

The Affordable Care Act and Electronic Health Care Records: Can Technology Help Reduce the Cost of Health Care?



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In the previous issue, we reviewed the ways in which the Affordable Care Act (ACA) promotes the continued development of electronic health records (EHRs) to improve the quality of health care.

In this companion article, we'll focus on the cost-saving arguments behind the development of a digital health care system by contrasting the utopian vision of the mid-1990s with its real-world implementation.

The entire concept of health care reform embodied in the ACA is dependent upon the generation, collection and sharing of information made possible by the advancement of health care information technology (HIT).

Widespread adoption of digital information throughout the system is pivotal for the success of many of the ACA's goals, including: comparative effectiveness research to yield cost-efficient, effective treatment protocols; reducing waste in the system; curbing hospital readmissions; and encouraging the development of Accountable Care Organizations (ACOs).¹

Many directives contained in the ACA implement HIT to promote cost savings, as first envisioned when the possibilities of computerized records and transactions were identified in the early 1990s. However, as HIT has been implemented over the past two decades expectations have often been thwarted by other forces, suggesting that any future results in the reduction in health care costs will not be automatic or easy.

Early experiences

In the earliest days of the transition to digital records, and particularly in the first salvos supporting the new Health Insurance Portability and Accountability Act

(HIPAA) in the late 1990s, the cost-saving benefits of computerized patient records were frequently touted by health policy wonks and government officials who endorsed the initiative.

Physicians were told that they would save on office costs such as paper, staffing (as no one needed to "pull records" anymore), dictation, and rent (for less physical space was required to store records).

Almost immediately, these arguments proved to be false. Any savings were quickly overwhelmed by the cost of purchasing an electronic medical record system; money previously spent on administrative support staff switched to fund IT personnel; dictation did not go away in a generation of keyboard-illiterate providers; and, even if the office footprint was reduced, the continuing upkeep and maintenance of digital records added significantly to office overhead.

In all fairness, the anticipated savings were never really about cost reductions for individual providers. The Holy Grail of HIT has always been improved cost efficiency for payers, especially the federal government through Medicare expenditures.

As is predictably true of most enormous policy transitions, the savings that were supposed to pile up during the transition to a paperless system have not met the dream's high expectations. Colliding with reality, any predictions about savings have been tempered by unintended consequences and adjustments by various players to preserve incomes at current levels.

The conflict between these forces can be demonstrated on the level of the individual patient, the treating physician, the disease process itself, the patient's community, and — ultimately — the American population at large.

Patient savings

The Institute of Medicine's 2001 report entitled *Crossing the Quality Chasm* waxes profusely about how an educated patient would essentially be a less expensive patient. Armed with an accurate, immediately accessible copy of their personal electronic health record and educational resources available on the Internet specific to their disease process, a cost-conscious patient (so the theory goes) would choose

prevention over intervention, and any medical intervention required would similarly be limited to precise, effective treatment choices.

In this utopian view of the impact of HIT, therefore, the paperless health care system facilitates the transformation of the patient to a healthier, cheaper citizen.

The ACA echoes this vision in multiple ways, including mandates that technology facilitate the enrollment of citizens into insurance coverage, and the creation of educational resources and other tools to promote increased patient participation in their own care, known as “shared decision making.”

As witnessed in physician offices and hospitals across this country, that vision falls short because it presumes that, if the patient is well-informed, his or her motivations will be logical. As anyone involved in patient care can attest, that is not always true.

All sorts of forces feed into patients’ perception of their own health: their definition of what “good health” is, as well as disbelief that weight tables, dietary rules and other health advice is realistic or should pertain to them.

Even if they accept the ideal medical model of fitness, large portions of the patient population arrive in a physician’s office resigned that good health is not attainable. They’re highly skeptical about their ability to work against genetic forces, the time and effort required to establish dietary and exercise routines, and failed past attempts to get healthy.

To compound the problem of achieving patient compliance with any medical treatment regime, patients have biases and beliefs about what will achieve an acceptable level of health for themselves, for they are swayed by societal and family input, ethnic and/or religious restrictions and traditions, evading bad news (i.e. avoiding the doctor in the first place), their own proclivity to resist authority figures,



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and their belief in — and insistence on — treatment advocated by the media and rumors.

Contrast this with traditional, researched, and professionally recognized medical treatment pathways, and the problems with achieving a maximally compliant (and therefore healthy and less-health-care-consuming patient) become apparent.

Perhaps the greatest fallacy of the cost-conscious, efficient model centered upon individual choices is the assumption that the patient will be motivated by costs.

