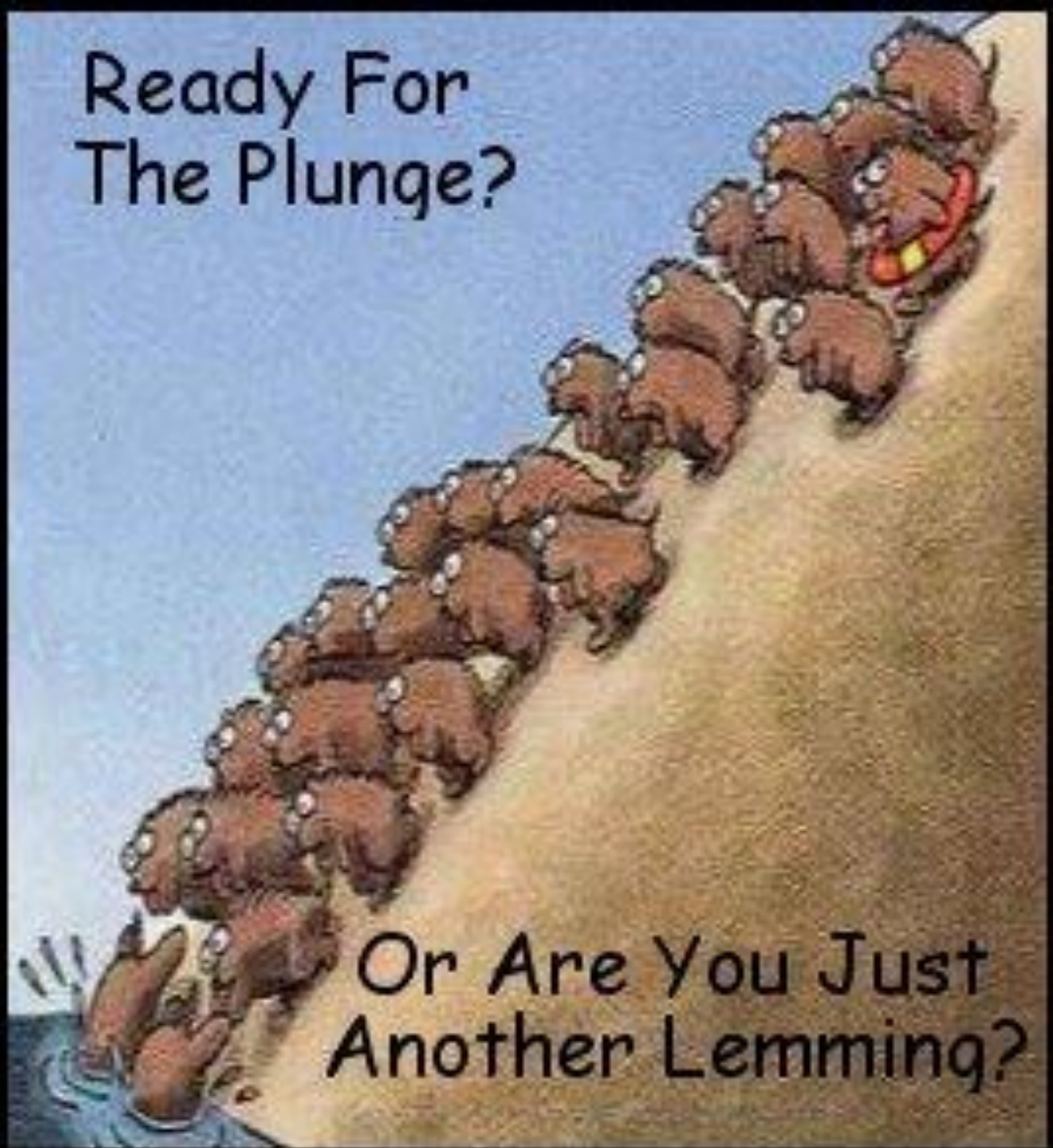


# Provider Conundrum— Barriers to Meaningful Use

Alan S. Kaplan MD

VP/System Chief Medical Officer, Iowa Health System  
President/CEO, Iowa Health Physicians

Ready For  
The Plunge?



