

Observing Healthcare

The Four Cs of Physician EMR Adoption

By Richard L. Reece, M.D., for HealthLeaders News, May 19, 2004

Mark Leavitt, M.D., Ph.D., is medical director and ambulatory care director for the Healthcare Information and Management Systems Society. In previous careers, he has been an electrical engineer, a practicing internist, founder of MedicaLogic, and a member of the senior management team of GE Medical Systems Information Technologies.

Leavitt spoke with HealthLeaders member Richard L. Reece, M.D.

Reece: You've given two reasons why physicians' offices adopt EMRs slowly:

1. Doctors are so busy they avoid IT systems that slow them down.
2. While EMRs may be economically valuable for hospitals, HMOs, and health plans, physicians are reluctant, indeed often unable, to capitalize this EMR effort for the benefit of other health care players. Why is that?

Leavitt: Suppose every physician used EMRs, records could be transferred, and automatic guidelines were used to prevent errors and promote safety. That would be great, right?

But what does computerization do for the physician pocketbook? Nothing. They're not paid for quality; or for reducing errors, or enhancing safety. They're paid for volume - numbers of procedures and office visits, be they of high or low quality. There's no incentive to do the right thing. The main EMR benefits flow to health plans, to patients, to those who study healthcare, and to those who want digital data on what really happened in the doctor's office.

So EMR enthusiasts are saying to the doctors: be our keypunch clerk, but we will not pay you. That's a non-starter for physicians, who are struggling to survive and to pay malpractice premiums.

Reece: Is there any tangible return on investment for physicians?

Leavitt: One point of view is that ROI is not good enough yet. But even a solo physician who dictates gets a payback in three years. Dictating runs about \$10,000 to \$15,000 a year. An EMR may allow you to eliminate transcription, and then it pays for itself quite nicely. And it will pay for itself even quicker if you're in a big office. We had one 150 person- group with 50 medical record specialists. With the EMR, they found they didn't need those 50 people.

Reece: But part of the larger problem is that 60 percent of doctors are in groups of six or less.

Leavitt: That's not going away. In the mid and late 1990s, groups acquired by hospitals and practice management companies didn't work very well. Now the numbers are going the other direction, with doctors who are spun off are going back into smaller groups or going solo.

Reece: So how do you break the problem loose? How do you bring EMRs to a fragmented physician market?

Leavitt: You need to understand the four C's: Costs, Culture, Connectivity, and Community.

- We have to lower systems' cost. Intel, Dell, and other players are driving down costs and driving up hardware performance, so you can now buy incredibly powerful computers cheap with more storage than a physician could ever need. It's wireless, so you can have a network of computers. Software costs remain an issue.

- By culture, I mean the physician mindset. I'm not one who believes physicians are technophobes. Go to most physicians' homes, and you will find high-tech audio systems. Their cars are laden with high tech gadgets. And they use high tech equipment in their offices. Another cultural obstacle is physician obsession with spending all of their time with patients. Doctors never step back and ask how they can make their practices more efficient?
- For these EMRs to work, physicians need connectivity. Physicians need to recognize that they don't work in a vacuum. You can't have a successful EMR that doesn't draw in information from other physicians and other care settings and doesn't send it back out electronically. Unfortunately, connectivity is not within the physician's control. You can pay all you want for an EMR, but without cooperation it isn't going to bring in lab tests from the hospital or send admitting information to the hospital.
- Finally, by community, I mean doctors have to stop trying to solve problems one at a time by themselves. They have to start to act in concert. A good example is the American Academy of Family Physicians. The AAFP is telling their 95,000 members we will help you act with one voice, drive down the price, and add standards.

Reece: Are doctors teaching other doctors a key to expanding the ambulatory IT market?

Leavitt: Yes, we have to take the one of 10 doctors who understands this, is passionate about it, can articulate it, and give them free time to go and make grand rounds, go to the county medical society, go to HIMSS meetings, and to spread the word in the doctors' dining rooms. Doctors have to tell the story and hold the hands of doctors who don't quite get it.

Reece: There's a buzz in Washington circles and in national healthcare associations about creating a national health information infrastructure. Why now?

Leavitt: I call it the "dot.gov boom." There's now a national dialogue. When the President said in his State of the Union address that we need computerized medical records, I fell to my knees and said: "Thank you! Thank you! It sends the message that this is going to happen."

The downside, though, is confusion. Everybody is now on the IT bandwagon. Every politician has an IT initiative. It's just like the "dot.com" times. There're a few good ideas, and many bad ideas. This gold rush mentality may generate destructive competition. Market competition creates the best product. But destructive competition between two government agencies doesn't help. We have to strike the right balance between regulation and free market

Reece: What about this talk of creating a national health information act as a model and providing rotating government loans to doctors?