In most instances, patients are not directly paying the costs that they incur. In our third-party payer system, the well-insured patient (such as a Medicare beneficiary) is insulated from the actual price tag of their care. To assume they will opt for less expensive care because they are concerned about the cost to the system is naïve at best; research published by *Health Affairs* in 2012 would argue the exact opposite.²

Physician savings

EHRs allow treating physicians to access all of their previous notes, concerns, problem lists and laboratory/diagnostic results in the patient’s record, which is far more efficient than flipping through a loose collection of pages in a paper file.

More important, with that same technology, widespread (and appropriately secured) sharing of patient information between various providers involved in a person’s care is possible, so treating physicians would have immediate, digital access to all of the records and lab tests of everyone else who had treated the patient.

This objective is central to major components of the ACA, for a well-integrated EHR with immediate access by all players allows for the reductions in waste and redundancy that are core to the principles behind the establishment of ACOs and medical homes.

Hypothetically, if faced with a recent, high-quality MRI, the current physician would forgo ordering

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a second study, thereby reducing duplication and costs. Unfettered by fragmented, paper records — proponents of HIT's ability to reduce costs say — the sharing of information between all the providers involved in a patient's care will certainly result in cost-saving efficiency.

Again, that argument may be logical, but it does not account for an unintended consequence of the very technology that was intended to bend the health care cost curve. EHRs actually make it easier for treating physicians to increase the cost of their services through the pivotal role of computer-generated templates that document patient care.

In the old paper world, doctors frequently complained that there was not enough time to write everything that they observed or did in the record, which lowered reimbursements because all charges must be supported by the patient record.

To this point, EHRs have had a magical transformation on the level of the individual provider. Suddenly, charges can be justified with a series of mouse clicks on a screen. Not surprisingly, the volume of documentation in the average patient chart and the cost of care have risen together.

Another factor inconsistent with the anticipated decrease in costs resulting from HIT is far more intrinsic to our health care system, and that is fee-for-service medicine. The model physician, as dreamed by HIT enthusiasts, is further removed from reality by another faulty perception: that he or she is operating with no other competing interests in the exam room.

With few exceptions, intervention equals income. Mythical physicians in an HIT world choose not to order a second MRI because they are exclusively searching for diagnostic information pivotal to providing excellent care; yet we cannot ignore the human impulse to order a test, even if duplicative and unnecessary,

because it supplements the ordering physician's income. HIT will not decrease costs until providers are no longer financially tied to their orders and/or prescription pad.

Disease savings

Even the patient's overall disease process would become more economical in the world envisioned by HIT enthusiasts. In a one-two punch, access to digital information would flow from millions of patients with similar conditions into appropriate research analysis, and then the results of that study would trickle back into the exam room.

The ACA envisioned the impact of such research that supports programs that promote care coordination and chronic disease management, prevent hospital readmissions, and improve health and wellness.

Once established, data sharing in disease management would result in a predictably healthier patient at a tremendous savings to the payer, for trial-and-error care would be replaced through ongoing research. True comparative effectiveness will be achieved for all of the major chronic diseases, pointing the treating physician to the most effective yet cost-efficient remedy. Healthier patients and reduced costs of care are a policymaker's dream. The logic of HIT in this realm is undeniable.

However, the goal of reducing the cost of disease through a digital system has been frustrated, though not defeated, by the realities on the ground. With global demographic study, disease processes (particularly chronic diseases) can be treated more effectively and efficiently.

Unfortunately, beyond the possible financial incentives for a physician to vary the treatment plan, the HIT vision assumes that highly educated providers want to execute what is derided as "cookbook medicine." Even more to the point, within our strongly held belief of informed

consent, it implies that all patients will want to be treated as an undifferentiated person and plugged into a specific treatment track.

If that were true, we would all be exercising seven hours a week, modifying our diet and there would be no smokers; if that were true we would all have an advanced directive, a will, an estate plan and provide our loved ones with both security and specific information about our wishes should we become incapacitated.

The point is this: American Individualism is what has made our system both the nexus for medical discovery and innovation as well as the system (compared to other nations) most recalcitrant to change. Policy dreamers should have a hearty skepticism about the likelihood of the majority of patients opting into and complying with a strictly controlled, authorized treatment plan.

