Generating Value in Healthcare: HIT is Just Part of the Solution

By David Hartzband, D.Sc.

We often hear the term "value" applied as part of the framework for evaluating the delivery of healthcare. As the focus of assessing healthcare delivery has shifted increasingly toward value, the role of health information technologies in securing that value has become even more significant. But what do we mean by "value?"

Generally, value is defined as some measure of relative worth. This can be a subjective measure, how we feel about something, or it can be a quantitative measure such as how much something costs or is appraised for at a specific time. In talking about the value of health information technology (HIT), we could be talking about either or both of these measures. The one thing that is true about both measures is that value is measured against or compared to a goal. In the case of HIT, the goal is to help attain the "triple aim" generally taken to mean: "improving the experience (and outcomes) of care (for the patient), improving the health of populations, and reducing per capita costs of health care."[1]

While there are a number of very visible and important efforts to use HIT to achieve the triple aim, perhaps the most important is the Centers for Medicare and Medicaid Services' (CMS) meaningful use incentive program, now entering Stage 2 of three proposed stages. [The CMS program provides financial incentives to providers for use of certified EHR technology to improve patient care.]

In January this year CMS reported that 76% of the 436,000 providers that have registered for meaningful use incentives since 2011 have received enhanced Medicare or Medicaid payments. This seems like a good measure, except we would have to ask, "Has adoption of EHR technology furthered the pursuit of the triple aim in healthcare?" The answer is not simple.

Results of a recent physician survey appearing in Medical Economics[2] found that 45% (of 1,000 physicians surveyed) believe that healthcare is worse as a result of EHR adoption, and 43% believe that EHR systems have resulted in significant financial losses.

1 (D. Berwick et al. 2008. The Triple Aim: Care, Health & Cost. Health Affairs. 27(3), 759-769 and many others).

In addition, the IDC Health Insights[3] report (*U.S. Healthcare Provider IT 2014 Top 10 Predictions: IT Priorities for the Post-EHR Era)* says that "first-generation EHR will continue to fail." This is intended to mean that a provider (or provider organization) can fully adopt and use current EHR technology and qualify for meaningful use incentives, yet still not achieve the triple aim, that is – not achieve improved patient outcomes or improved population health and not decrease costs.

The IDC report points out that in order to make progress there are many functions that will need to be provided including provider-to-provider and provider-to-patient connectivity, continuity of care and care transition as well as medication reconciliation and many others. The report suggests that EHRs must evolve to provide infrastructure that layers these capabilities on top of the more limited existing functionality, while addressing current and near-future meaningful use requirements.

Finally, in a recent paper in *Health Affairs*[4] RAND researchers reviewed what they characterized as the disappointing progress of health IT to date and attributed this to several factors including: sluggish adoption of health IT systems, coupled with the choice of systems that are neither interoperable nor easy to use, and the failure of healthcare providers and institutions to reengineer care processes to reap the full benefits of health IT. "Disappointing," to say the least.

Finally, CMS reports, as of late 2013[5], that 79% of Regional Extension Center (or REC) registered providers are live on an EHR, although only 9.5% have qualified for meaningful use incentive payments.

So what are community health centers to make of this? Health centers have been in the forefront of adopting EHR technology. Has EHR adoption been a failure for health centers? To answer this we have to remember several things. First is that health centers have a clear set of goals against which value can be measured – in large part because the triple aim has been a focus of health centers for many years now, even before that phrase was first adopted. Second is that health centers have an operational model for care that has been steadily evolving. The vast majority of health centers have adopted EHR technology, but more importantly, health centers are providing their broad range of services through a patient centered medical home model that incorporates a good start at workflow reengineering.

What health centers need to do next is to understand how HIT is evolving and make plans for continued IT use in alignment with that evolution. Additional capabilities, including those required by Stage 2 and Stage 3 meaningful use, should be looked at as applications that are supported by the EHR, but not necessarily provided as part of a single-application, monolithic EHR. This is especially true of capabilities such as eReferral, care transition activities, medication reconciliation, etc.

Vendors may still be committed – for both business and technical reasons – to the monolithic view of the EHR. Health centers, primary care associations and health center controlled networks, however, should urge vendors to offer more contemporary and web-based models for providing new capabilities and should make their preference known for these application-based capabilities. And planning ahead in anticipation of expansion, new services and new capabilities is essential. It's important for health centers to have at least medium-term plans (2-4 years) for what will be required in terms of new software technology including EHR and how the health center will acquire the capabilities it needs to generate value.

Notice I said *capabilities* that generate value, not technology. ***Technology is an enabler in the generation of value.*** Acquiring and using technology as it is designed (or sometimes even outside of its design center) can facilitate the generation of value.

In our effort to improve the quality of care and outcomes for the patient (and caregiver), improve the overall health of the populations we serve and reduce per capita healthcare costs, we can and must use HIT, including EHRs, as a way to enable the generation of value. However, it is essential that we engage in the difficult and real work to provide all of our services through a medical home model, rethink and remake, where needed, clinical and operational workflows to facilitate the new care models and undertake specific work to make our use of HIT more effective and goal aligned.

Without these efforts, we can adopt and use all of the HIT that we can afford and have the resources to deploy, but still not generate value for our health center or for our patients.

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2 Physician outcry on EHR functionality, cost will shake the health information technology sector - Medical Economics, February 10, 2014. http://medicaleconomics.modernmedicine.com/medical-economics/news/physician-outcry-ehr-functionality-cost-will-shake-health-information-technol

3 U.S. Healthcare Provider IT 2014 Top 10 Predictions: IT Priorities for the Post-EHR Era http://www.idc.com/getdoc.jsp?containerId=HI244741, accessed February 20, 2014.

4 Kellerman, A. L. & S. S. Jones 2013. What It Will Take to Achieve the As-Yet-Unfulfilled Promises of Health Information Technology. Health Affairs. 32:63-68. January 2013.

5 http://www.healthit.gov/sites/default/files/rec-fqhc_data_brief_final.pdf, accessed 10 February 2014