Leavitt: It's a start. But if loans were the answer, why wouldn't doctors just go to a leasing company and lease an EMR? When government money is involved, you add complexity. Doctors don't have time to jump through bureaucratic hoops. I'm not sure government loans will break it loose. What will break it loose is coupling reimbursement with using an EMR.

Reece: So clear financial incentives will move the EMR market?

Leavitt: Yes, and it doesn't have to be major. All you need is something clear, consistent and reliable.. Say you're paid \$35 for a limited office visit. Say starting in six months, we will pay \$38 if you use an EMR and submit an electronic claim with an attached EMR record, but only \$33 if it's paper. You create a differential. It's revenue neutral, and it's not a big handout to doctors. Doctors will soon see they can make \$10,000 more a year using an EMR.

Reece: How many doctors use EMRs? I've seen estimates from 5 percent for complete EMRs to 40 percent for partial EMRs.

Leavitt: The difference boils down to a matter of definition. A 2003 HIMSS study defines a "full" EMR as something that stores a patient's entire record, structures the data, allows you to find patients with a given condition, gives decision support and detects drug interaction. Only 5 percent of physicians of 450,000 practicing physicians have such an EMR. Around 22 percent have a partial EMR. Their records aren't fully structured. You might just be dictating notes and capturing and saving them. I have never heard the 40

percent figure, but if you separate EMR use into large and small offices, in the large offices you will get numbers that exceed 40 percent.

Reece: Is there a "digital divide" among older and younger physicians?

Leavitt: There is a digital divide among physicians. "Older" and "younger" isn't the best way to characterize it. Surprisingly, physicians nearing retirement are often more open to this transformation. The ones having the most trouble are those in mid-career because they are the busiest at work and home. The question is not your age but are you flexible enough? Are you willing to embrace this change? It's the flexible against the inflexible.

Reece: So physicians aren't complete computer illiterates?

Leavitt: The problem is despair, not technophobia. These mid-career physicians suffer from diminished expectations. Managed care decreased their power and increased their hassles. Administrative details bury them. Now we come at them and say, "Now you're going to use the computer, whether you choose to or not." Many of them simply can't stand one more thing.

But there are ways of working with doctors who can't stand any more change and refuse to work with the EMR. Let them keep dictating, get their transcription into the medical record, don't make them enter their orders. But gradually let them see the economic consequences of their resistance to change. Let them pay for the extra dictation, let them pay for the extra staff, and then let them make their own decisions.

Mark Leavitt, M.D., Ph. D., is medical director and ambulatory care director for the Healthcare Information and Management Systems Society. He may be reached at MLeavitt@himss.org

Richard L. Reece, M.D., is a pathologist, writer and editor. He is the author of *A Managed Care Memoir: A Physician's Whistle-Stop Journey*. He also serves as editor of *Physician Practice Options* and *The Quality Indicator*, two nationally distributed newsletters for physicians. He lives in Old Saybrook, Conn., with his wife, Loretta, and Paris, a French bulldog of impeccable heritage. He may be reached at **860-395-1501** or reece1500@aol.com

10 Opinions

The Four Cs of Physician EMR Adoption by don on May 19, 2004 at 9:07AM

Yes, that's what we need to do.....pay more to our docs. Well it is time that someone looked at the average pt and said "We need to do something to help them". For example; pt X come in to see her doc. she is 72 years old has DM11,cardiac problems,PVD,HTN,gastritis and now her renals are failing. she pays a \$30. copay to see her doc. receives 5 scripts that total well over \$500.00 and is on a fixed income. she belongs to an HMO which helps/hinders her. the doc increases her blood sugar checks to 4 times a day from 2 times a day because her glucose is fluctuating. now 1/4 of the way through the month she is out of gluco-stix. she calls the HMO and is denied an increase in her allowance of gluco-stix. so now she cannot check her glucose at all. also she is out of money for the month, has little food, lots of meds and all because she was following her doctor's instructions. we do not pay the docs to use paper so why should we pay them to make the switch to EMRs? THIS KIND OF THING CANNOT COME OUT OF THE PT'S POCKET.....AGAIN! instead why do we not lobby to drive down the price of medications, medical devices and of course access to medical help. it is not that i am against EMRs. i am completely for it but the pts cannot afford to have the cost charged to them.....again. this is why we need more PRIORITY CARE programs out there to help these pts. but they cannot continue to foot the evergrowing bill.

[Reply](#)

EMR in doctors' offices. by richard on May 19, 2004 at 9:51AM

I do not know exactly where the writer of this opinion is coming from. The interview did not suggest patients be charged for EMR use. It did suggest doctors who use EMRs be paid a fraction more and those who don't use it be paid a fraction less. We are all for charging patients less when increased efficiencies are achieved. Taking the 30% administration fees charged by health plans out of the loop in a consumer-riven environment might also help relieve the costs burdens on patients.