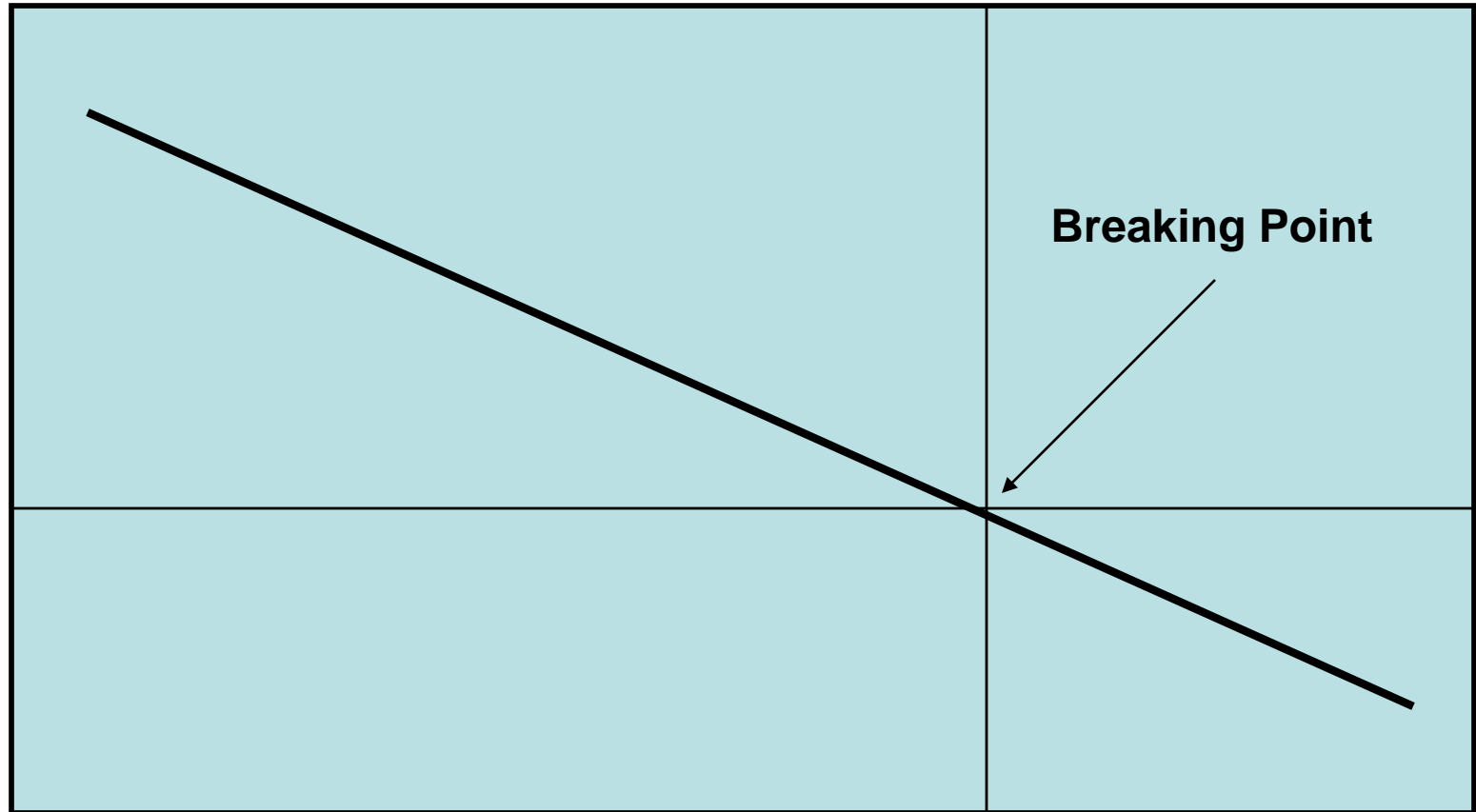
Or Are You Just  
Another Lemming?



