

Health Insights Today

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Electronic Health Records: What the New Policies Mean for Chiropractors: Interview with Joe Brisson

Joe Brisson has over 20 years of experience in the arena of health information technology. As the principal of HIT Associates, he has guided and developed enhancements to health information exchanges at the community, regional, state and federal levels. His experience includes chief information officer level responsibilities in a variety of health care provider settings from physician offices to hospitals to health plans to quality improvement organizations. Most recently, he completed the orchestration and delivery of the Nationwide Health Information Network Trial Demonstrations under contract with the Office of the National Coordinator of the U.S. Department of Health and Human Services.

Political and health policy leaders have expressed great hopes for the potential of electronic health records and health information technology. What needs are met by converting records at doctors' offices, clinics and hospitals to an electronic format?

Probably the greatest gap we see right now, if we look at our health care system (and you've probably heard this many times) is that we don't actually have a system. It was Mike Leavitt, the former Secretary of Health and Human Services, who first made that statement. A big part of why we don't have a system is that medical records locked in file cabinets can't be shared. In fact, even within a practice they can't be quickly addressed to meet the needs of a patient.

Let me take you down a bit of a path, if we could. If a patient has come to my office for five or ten years, I have many, many paper records in a chart. So how do I quickly assess what is the critical information that I need to get to the top of that record? Very important things can be buried in that history. As we move to electronic records, one great immediate benefit is that *I can now organize my view of how I see that patient's history*. If the patient has allergies, those can be drawn right to the top. If I'm looking for medications the patient may be on, that information can be drawn right to the top, and it can be updated much more readily. I can be prompted to update that conversation with the patient. Also, if the patient happens to have a chronic condition, such as diabetes or chronic lower back pain, I can see what's been done previously.

So this allows a significant increase in speed.

It enables me to see those things quickly so that I can address that patient's needs faster. We all know that we're being forced to see more and more patients in order to increase the revenue stream. When I have to quickly see patients, while dealing with three-inch thick paper charts, how do I get this done and be sure that I didn't miss things? Even new information that may have been gathered by the receptionist when the patient came in today, is now available. It can be folded in and viewed with the rest of the historical data.

This certainly represents a significant change in work flow, but it can help me to achieve a better outcome for this patient because I have access to all of that information. We can only have a paper chart in one location. I've watched many practices that have three or four locations, where the support staff has to spend a good deal of time gathering up charts to be brought over to the next location, and then having to refile the charts that were just brought in from the last location.

So in a practice that has electronic health records, you've got immediate access to the information, wherever it's housed.

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Yes. I can even access it from my home, if I set it up appropriately. Not that I want to extend everyone's hours, but if I'm called in an emergency circumstance after hours, where's the chart? It's at the clinic. I can't look at it, I can't eyeball it unless it's in electronic form. I'm remembering that they were in today. But what medication were they on, or at what level of the spine did they have a problem?

So far you've been addressing the value of EHR within a practice. What is envisioned in terms of communication from one practice to another and the development of a single comprehensive electronic health record for an individual?

Before we leave the topic of what happens inside a practice, let me touch on one thing that's important. One of the greatest challenges that we're having as we evaluate electronic health records is economies of scale. If I'm a chiropractor practicing by myself, affording electronic records is not high on my list. It just isn't. When you start to talk in terms of anywhere from \$20,000 to \$50,000 to make that happen, where am I going to recoup that? And what is the benefit to me?

Just today, the Wall Street Journal's health blog had an interview with a medical physician, who said that he had spent \$300,000 to get his practice up and running with electronic health records. That sounded unusual to me. Are the figures you just cited more common? Might he have been dealing with a larger or more complex practice?

One can always make bad choices. \$300,000 is an extraordinary number. I've never heard of one that large. It may be that he scanned all of his existing records. *I believe that is a massive waste of time.*

So your recommendation is to make everything electronic from the day you start to use EHR, but not to go back and scan your old records. Scanned records are not searchable electronically, which undercuts most of the purpose of going electronic. Now, going back to the still sizeable \$20,000-plus price tag, it's my understanding that because the federal government considers health information technology to be a key priority in reforming the health care system, there's a substantial allocation in the recent American Recovery and Reinvestment Act, the "stimulus bill," for doctors to get started on this. Do we know yet to what extent these funds may be available to individual practitioners, including chiropractors?