Richard L. Reece, MD

[Reply](#)

The fifth "C" by donald on May 19, 2004 at 10:08AM

Do not forget the consumers strategic role in EMR adoption. I believe EMR adoption is dependant upon the health industry accepting the personal medical record (PMR) premise. As with any technology solution, a clear and measurable benefit must be realized to offset the added expense and manpower effort to launch and provide ongoing maintenance. EMR systems that accept data from PMRs will become immediately more valuable to the healthcare provider decision process because the longitudinal health status information contained within the PRM will add context to the current acute care situation. Moreover, EMRs that integrate with PMRs encourage consumers to become 'off-site' data entry sources for the health industry, yielding more comprehensible information, and at lower administrative costs. The banking industry learned this work-flow lesson and realized the benefits during the '80s.

To be clear, PMRs answer the consumer's need for a provider independent, longitudinal health management solution, encompassing a family-centric philosophy, that streamlines administrative and information sharing with the health industry and healthcare providers. And most importantly, PMRs ensure patient privacy since only the patient may authorize third-parties access to their information.

Don Hackett CEO myDNA Media, Inc.

[Reply](#)

The Four Cs of Physician EMR Adoption by don on May 19, 2004 at 10:22AM

The point is that the cost is to often passed on to the pt.

[Reply](#)

EMR and PMR by richard on May 19, 2004 at 4:36PM

I agree. The EMR and PMR go together. That's optimal. No one disputes that the two are inseparable. Doctor Leavitt has done a lot of work on the PMR component. A continuous patient record available to all clinicians will be indispensable to avoid confusion, duplication, and continuous care.

Richard L. Reece, MND

[Reply](#)

The complexity of physician EMR "adoption" by Francine on May 19, 2004 at 12:31PM

Thank you for articulating what is often glossed over in discussions regarding physician's use of EMR and other healthcare technology: it's not about technophobia, but about deeper issues related to the physician's core values and his/her ability to satisfy a hierarchy of personal and professional needs.

Every physician would like to offer their patient the best, most efficient, safe, coordinated care---AND the reality is that every physician has constraints (time, money, energy)which limit how much he/she can personally give to that cause.

This is a catch-22, until technology investment delivers a real ROI to the individual doc, or the investment is shared by other stakeholders.

Francine Gaillour, MD, FACPE The Gaillour Group francine@gaillogroup.com

[Reply](#)

Four 'C's of Physician EMR Adoption by Steve on May 20, 2004 at 12:06PM

Thank you for this article, well done. Particularly enjoyed your comments about compensation incentives.

[Reply](#)

Aligning Incentives by Elizabeth on May 21, 2004 at 7:25AM

It's all about aligning incentives. If the payors and others reap the benefits in terms of lower transactional fees and increase access to data, why can't that savings be passed along to the physicians? This would help to offset the cost for IT and encourage physicians to opt in.

What I would find interesting, is to know if the healthcare IT companies and others have approached the payors to work out a new reimbursement model. Has this happened?

[Reply](#)

EMR by Sid on May 24, 2004 at 8:56PM

Dr. Leavitt: Your response is the best description of the current situation that I have read. I am a 53 y.o. Internist and the manager of an 18 provider group. In the early 80's I took on computers as a challenge. I taught myself programming in BASIC on a TI-994A. I have owned everything from a Commodore 64 to a Dell 1.3Gh system. I built and sold PC compatible systems from 1984 until 1992. Despite my IT knowledge, I cannot recommend an EMR to our group. You outlined the reasons well. If in the early 90's, the HMOs had given us incentives to use EMR, develop disease management plans, and look for way to add value to the system, then we could have afforded to all this. Instead they opted to cut our reimbursement so that there was no way for us to afford these things. Now I see disease management companies receiving more money PMPM than the PCPs do. And, the information does not flow well from the DM company to the PCP and vice versa. We are currently working with American Heathway's and a local HMO to align the incentives, and improve information exchange. Physician groups need to become more proactive. Challenge the payors to pay them for health maintenance and DM; then measure the outcomes. I believe that Physicians, with the help of services that understand HM and DM, can do a better job than the HMO's and DM companies alone. Sid King MD Sumner Medical Group Gallatin Tennessee

[Reply](#)

Incentive for EMR's by wayne on May 25, 2004 at 10:39AM

If EMRs made sense for physicians then financial incentives wouldnt be necessary. What happens if/when the incentives are removed?

Look at PDAs and software such as ePocrates. They have caught on like wildfire with physicians and no one had to provide incentives for this to happen. They make sense because they are a natural fit with the work physicians do (e.g., providing rapid, mobile access to prescribing information at the point of care). They are natural fit without disturbing the equilibrium of the clinical health care work flow, and probably improve quality and cost efficiency. If EMRs havent similiary caught on on their own merits, then there is a reason (or a whole host of reasons), and providing an artificial incentive in the form of a few dollars isnt going to make those problesm go away.

[Reply](#)

© 2004, [HealthLeaders, Inc.](#)