CRAIG SWANSON © WWW.PERSPICUITY.COM

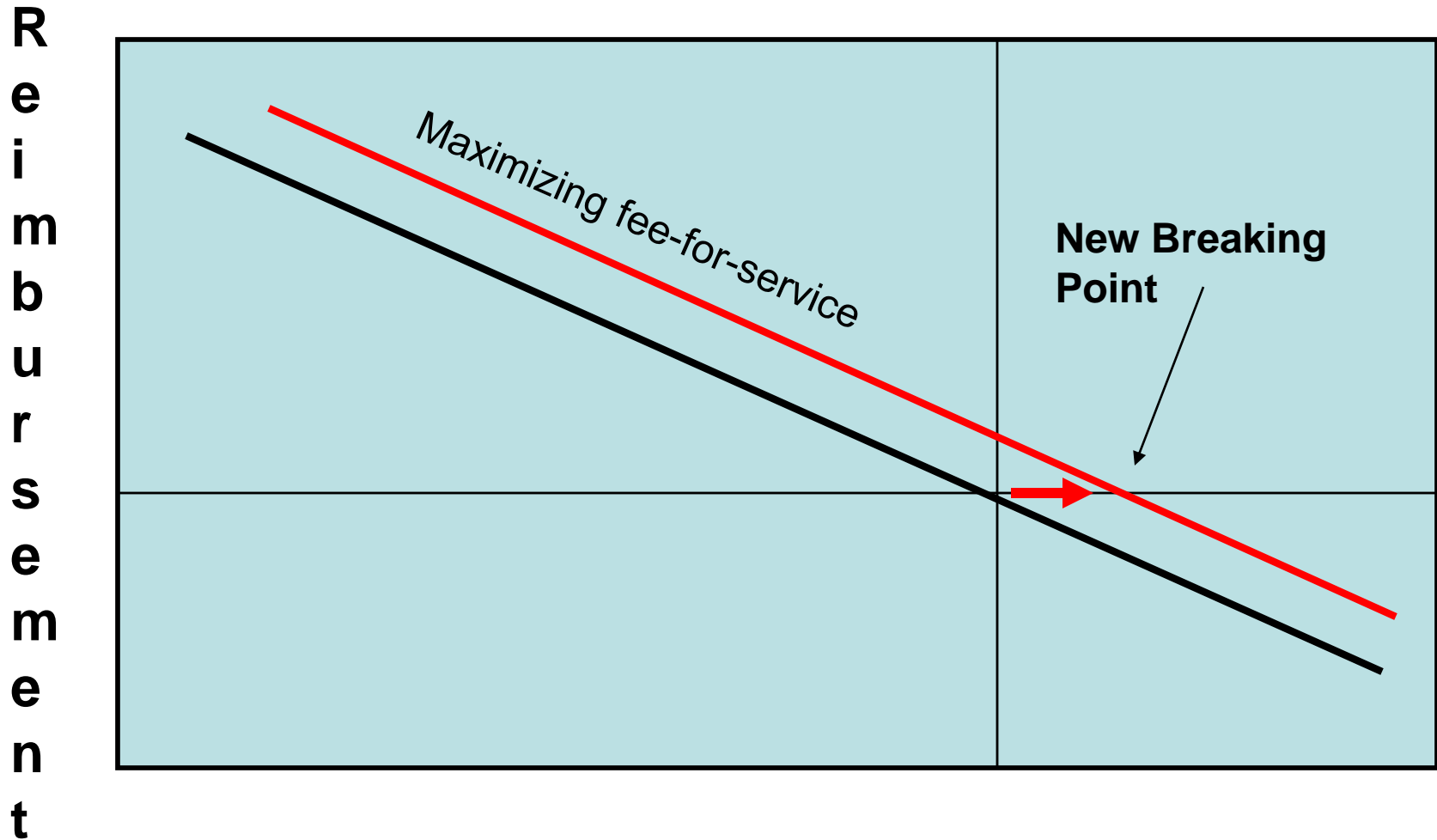
# Fee-for-Service Problem

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**Episodes of Care**

# Specialists Defying the Inevitable

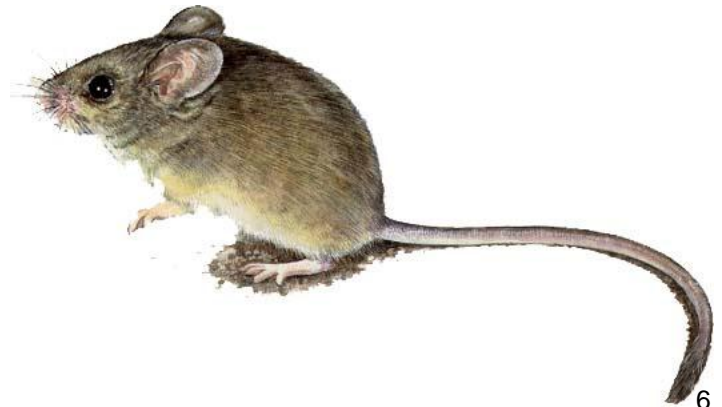


**Episodes of Care**

# What we want from our affiliated physicians...



- High quality care
- Participation (e.g. committees, initiatives)
- Responsiveness
- Compliance (e.g. regulatory, records)
- EBM & standardization
- Control utilization
- ER coverage
- Learn and use EHR & CPOE



