MedStar Health
e-Health Initiative

Overcoming Physician Resistance to the Personal Health Record

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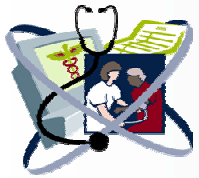

Bio

- Practicing physician
  - General internal medicine since 1981
  - Small practice on Capitol Hill – bought in 1995 by a hospital system
  - Early adopter of (and “missionary zealot” for) EMR, eRx, physician-patient email, etc.
  - Frequent speaker on issues of business case for information management with IT, overcoming MD resistance to tech adoption
- Medical director for eHealth – MedStar Health
  - 7-hospital system in the Baltimore-Washington corridor
  - Role is to discover / “unveil” applications of value to clinicians for their outpatient practices or their connectivity to their hospitals – then build or buy, or build and buy
- Board member of the Foundation for eHI
- Board member of the Maryland-DC Collaborative for HIT
- Co-Chair and ACP representative to the PEHRC
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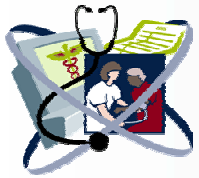
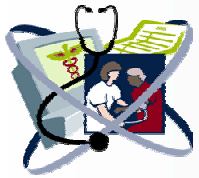


Physicians embrace the PHR!

- “Well of course,” why wouldn’t we do this?”
- “It will not only make things better for patients, it will improve quality of practice life for us…”
- “Duh.”

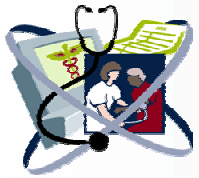


Physicians reject the PHR!

- "Well of course," why wouldn't we do this?"
- "It will not only make things better for patients, it will improve quality of practice life for us…"
- "Duh."

- "That's crazy?"
- "No way, never!"
- "We can barely afford to buy technology for ourselves and our own staff, and certainly can't afford to use them in the way that you have suggested*. Yet you are now suggesting something that will add further cost, time, and complexity – have you gone (even further) off the deep end?"

**Using the EHR to inform practice, interconnect clinicians, personalize care, improve population health, and NOT to attempt to enhance productivity and "right-coding."*



Descriptions of the PHR

- Your record is yours; the PHR simply provides patients with a copy of their own information (with no added work or cost to you or your staff).
- You maintain medico-legal responsibility for your record – the PHR just simplifies getting patient history into your chart.
- You buy / implement / maintain your EHR; patients do the same for their PHRs.
- Your record belongs to the patient, and your patients control your access.
- As the record is theirs, your patients can make additions / changes / deletions at will.
- After you have bought and implemented your own EHR, you will also have to buy, maintain, and reconcile PHRs for all of your patients.

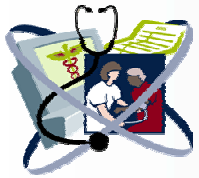
Overcoming MD resistance to the PHR

- Clearer definition of the PHR
- Clear demarcation of ownership / control
- Consequences of PHR use on MD time, cost, and complexity

- Three further thoughts on PHR-EHR integration
  - PHR – why bother? What problem are we trying to solve?
  - Business case for information management – necessary for optimal use of the EHR, and the PHR
  - Implications for medical documentation

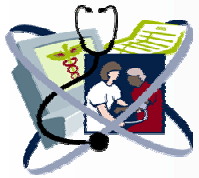
Definition of the PHR acceptable to MDs

- "Most Americans will have an electronic record by 2014."
  - Most doctors will be using EHRs by 2014
  - Most patients will have PHRs by 2014
  - We are switching to a health delivery system where every patient has one shared record – and it will be digital
- Unless we make radical and concomitant changes in reimbursement and liability – each MD will continue to be responsible for creating / maintaining his/her own records
  - Electronic
  - Shareable
- Implications:
  - Most (or many, or a few) patients will have PHRs by 2014 – but the PHR will not replace the EHR
  - The PHR can be "tethered" or "untethered"



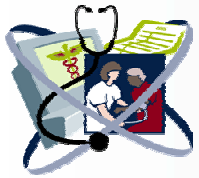
Ownership / control of the record

- Medical record currently has three functions
  - Record of complaints, findings, diagnoses, medications, etc
  - Basis for payment (defense against claims of billing fraud)
  - Defense against future malpractice claims
- Unless we make radical and concomitant changes in reimbursement and liability – use of the PHR can not alter the physician's record, or control of the record (at least for purposes of payment and establishment of defense against malpractice)
- Implications:
  - MDs own / control their EHR
  - (Hopefully) information within EHRs is formatted (or "formattable") in such a way as to make data exchange easy, inexpensive (free?), and accurate
  - Tethered PHRs are owned / controlled by MD (maybe ok)
  - Untethered PHRs are owned / controlled by patient (certainly ok)

