to access health information easily, regardless of where in the country (or for that matter, in the world)they were located. Variability in the quality of care would diminish, with easier tracking of quality improvement program outcomes. Test duplication would be reduced. Encryption technologies used for banking would safeguard patient data. Patients, armed with new data and enhanced motivation, would modify their health behaviors, and be accountable for their own health decisions.

How "blue sky" is this vision? O'Malley and colleagues point out that physicians identify a number of barriers to EHR adoption. Without additional governmental regulations to create interoperability, perhaps via health information exchanges or hubs, financial disincentives exist for health care companies to share data amongst themselves. While industry consolidation (currently occurring with enterprise level EHRs) is inevitable, the proliferation of small to mid-sized EHR companies will likely continue for the next 5–10 years. Patient EHR portals using cloud computing systems would need to be secured and customized, drawing from multiple information sources simultaneously. Although HIPAA provides some regulatory protection of individuals, EHR-enabled patients would need to decide with whom and what health data to share—with serious implications for insurability and employment. And, disparities between those who have, and don't have, access to these technologies could increase health disparities. Safeguarding every patient, for every encounter, will be an enormous task across all socio-economic levels.

Technological paradigm shifts, coupled with careful research, implementation and sufficient incentives will likely move American medicine forward in the next decade. While not as dramatic as new discoveries or innovations, well-reasoned health care legislation promises to move the dial in the direction of improved processes and outcomes in health care. Incentives to increase the adoption of new health information technology may be the right prescription for the times.

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