# Healthcare Reform Bills

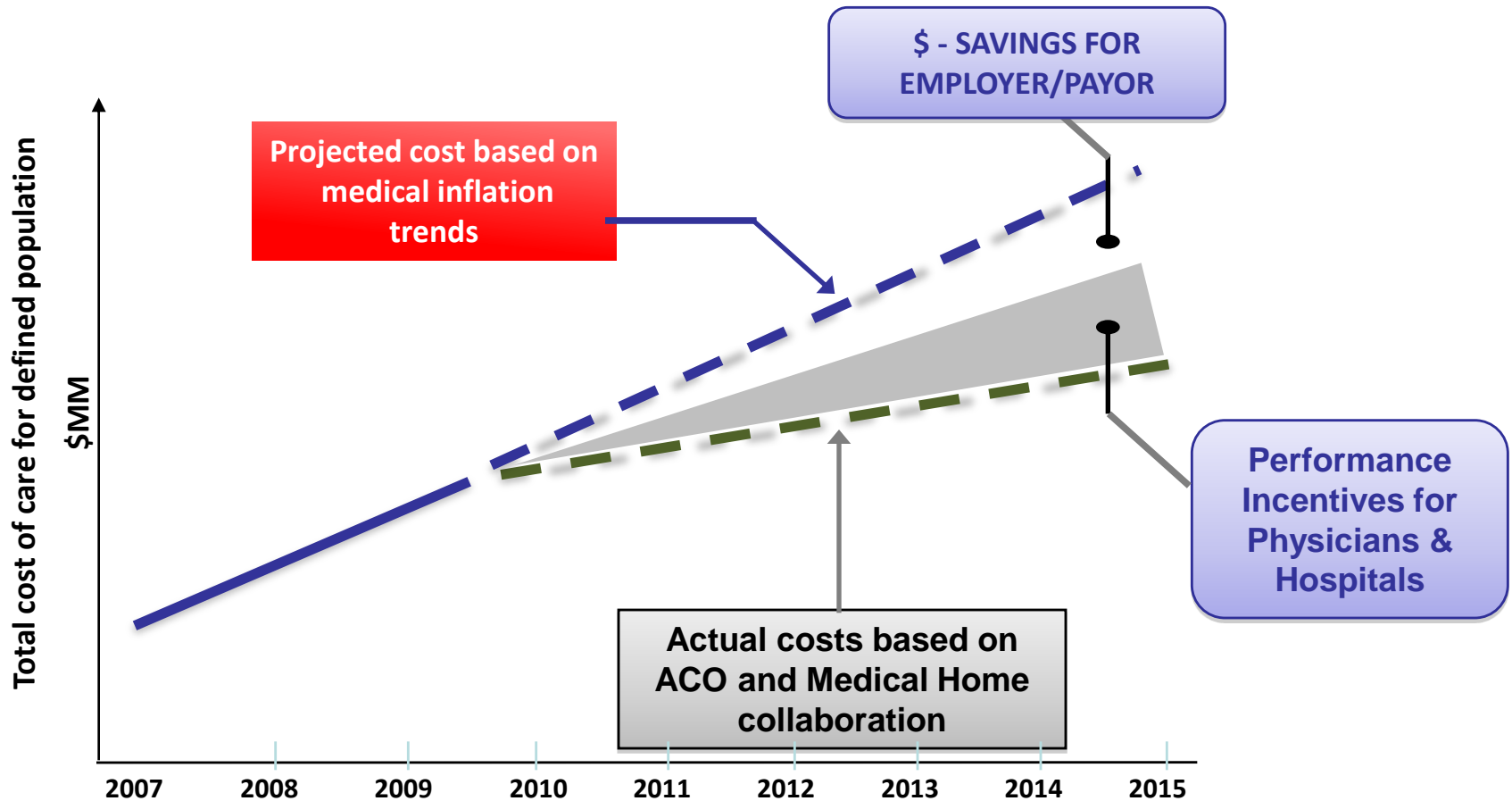
**Insurance reform**

**Not...**

**Payment reform**



# ACO Model: Bend the Cost Curve



# Transitional Approach—5/50 Rule

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**Doing Well**



**Episodic**



**Perpetual**



**5% of Patients  
50% of Cost**



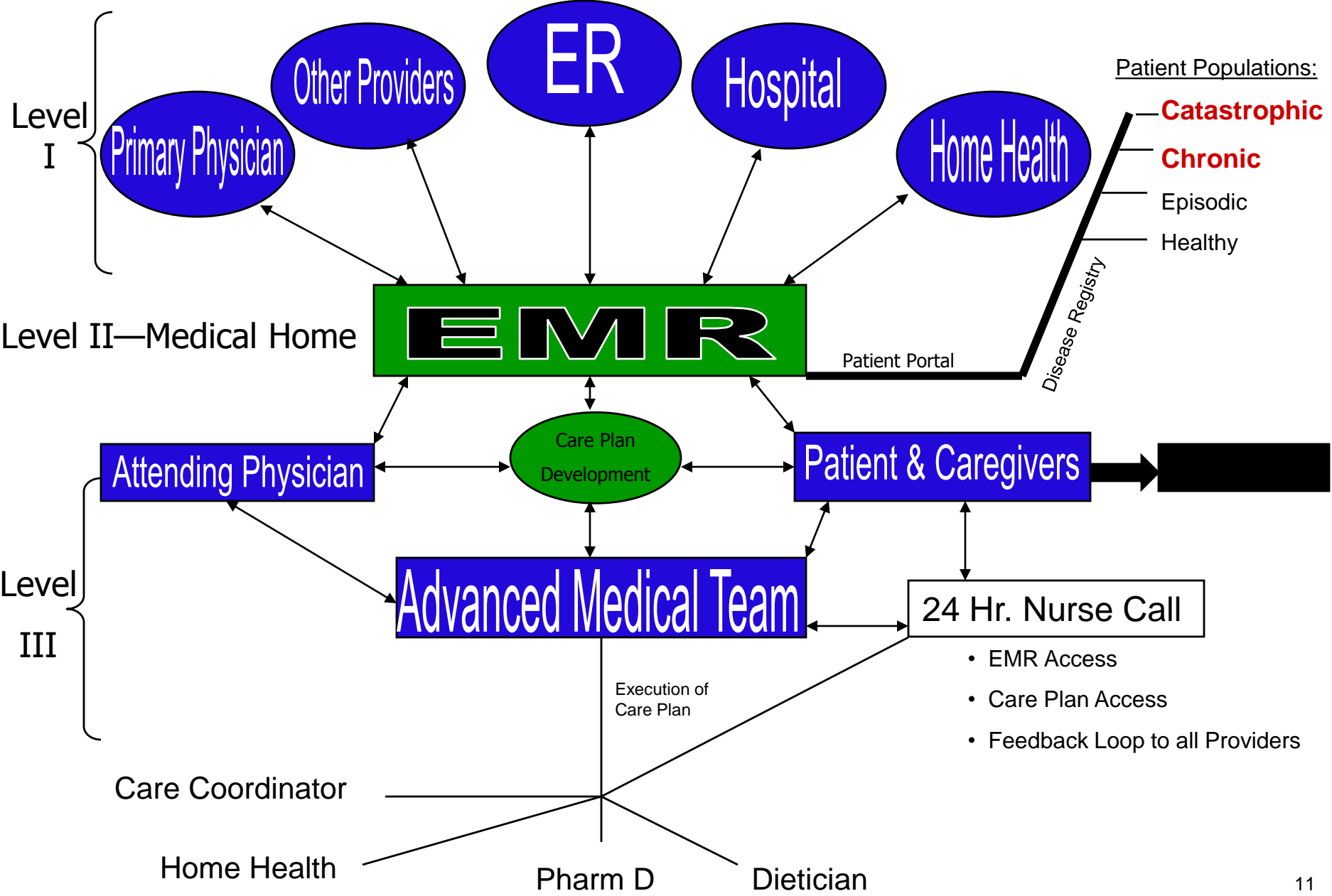
**Critical**

# The Chronic Care Patient

- 67 year old widow
- Diabetes
- Dementia
- Non-healing foot ulcer
- Lives Alone
- No home health
- Long medication list