The \$19 billion that they set aside for EHR is tied to Medicare, and would be available only in the form of enhanced reimbursement for treatment of Medicare patients. Let's talk about what is happening in this bill and then take it down to the chiropractor. First, it's important to understand that this is not just the Obama Administration. I was working on this for three years before he was elected. There was an executive order from the Bush Administration.

What we've been trying to drive is continuity of care. That's what this is all about. The first leg is getting EHRs adopted. The second is that once I have records into the EHR, I want to be able to look at the continuity of patient care on the community level. So I want to know what drugs that patient is on, what allergies they have, what primary care physicians they're seeing, what specialists they're seeing, what chiropractors they're seeing and what hospitals they've been in.

I want to be able to look at a quick snapshot of the patient's care. That's really what we're working on in deploying health information exchanges (HIEs) regionally. This is what I've worked on for the last three years. They are connecting together the local hospitals, clinics, specialists, and pharmacies, and they're able to share all of those records.

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What does an individual chiropractor gain or lose by being in or out of this health information exchange.

If we're thinking in terms of holistic patient care, I need to know what treatments they're having and what medications they're taking. And other doctors need to know that I'm treating them, as well. We can take an island perspective if we want, but this legislation is effectively going to throw up an embargo. So you can choose not to be part of a care delivery system, but chiropractors who do that will be on the outside.

So assuming that a chiropractor, or chiropractors in general, want to be integrated into this system, does it look like they will they need to contract with private vendors, and pay the tens of thousands of dollars you mentioned earlier, in order to become part of the system?

Yes, they will.

Do chiropractors qualify for government aid or subsidies in order to make this transition?

Only if they take Medicare. The way it's structured is that in year one, a physician can recover as much as \$15,000 on this scale by an increase in their reimbursement rate. The maximum is up to \$44,000 over five years.

Confidentiality is a major concern for many people inside and outside the health care professions. When you're dealing with an electronic health record, accessible by various practitioners, how is the confidentiality of these records guaranteed?

Even the CIA can't protect their system 100 percent of the time. There's a tradeoff to this. But we've done a lot of work to develop very secure infrastructures to protect the information, and if you look at the core specifications that support the nationwide health information network, they are comparable to what we see in the banking industry, as far as keeping one's money safe.

Does that mean somebody can't hack it? No. But one of the things we've tried to do as much as possible is to create federated systems. That is, we don't build huge repositories of data. We build patient records on the fly as we need them. When you talk about a continuity of care record, if I go and ask for information on a particular patient, it will go to all the community sources and assemble it on the fly for me. So rather than have somebody hack into a repository that has 100,000 or a million records in it, we try to federate, or decentralize, everything and assemble them on an as-needed basis.

So what's centralized is the way the patterns of information are stored and accessed, and what's decentralized is the data itself.

Correct. We have master patient indexes at a community level that point us to your records.

Does that mean that if I am seeing a patient, and I have the proper code to gain access to their electronic health record including the treatments of other practitioners ...

The proper consents have to be in place. Then, it remembers you, it remembers what you looked at.

So I can't take someone's psychiatric records and post them on the World Wide Web.

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First off, psychiatric records for the most part are set aside. They're protected by a whole other set of laws. Although it does get a little dicey when you talk about the medications they're on, because those are more readily accessible. But the psychiatric notes are a far-away set-aside. But you could, if you are an unscrupulous physician and you have consent to enter that system, you could do that. But if you did, it would probably be the last time you practiced.

What other aspects of the new law should our readers know about?

Another leg of this bill is a major push to upgrade quality. We're going to see quality reporting done and we're going to see the transparency that everyone has tried to avoid for so many years. That could be an opportunity for the chiropractors to step up, to show the efficacy of chiropractic treatment. Electronic records allow quick access to large amounts of data for researchers to use in determining effectiveness. It's far more difficult to do this by just pulling paper charts. This is a chance to shine. Most medical professions that I am working with are terrified of having their quality data reported.

My sense is that chiropractors would welcome such scrutiny. Of several dozen randomized controlled trials comparing spinal manipulation to other treatments or placebo, none have shown chiropractic to perform worse than what it was compared to, and a substantial majority have shown it to be superior.

That's why I think this is a real opportunity.

Daniel Redwood, DC, the interviewer, is Editor-in-Chief of *Health Insights Today*.