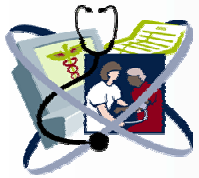


Consequences of use

- PHR's value increases (exists?) only when connected to a qualified and relevant clinician
  - Requests for appts, refills, etc.
  - Medical questions
  - Reconciliation of conflicting data
  - Second opinions
  - Facilitate care coordination
- These tasks will not fall equally on clinicians, but primarily on PCPs (pediatricians, family practitioners, internists) – already dissatisfied, and with a threatened future
  - If the optimal use of a PHR results in ↑ cost, time, or complexity for PCPs – will it further hasten the demise of primary care?
- Implications:
  - The business case for information management (which would now also include responding to medical questions, data reconciliation from the PHR, and care coordination) is more important than whether the PHR is tethered or untethered



Three additional thoughts…



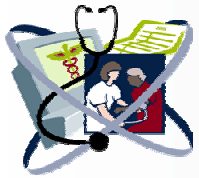
Why do patients want a PHR?

- Access to their own information
- Access to their own physicians
  - Request appointments, refills, referrals
  - Medical questions
  - Care without an office visit
  - Care coordination

  (All of which can be done without a PHR)
- Less work in providing relevant information to another clinician

  (Also can be done without a PHR)
- Retain control over one's own information

  (Also can be done without a PHR)



Why do I want some patients to use a PHR?

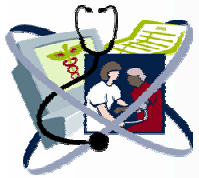
- Access to their own information
- Access to their own physicians
  - Request appointments, refills, referrals
  - Medical questions
  - Care without an office visit
  - Care coordination

  (All of which can be done without the PHR)
- Less work in providing relevant information to another clinician

  (Also can be done without the PHR)
- Retain control over one's own information

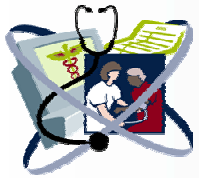
  (Also can be done without the PHR)
- Enables ability to become active collaborator in one's own care

  (Critical for achieving enhanced quality for many chronic diseases)



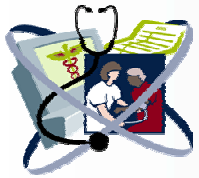
Business case for information management

- A major cause of medical errors and suboptimal quality in the US is the lack of proactive population management, chronic disease management, and care coordination
  - These activities are all made possible and easier with HIT
  - There is NO evidence that adoption of HIT without a concomitant business case for population / disease management / care coordination will lead to these quality enhancements
  - Basis for pay-for-performance “incentives”
- Widespread EHR adoption (without reimbursement changes that reward desired use / targets) will not result in the four major goals laid out by Dr. Brailer – but rather “digitized dysfunction”
- Widespread PHR adoption (without reimbursement reform) will likely result in similar waste of technologic potential



Rethinking medical documentation

- Medical records “bloat”
  - Average note is 3-5 times longer than it needs be
    - Compliance with E/M coding guidelines
    - Misconception that ↑ verbiage protects against errors / malpractice
  - ↑ sharing of these bloated “textblobs” with patients via PHRs
    - Cause of MD concern
    - Not particularly useful
- However, if the current “problem oriented medical record” → “quality-oriented shareable record”
  - Shorter notes containing more structured elements
  - Focused on documenting only what is necessary, no incentives for verbosity
  - Focused on improving quality
  - Focused on (where appropriate) longitudinal care rather than documentation of episodic care
  - Focused on share-ability



Summary

- Whether the PHR is tethered or untethered is not very important
- Defining the PHR is important – in so far as to assuage legitimate concerns about ownership / control of physician records (for purposes of payment, defense against malpractice)
- Pressure to share data (via PHRs or HIEs) presents an opportunity to revisit and fix medical documentation standards
- Establishing a business case for information management will:
  - Create workflows that better service patients' informational needs
  - Almost certainly encourage adoption and optimal use of standards-based and connected advanced EHRs
  - Almost certainly encourage use of health information exchanges
  - Will encourage use of PHRs for those patients who really need them (and allow for PHR use by those who prefer to use one)