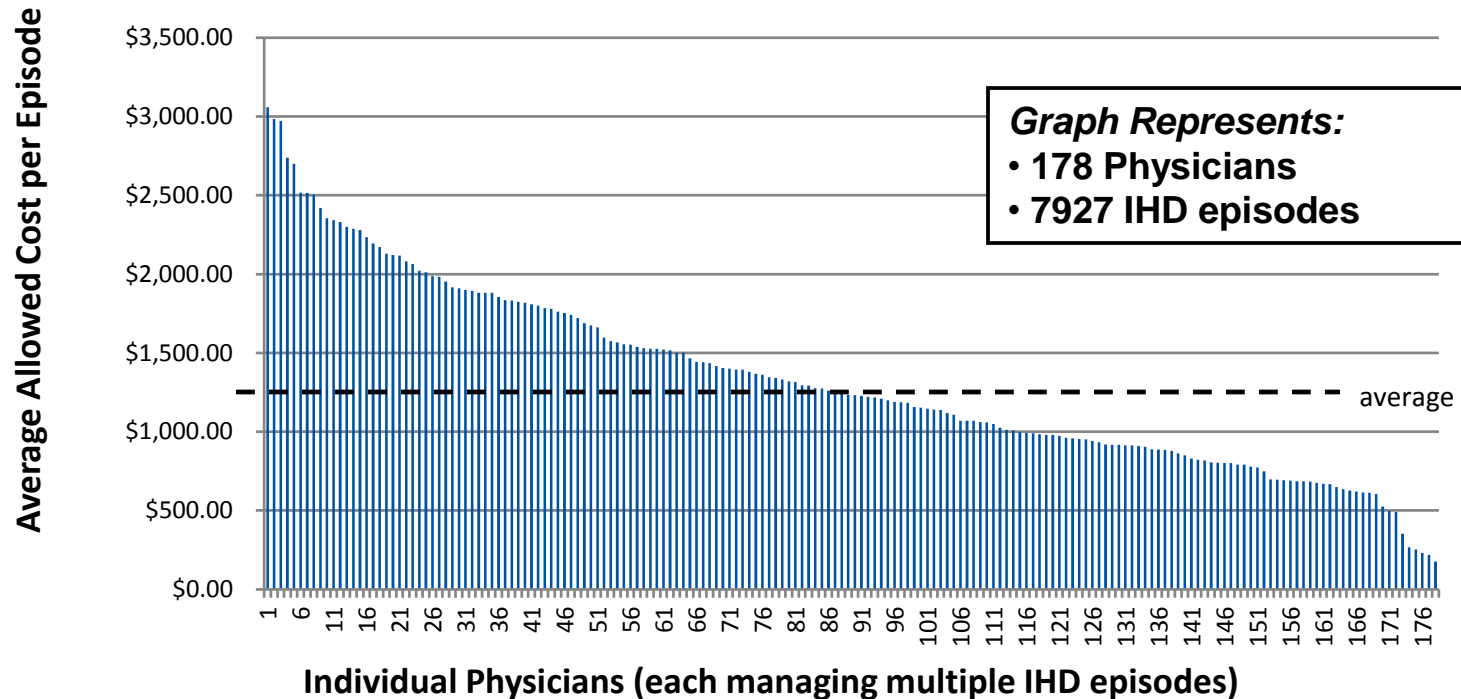
- Multiple providers with little communication
- Poor coordination of foot ulcer care
- ER is default provider
- Multiple hospital admissions

# Coordinated Care Delivery



# Data-Driven and Disease-Specific

## Management of Ischemic Heart Disease (without surgery) – IHD *Distribution of Physician Performance based on Cost Efficiency*

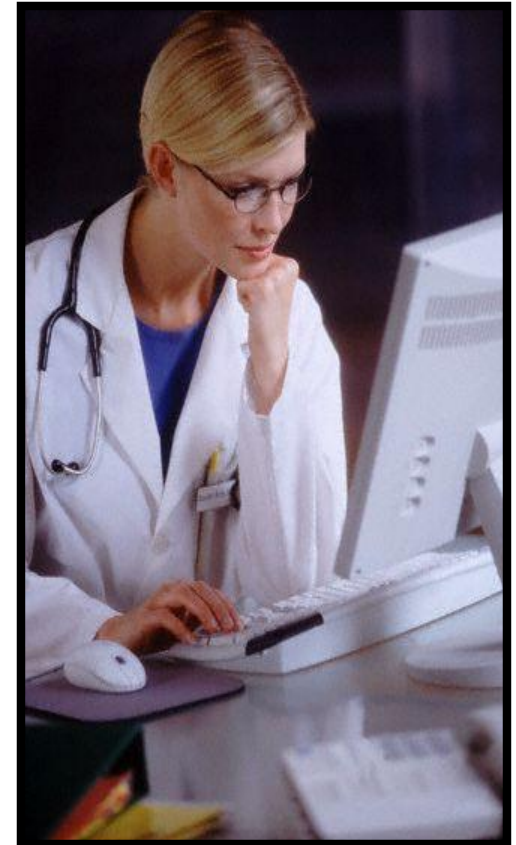


Notes: Claims period 7/1/08-6/30/09 with 90 day claims run-out; episode grouping includes severity adjustment; additional risk-adjustment done by excluding patients with overall health risk  $\geq 2.0$  ; data includes physicians with minimum of 10 IHD episodes per physician; physicians with outlier episodes excluded on both the high and low end based on average cost/episode

# Technology vs. People, Process, & Culture

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- IHS purchased 500 e-Prescribe licenses to be distributed at no cost to providers
- Culture, education, incentives, metrics
- Chicago health system saved \$35M!





