

Does Health Care Have an Electronic Future?

by William J. Holstein

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The Obama administration's focus on digital patient records to minimize medical errors and improve efficiency has promise, but will face significant obstacles.

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The Obama administration's decision to spend an unprecedented US\$19 billion over the next seven years to encourage the use of electronic medical records is triggering a scramble among government officials and health-care industry chiefs to define how such a system will work.

Hundreds of vendors, from small consulting firms to large systems integrators, from makers of software to all manner of hardware, are jockeying to take advantage of the new funding. Doctors, hospitals, and the dozens of entrenched subprofessions and interest groups are locking horns over which standards will prevail. It's generally felt by health-care experts that President Obama's goal of nearly universal use of electronic records is possible, but it could take several years — with some stutter steps in between — before it becomes clear what form electronic files will take and which companies will profit.

The U.S. health system is fragmented among hospitals, doctors, nurses, testing laboratories, and drug wholesalers and retailers. By and large, this eclectic roster depends on paper to collect, communicate, and share its most valuable information — patient files and prescriptions. A mere 17 percent of doctors have even basic electronic systems for patient records, and only 10 percent of hospitals do, according to David

Blumenthal, the Harvard Medical School professor who has been named Department of Health and Human Services (HHS) national coordinator for health information technology.

Obama supports electronic records primarily because he believes computerized health-care networks would drive down the cost of health care and improve its overall quality. With such a system, doctors could be instantly alerted to possible dangerous interactions between different drugs, the spread of illnesses, and breakthrough treatments for persistent conditions. Money-saving efficiencies could be introduced as hospitals, physicians, and insurers avoid the need to reenter patient information numerous times, which often introduces mistakes, and medical mishaps based on illegible files would be minimized. And e-prescriptions would prevent doctors' handwritten notes from being misread by pharmacists.

To jump-start the e-records effort, Blumenthal is expected to collaborate with Chicago-based Certification Commission for Health Information Technology (CCHIT), a five-year-old nonprofit that has been working with vendors to establish standards that will let different participants in the health-care profession exchange patient information. Although the CCHIT received a small grant from the federal

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government initially, it is mostly backed by the private sector and is credited with being a fair arbiter both in setting standards and in certifying hardware and software that meets those standards. “When the cardiovascular group says, ‘We want to send a summary about a patient,’ we won’t let that be incompatible with the format that is used by other specialists in other settings,” says Mark Leavitt, CCHIT chairman and a former internist who built an electronic records firm that was acquired by General Electric Company. “Because we’re certifying all the different systems, we’re making sure that they are compatible.”

Already, the CCHIT has certified electronic record systems used by physicians, hospital emergency departments, and children’s health and cardiovascular departments that comply with prevailing standards. This year, the group is tackling standards that will be used in e-prescribing, long-term care, and seven other subspecialties.

Doctor practices and hospitals that make “meaningful” use of certified systems for electronic patient records will be rewarded with additional Medicare or Medicaid funds; those that don’t do so by 2015 will start losing federal money. The push toward electronic records should accelerate after Blumenthal and the HHS define what meaningful use is, which is expected in just a few months.

The electronics records market is divided into two main sectors: hospitals, also called acute care, and doctors, or ambulatory care. It’s generally believed that hospitals will be more receptive than doctors to going fully electronic over the next few years, particularly those in small one- or two-physician offices with limited budgets. Nonetheless, with about 10 companies seeking to sell e-systems to hospitals and more than

400 vendors hoping to tap the physician market, activity in the electronic records market should be robust for the foreseeable future. “You’ve dumped a lot of federal money into the picture,” says Sarah Corley, chief medical officer at NextGen Healthcare Information Systems, which makes electronic patient records programs for physicians. “A lot of players want to get their hands on that money.”

The largest e-records companies by market share are conglomerates like General Electric and Siemens. Among the second tier of smaller companies specializing in health records, Cerner Corporation, Eclipsys Practice Solutions, NextGen Healthcare Information Systems, and Epic Systems Corporation stand out. In general, companies focus on either the hospital or doctor segment but GE Healthcare is an exception, competing in both markets and building its business by acquiring smaller, specialized companies.

Smaller vendors like NextGen argue that because they deal solely with medical practices, their products are tailored more to doctors’ needs. GE and other large firms counter that they sell everything from hardware to software and equipment like x-rays, MRIs, and other scans, so they can better integrate electronic patient record systems into the broader medical setting — which is critical to achieving streamlined, less-expensive medical care. But if doctors and hospitals are served by different vendors, questions arise about how the two groups will eventually share information. Resolving that dilemma tends to play to the strengths of the big providers because they can more easily knit together all the elements of the disparate networks. GE is selling one product, for example, called a “health information exchange,” that should allow a hospital in

California to instantly access the medical records of a visiting New Yorker.

The ultimate goal is to make all the systems interoperable, like a bank card that can be used at the ATMs of different underlying networks at different banks. But health-care files — packed with information on any number of procedures, treatments, prescriptions, and tests written in any number of ways — are far more complex than relatively straightforward bank account records. “Look at the transactions that are available on an ATM,” says NextGen’s Corley. “You can deposit money, you can withdraw money, or you can check your balance. Those are simple. But in health care, if the system is not using standardized codes for saying your big toe itches, we can’t easily share that information.”

CCHIT’s Leavitt agrees that there are still significant obstacles. “The work of making sure the systems are interoperable is just on first base,” he notes. But, he adds, “we could see substantial movement in five years; we could even be halfway to the ultimate destination by then because the incentives are powerful.” +

Resources

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