Community savings

In recent years, there has been increasing recognition and debate about communities of similar size and patient demographics that have different utilization rates of Medicare services.³

Identifying these outlier communities was difficult in a paper-based medical culture; with HIT, however, it can be done easily with quick computer processes. Accordingly, under the ACA, reports are generated that compare the per capita utilization rate of physicians or groups of physicians with similar patients and local health care costs, and uses HIT to further understand health disparities in different patient populations.

Presumably, once identified, work within a variant community can address factors that result in disproportionate utilization, thereby decreasing expenditures for the entire region. This could include focusing on particular providers that skew the area's numbers, patient education, improved preventive efforts

and addressing access and efficiencies of scale in the community. In the HIT utopia, identification of such communities leads to better local health care and decreased costs.

Yet, once again, the vision is not matched by reality. Even community disparities as identified through an analysis of digital data may not be as closely tied to cost containment as it might appear on the surface. Communities that have come under scrutiny have argued that the demographics of their population do not bear cross-comparisons to other locales.

Hypothetically, location near industrial fumes, insufficient access to fresh produce, a condensed block of infirm patients, or a minority of patients devastated by disease can all lead to disparities in utilization rates in that city. However, any of those examples also prove the point of the

policy of digital health care for, once identified, all of those issues can be addressed and modified, if not alleviated altogether.

Recognizing it is possible that different towns may have unusual health risks, it is more likely that outlier communities favor an abundance of unnecessary, duplicative care. In a nutshell, some communities seem to just like aggressive medical intervention, and the more the better.

It is true that some communities consume more health care — as the demographic data reveals — but which comes first? Does the community prove itself to be ripe for a lot of “extra” care, or vice versa? Do the doctors teach the patients to want more, or do physicians gravitate to communities that will allow excessive intervention so as to increase their personal income?



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A solo physician could probably not order enough extra services to change the costs of the community on the whole, but solo physicians spread across a locale can and do practice in a similar manner that results in the entire region accessing an unusually high level of health services. What made those physicians all practice in a similar manner? How do you defeat a culture of excess?

Given the lack of financial pain for the over-consuming patient in our third-party payer system, coupled with the income incentives promoted by our fee-for-service culture, flattening utilization disparities among communities is difficult. Even the most rigorous government agency will tend to shy away from stepping between a patient and their physician's professional judgment.

At the same time, identifying high-cost providers through HIT does allow measures to be taken up to and including investigation for criminal billing practices. That, too, will take time and resources, and in the meantime, disparities between communities will exist well beyond the establishment of a digital health care system.

These communities were not invented by EHRs, yet with HIT, they became easier to identify. However, EHRs presumably will not reduce these inequities in utilization until far more fundamental issues, such as the lack of patient accountability in the third-party payer system and counter-productive incentives in fee-for-service medicine, are addressed.

Population savings

With all of this HIT-induced efficiency, predictably we come to the ultimate vision of all: a healthier America. With prevention and primary care prevailing in an educated patient population, duplication and ineffective treatment eliminated, and standardization of utilization, the country is promised to be healthier

overall. These vital, healthy citizens will be able to work longer, thus paying premium taxes, all while reducing the outlay for actual health care.

As to the level of a healthier American population, the vision is desirable because it makes fiscal, medical and moral sense. However, does it suit us as an eclectic, vibrant and inherently emerging culture? Are we a uniform population responding in lock-step to dictates from above, or a melting pot of innovation and opinion? Where does the vision of standardized care as allowed through HIT make allowances for individuality, informed consent (including refusal of care) and patient choice?

As Americans, we are determinedly, obstinately and passionately individualistic. Will a paperless health care system nullify our primary personality characteristic, even when it is more a curse than a blessing?

Conclusion

Our health care system reflects our country perfectly. Like us, American medicine is innovative, dynamic, personalized and altruistic, but it also reflects our demons as a society, as the system we have created is unwieldy, fiercely individualistic, recalcitrant to dictates and entrepreneurial to the point of defeating efficiency. Reform of the American health care delivery system is now necessary for its very survival.

Although there may be differences of opinion about how to resolve the problems we are facing, no informed person can argue that it isn't imperative that we improve outcomes across the country and replace the unsustainable economics of care. That necessity requires inclusion of every possible means toward that end, and information technology offers assistance in reaching the goal of reform in ways unimaginable only decades ago. It would be inane to argue that HIT is not key to achieving our nation's goals.

Any dream worth envisioning should be idealistic and difficult to attain, and the utopian vision of HIT to cure the ills of our health care system isn't entirely futile. The point of these companion articles is not to argue against HIT as a fundamental component of creating a better American health care delivery system. Rather the aim is to point to the fallacy of thinking HIT provides an easy answer.



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