# Care Coordination in the Current Fee-for-Service System

**Cost**



**Benefit**

**Cost savings will be forced upon us even if we don't do anything!**

# Fee-for-Service System Deeply Embedded

---

- Major capital and human resource investments
- Data rich—information poor—silos
- Providers still practicing in cottage industry
- Focus on insurance reform; not payment reform
- No meaningful payor-provider partnership

Widespread EMR  
implementation...\$81B  
“potential” savings—maybe  
double if coupled with effective  
prevention and chronic care  
management

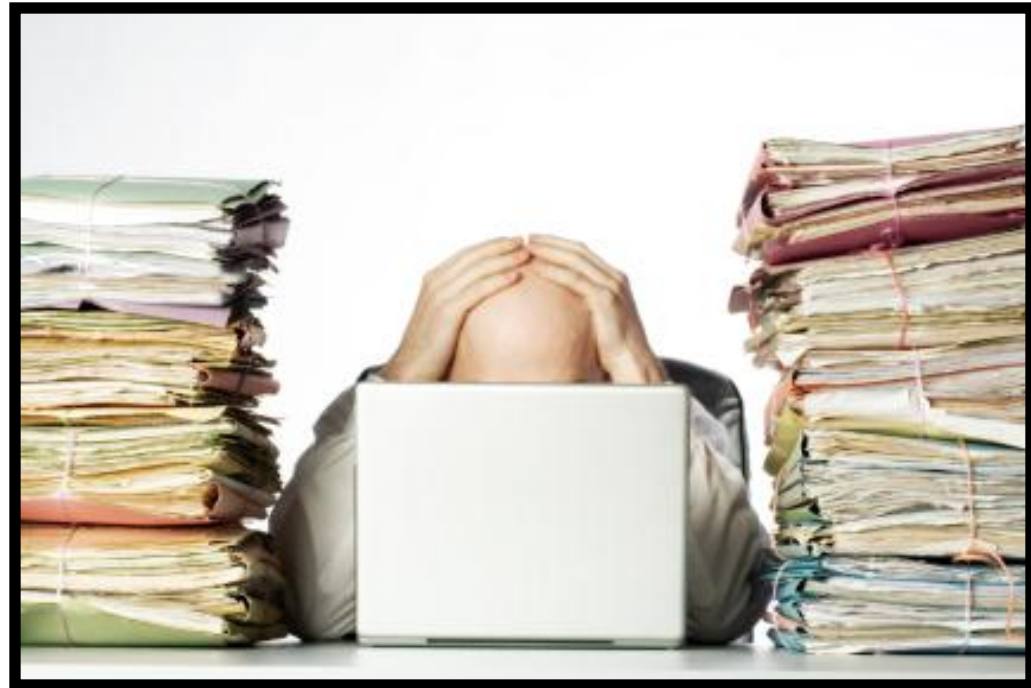
(NEJM, 2008)

# Physician EHR Adoption

- 20% of physician practices have basic EHRs
- < 7% have a fully functional EHR

(CDC, December 2009)

With so much money to be saved why does the government need to spend \$14B - \$27B in EHR incentives?







Does HITECH move the food  
bowl?

# HITECH: Incentives (and Penalties)

<b>PROVIDER: MEDICARE</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017 and beyond</b>	
Payment for Meaningful Use before/in 2011	\$44,000							
First meaningful use by 2012		\$44,000						
First meaningful use by 2013			\$39,000					
First meaningful use by 2014				\$24,000				
If not Meaningful User, Providers face Medicare Reimbursement cuts of:					1%			
						2%		
							3%	3%

# What Practices without EHR say are the major barriers to adoption:

- **66%**      **Capital requirements**
- 54%      Finding EHR to meet needs
- 41%      Concern about productivity loss
- 50%      Uncertainty about ROI
- 29%      Physician resistance
- 44%      Concerns of system obsolescence

(New England Journal of Medicine, 6/18/2008)

# Capital Requirements (66%)

EHR Cost Component	5 Year Per-MD Cost	
Software Capital	\$30,000	Not Bad
Hardware Capital (PCs, Printers, Tablets, etc)	\$25,000	
Office Networking	\$6,000	
Staff/Provider Training	\$10,000	
Go Live Productivity Loss	\$10,000	
Software Maintenance (4 yrs total)	21,000	
HW Maintenance (4 yrs total)	\$10,000	
Ongoing Tech Support	\$6,000	
<b>Total Spend: Capital + 4 Yrs Operating</b>	<b>\$118,000</b>	Bad

## Models Assumptions:

- 4 MD Practice (total # users ~ 20, incl staff and mid-levels)
- “Top Tier” EHR offered, but not subsidized by, a hospital or IDN

# Concern about productivity loss (41%) Uncertainty about ROI (50%)

## Independent Physician

Primary care & Medical Specialists ~50%



## Employed Physician

Many are paid on productivity, but...



