



AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

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HEALTH INFORMATION TECHNOLOGY & E-PRESCRIBING

Recommendations

1. Use federal incentives to support a system of "Connected Medical Homes," electronically networking patients with their family physicians and other "medical home" providers." More than 80 percent of health care is delivered in doctors' offices and HIT should be used to those settings.
2. Provide differential payments to physicians who can demonstrate that they use Electronic Medical Records (EMRs) for e-prescribing, care coordination, disease management, referrals, and for communications with patients and other doctors. Give positive incentives to physicians who provide these services, but do not take away funds for those who do not yet have an HIT system.
3. Target federal financial support for HIT to physicians who are serving the underserved or those at risk for health disparities. These vulnerable populations would benefit particularly from a system of connected medical homes.
4. Support private sector efforts to apply broad computer and communications standards to HIT for portability and interoperability. A national health infrastructure could be accomplished in a more simple and efficient way by using the Internet.
5. Ensure privacy protections for apply to all parties who store, organize, manage, and transfer patients' personal health information, not only to HIPAA covered entities.
6. Guarantee system-wide interoperability of e-prescribing systems that includes physicians, practices and small and large pharmacies.
7. Include all drugs, including Drug Enforcement Agency (DEA) pharmaceuticals, in e-prescribing requirements.

Background

Patients, providers and employers need health information technology (HIT) systems in the US that are affordable, interoperable, private, and networked. The current governmental approach has tended to support large enterprises and their HIT vendors in efforts to build large-scale, complex systems, such as Regional Health Information Organizations (RHIOs). These coalitions, most often led by hospitals or large enterprises, have received federal dollars to integrate health information in a single area. However, regional solutions may or may not be transferable, do not reach the majority of U.S. communities, and are proving to be economically unsustainable past the grant period.

Simultaneously, we have seen the private sector, including individual physicians and American consumers, use interoperable EHRs and technology that are scalable and do not require multi-million dollar federal investments or the purchase of proprietary and possibly redundant local

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infrastructures. The results have been exciting: most of the progress towards health information technology adoption is due to this research and experimentation in the private sector.

Why Change Course?

When HIT was in its infancy, it seemed simple and efficient for the federal government to support large entities and hospitals with grant funding to encourage the adoption of HIT. The problem with continuing this approach, however, is that most health care in America does not take place in hospitals or large enterprises: it takes place in doctors' offices and, specifically, in primary care practices with five or fewer providers. For example, nearly half of all ambulatory care visits in the U.S. are made to family physicians, pediatricians, and general internists in the outpatient setting: *over 400 million visits each year*. We will not improve health care in America if federal dollars only empower large enterprises -- at great cost and complexity -- to communicate with other big institutions, while doctors and patients in tens of thousands of local community practices and clinics cannot access and share information for the good of their patients.

Building a System of "Connected Medical Homes" Linking Small and Medium-Sized Physician Offices with Their Patients and Information Sources

The AAFP believes the federal government must switch its emphasis from a focus on hospitals and large enterprises to one that helps networks of small and medium-sized physician offices acquire affordable and interoperable HIT systems. We need to link these offices so that primary care physicians, specialist physicians, pharmacists, and hospitals can communicate, locally and across the globe, to provide integrated, coordinated, quality care for all patients. Connected medical homes are more likely than other practices to be able to automate the patient care processes necessary for quality improvement and accountability. Data collection should be the by-product of the use of EHRs in connected medical homes, and not the reason they are purchased in the first place.

Providing Differential Payments to Physicians Who Use HIT Effectively

Special payments should reward physicians who can demonstrate the use of EHRs and other HIT, such as e-prescribing as a way to improve and coordinate care. Current reimbursement methods tied to face-to-face visits discourage efficiencies brought about by the use of EHRs, for example, asynchronous communication with patients using secure email and web-based consultations. Reimbursement strategies must change to reward quality and efficiency enabled by HIT.

Target Federal Dollars to Support Physicians Who Are Serving the Underserved

Any specific payments to physicians to purchase HIT systems should go to those serving in underserved areas where the capital to purchase EHRs is hardest to obtain and practices may be small or medium-sized. These payments should not go through third-parties such as hospitals, integrated health systems, or health plans, but directly to clinics and practices based on financial need.