The pocketbook impact of electronic health records: Part 1

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It is estimated that only 30% of Canadian physicians employ electronic health records (EHRs), as compared with 50% in the United States and more than 90% in Denmark and other European nations.

The slow rate of EHR uptake by Canadian physicians has been traced to such causes as confusion about products, lack of government investment, government mismanagement and the often-Balkanized nature of the health systems operated by the provincial, territorial and federal governments.

But what about the doctor's role?

Explanations for the physician/EHR disconnect include the high costs of implementation, a paucity of financial incentives for physicians, misguided government strategies and a reluctance among physicians to adopt new technologies.

It has also been suggested that physicians may hesitate to adopt EHRs because they fear the impact on fee-for-service incomes. For many, EHRs may appear to be little more than an expensive, puzzling new technology requiring large amounts of unpaid time to adopt. And once adopted, they may threaten the tradition of the physician–patient consultation that underpins the fee-for-service model.

If patients no longer need personal consultations with physicians, will billing amounts decline? That's no small matter when roughly 70% of Canadian physicians are paid using the fee-for-service model.

CMAJ invited 12 physicians, researchers and managers experienced with Electronic Health Records (EHRs) from across Canada and the United States to weigh-in on whether the fee-for-service PAYMENT model is compatible with achieving the full benefits of Canada's multibillion-dollar EHR investment.

Six view the fee-for-service model as compatible with EHRs, while six argue that it will have to be reformed or abandoned.

Fee-for-service billing is compatible with EHRs: Agreed

Dr. James Lane, a Collingwood, Ontario, family physician, has worked with EHRs for nearly a decade, even winning an award from the provincial government for his leadership in the adoption of electronic records at 21 sites used by the 37 doctors within the Georgian Bay family health team.

A year after the group "went live" and connected to the same database, Lane says, EHRs are beginning to yield all sorts of efficiencies and benefits. But he doesn't think it makes much difference whether physicians using EHRs bill on a fee-for-service basis. He did so the first six years after moving to EHRs but now is salaried. "I've seen the advantage of the EHR in both systems of payment," he says.

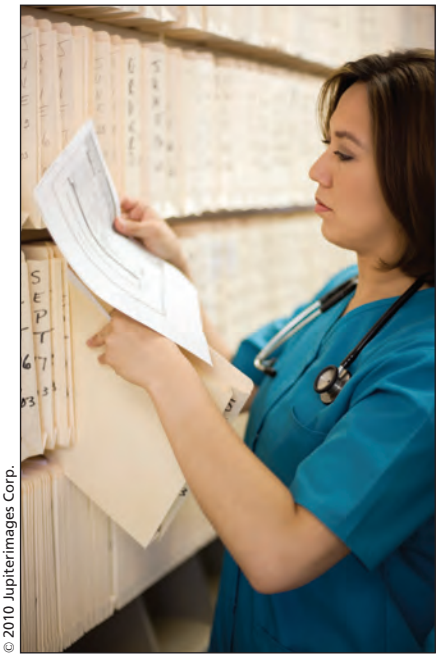
In Lane's experience, EHR adoption does not reduce patient visits — it simply allows physicians to operate more efficiently by reducing paper chases. And that means more time for preventive work with patients.

EHRs offer enormous potential for efficiencies, says Dr. Rob Wedel, a family physician at the Chinook Primary Care Network in Taber, Alberta, and cochair of Alberta's Access Improvement Measures program. At Chinook, electronic records have "made a huge difference to staff efficiency and savings. The workflow process is significantly improved over paper-based records."

Payment method makes little difference, he adds. "Everybody has the same capacity issues no matter how they are paid. There's the same insatiable demand. But the [electronic record] allows you to use a team far more efficiently. You get to see more of your patients."

Robin Tamblyn, professor of medicine with the clinical and health informatics research group at McGill University in Montréal, Quebec, believes fee-for-service may require a rethink as EHR integration reaches more doctors and, ultimately, patients.

But it's not flatly incompatible with EHRs, she says. By paying physicians



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Proponents of the adoption of electronic health records, even within the framework of a fee-for-service payment model, say that it reduces paper chases and frees up time for physicians to undertake preventive work.

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for the time they spend dealing with patient concerns via an EHR system, fee-for-service can be successfully adapted to a fully integrated system.

Tamblyn points to Denmark, where physicians are paid for electronic consultations via email, and where EHR usage is almost universal within a system where physicians largely rely on fee-for-service models. "If you restructure fee for service well, it can drive EHR use."

Brian Hutchison, a primary health care analyst at McMaster University in Hamilton, Ontario, thinks adoption of EHRs is fundamental to primary care reform. And he praises Ontario's efforts to shift physicians toward other payment models than fee for service, partly because such alternative models promote teamwork, which is further enabled by EHR usage.

But that doesn't mean Canada must immediately embark on Draconian measures to phase-out fee for service, Hutchison says, noting that many jurisdictions in Europe grafted EHRs onto fee-for-service payment models.

Although fee for service is "quite toxic" when it comes to enabling quality-of-care reforms, it is not fundamentally incompatible with EHRs, says Cathy Schoen, research director of the Commission on a High Performance Health System at the Commonwealth Fund, a New York City, New York-based private foundation, which produces an annual survey of primary health care measurements, including EHR usage in 11 countries.

"You want to free physicians up to do what they have been trained to do," Schoen argues, pointing to the successes in Europe.

EHRs can make sense even in a conventional fee-for-service model where physicians are not reimbursed for computer-based care, says Michael Hindmarsh, a Toronto-based consultant with two decades of experience tracking the dynamics of EHRs as associate director of clinical improvement at the MacColl Institute for Healthcare Innovation at the Center for Health Studies Group Health Cooperative of Puget Sound in Seattle, Washington.

Because EHRs vastly improve case-finding and reduce check-back from low-payment code visits in the US, Hindmarsh says, "many fee-for-service providers that integrated EHRs have made more money." — Paul Christopher Webster, Toronto, Ont.

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The pocketbook impact of electronic health records: Part 2

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Fee-for-service billing is compatible with EHRs: Disagreed

In the opinion of Dr. Karim Keshavjee, a Toronto, Ontario, family physician and associate member of the Centre for Evaluation of Medicines affiliated with McMaster University in Hamilton, Ontario, Canada's experience with EHRs has largely been a failure.

Part of the problem, Keshavjee says, is that EHRs are incompatible with the dominant model of physician payment in Canada — fee for service. If Canadian patients, physicians and taxpayers are to get the maximum benefit for their ongoing $10-billion investment in an EHR system, "reforms to the payment system are required," says Keshavjee, who has often advised both governments and primary health care organizations about how to adopt EHRs.

The power of EHRs is best harnessed when physicians use them to reduce patient-related workload, Keshavjee explains. EHRs reduce paper chases, which consume an estimated 30% of time spent with patients. They also enable physicians to delegate work to other caregivers.

But within a fee-for-service system, physicians who delegate patient contact to other caregivers lose income opportunities, Kashavjee says. "If you've got

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