Finding EHR to meet needs (54%)  
Physician resistance (29%)

**"Faster"**



***Money***

**"Easier"**



***Lifestyle***

**"Better"**



***Quality***

# Providers' Perspective

## Is “Meaningful Use” a Disincentive?

- American Association of Family Physicians
  - *“Administrative burden” may be a disincentive for some providers from pursuing Meaningful Use and the incentive funds*
- MGMA
  - *The rules will create "significant barriers" for physicians*
  - *Unreasonable thresholds for some criteria:*
    - *CPOE*
    - *Electronic claims submission*
    - *Electronic insurance checking*
    - *Clinical Decision Support*

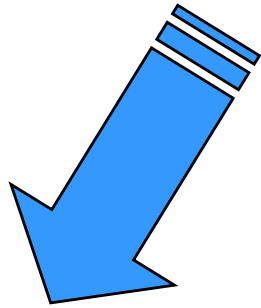
# Concerns of system obsolescence (44%)

Right on!

# Vendor Economics 101



**\$100B +/-**



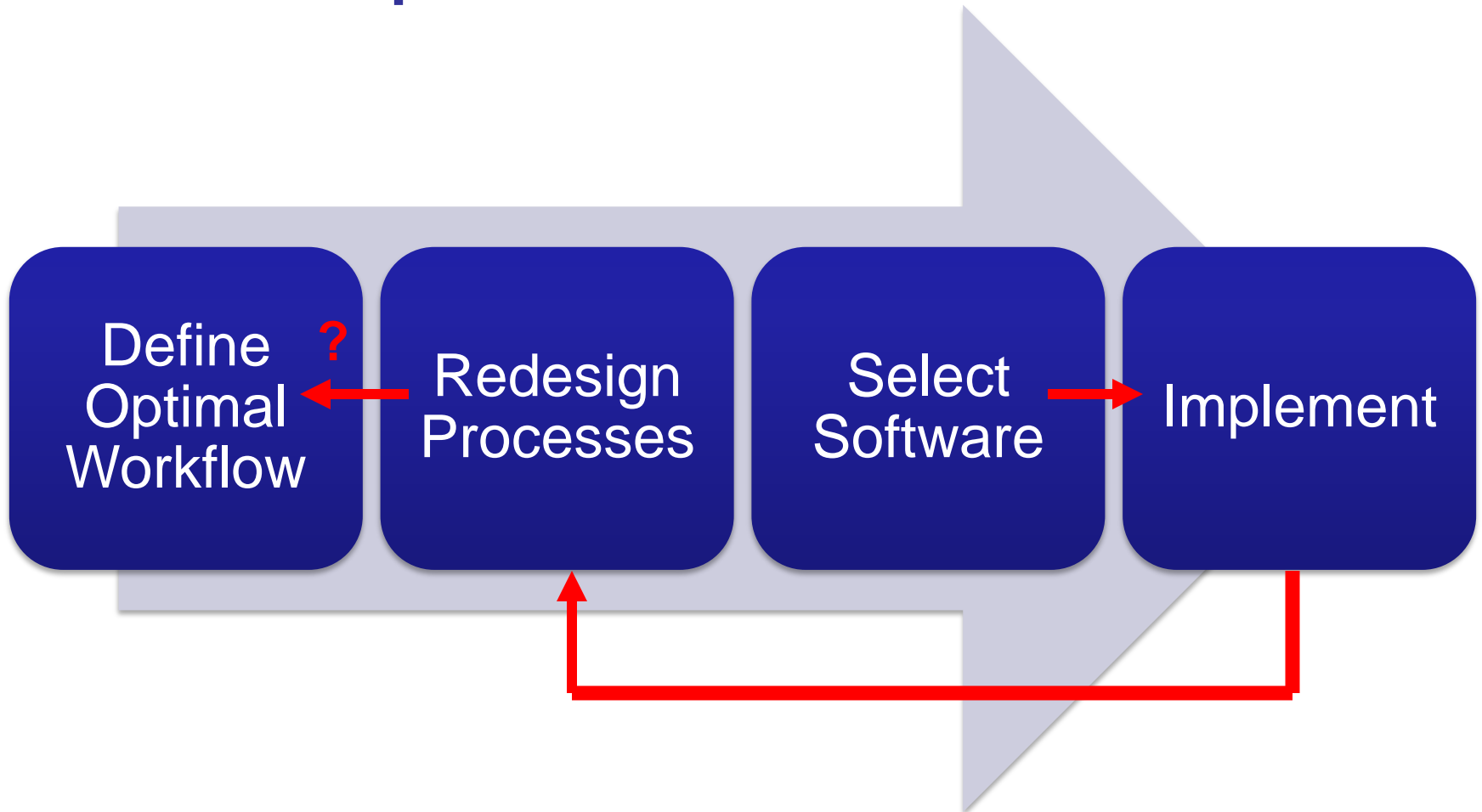
# Economics 101

- Business seeks “wallet share”
  - Design and deliver to required standards not to optimal workflow
- Demand > Supply
  - Deluge of Implementations
  - 😊 \$ 😊 \$ 😊
- Political influence ( the “good guys” )
  - Environment of over promising (quality & savings)
  - Not held accountable to the promise

# Progressive Stages of Meaningful Use

- **Stage 1** (*criteria released YE 2009*)
  - Implement clinical decision support tools and at least 5 CDS rules
  - Using EHR to track conditions and coordinate care
- **Stage 2** (*criteria release eta YE 2011*)
  - Structured data exchange
  - Continuous quality improvement
- **Stage 3** (*criteria release eta YE 2013*)
  - Advanced decision support
  - Population and public health

# IT Implementation Basics

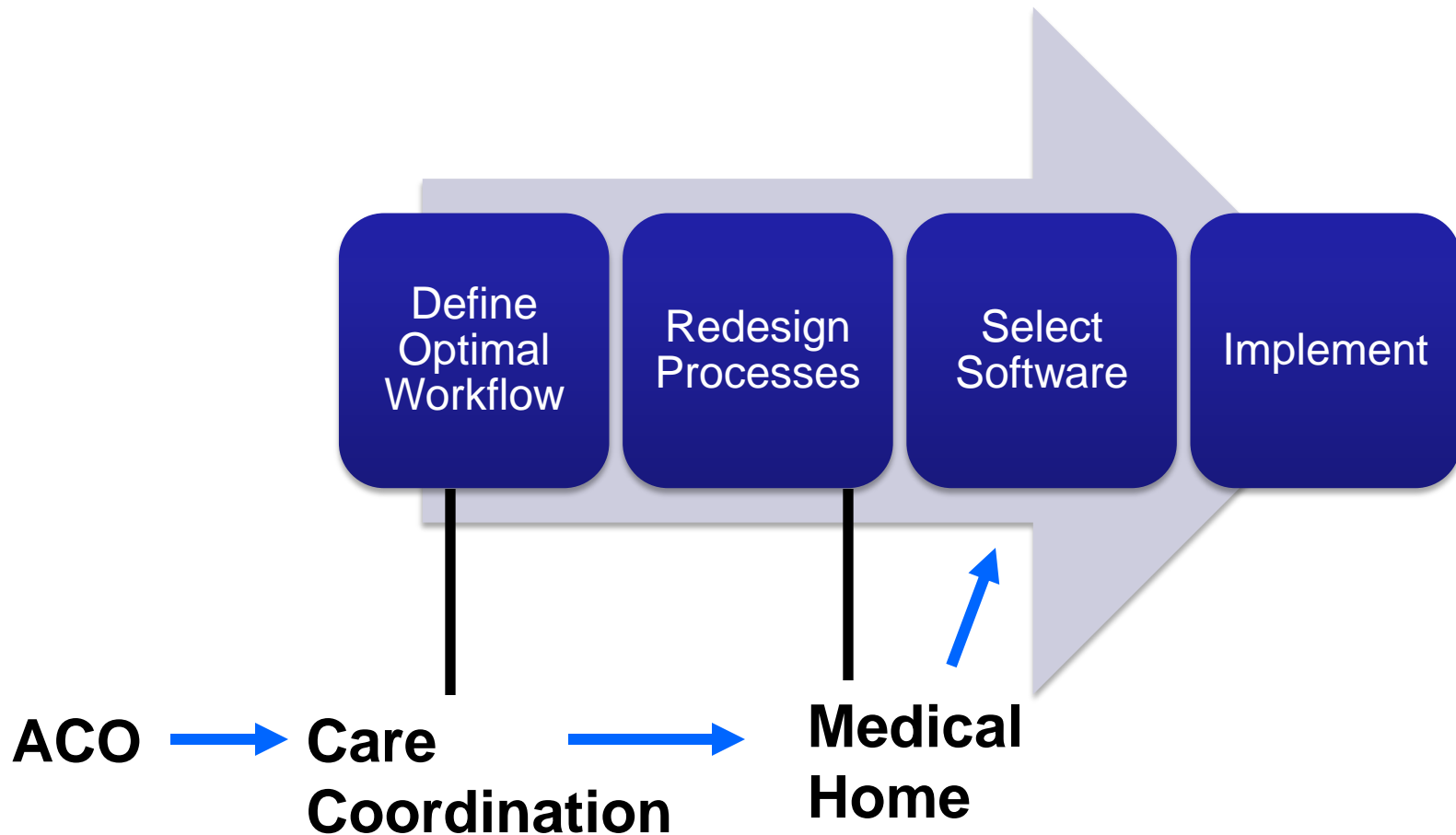


***Are the incentives promoting a “reverse” implementation process?***

# Potential Unintended Consequences

- EHR implementation & ownership costs will increase (i.e. supply & demand)
- Systems will not be used as envisioned
  - Promise of quality and cost saving improvements will not be realized
  - “Meaningful use” EHR features will remain stagnant or potentially “collect dust”
- Reporting requirements will lead to increased bureaucracy and new wave of “fraud and abuse”

# Lost opportunity to fund through savings!



# Likely Benefits

- Accelerate provider EHR adoption rate
- Incent vendors to develop population management tools, improve interoperability, and enhance data reporting capabilities
- Disrupt stagnation of health system
  - Increase focus on information technologies
  - Promote population management concepts and health information exchange

# Maximizing the HITECH Opportunity

Concurrent health system payment reform  
(i.e. ACO concept):

- Drive “meaningful use” adoption
- Fund EHR through savings
- Create economic incentives for EHR vendors to compete on product, service, and price
- Decrease overall national health care spending

