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PHRs Assuming Their Rightful Place in the Alphabet Soup of Digital Health Records



BY JEFF MARGOLIS

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***What's in a name? That which we call a rose
by any other name would smell as sweet.***

– WILLIAM SHAKESPEARE

The use of information technology to improve U.S. health care is front and center following passage of historic national health care reform legislation. In the popular press, health care IT has become synonymous with the concept of electronic health records (EHRs). Moreover, many people believe that if health records can be computerized (digitized) and shared (with appropriate security), they will help solve both cost and quality problems in health care. It's interesting to note that because the federal government is allotting large sums of money to promote the adoption of EHRs, nearly every major technology company suddenly has an EHR solution that is worthy of consideration and re-

imbursement. I'm reminded of the explosive hype around the initial development of the internet in the late 1990s, and how even though massive capital was applied to unlock the usefulness of the internet communications channel, only a small handful of companies developed solution models that survive today.

The fact is, while electronic records will be a key component of improving the U.S. health care system, the implementation of a meaningful, sustainable solution requires a combination of people, processes and technology.

In order to change things in a coordinated, systematic way, we must incorporate applied technologies as pieces of an overall design that considers all requirements of the system. The overall design, integrated health care management (IHM), is intended to optimize both benefits and care for the consumer and requires that we incorporate the EHR as part of a broader enterprise framework that promotes value-based benefits, value-based reimbursement, systematic health management, and evidence-based medicine guidelines within a culture of health.

First, let's clarify the alphabet soup of EHRs, electronic medical records (EMRs), and personal health records (PHRs) under consideration. These acronyms refer to just three of the many different types of health records either in use today or under development, and many people are confused as to which is which. *EHR* is the acronym you see in the news most often, as it became the subject of government health care reform, and has therefore entered the public lexicon. *EMRs*, which are used primarily in hospital settings, are hospital visit-specific, and are in fairly widespread use today, particularly in integrated delivery systems. *PHRs* typically are designed to be used by both consumers and providers. Like EHRs and EMRs, PHRs are being implemented and adopted at various rates across the country. Yet by their very nature, PHRs offer an opportunity to accelerate the progress toward IHM.

A Closer Look at EMRs, EHRs, and PHRs

The EMR is a deep record in that it contains a tremendous amount of detail, potentially including data-intensive lab results, patient readings and X-rays, EKGs, or other diagnostic images used in determining or adjusting treatment at any point in time or location within the hospital. The format of the EMR is designed to be understood by health care professionals and is not intended for distribution beyond that narrow clinical setting.

In contrast to the hospital-based record, the practice-based EHR is designed to give the doctor a longer-term view of the patient, usually the length of the relationship between the patient and physician. Patients receiving treatment in the office setting typically have fewer critical conditions than those who receive treatment in the hospital. For example, they may go to their doctor's office for routine examinations or for ongoing treatment for chronic conditions. However, both of these scenarios require care management over a much longer period of time than for an acute care hospital situation. Record systems in physician practices also are designed for use by a more limited number of staff who tend to be familiar with one another and deal with less day-to-day clinical intensity than their hospital counterparts.

Some health care advocates have suggested that physician-based EHRs become transportable across the

health care supply chain to eliminate errors and redundancy. Systematically, one needs to consider whether using records in that manner is congruent with physicians' objectives for their own record systems and workflow. The workflow in an orthopedic specialist's office, for instance, is and should remain quite different than that of an oncologist or primary care physician.

The third type of electronic record is the PHR. There are many variations of this type of record. They range from the do-it-yourself variety, where consumers enter data about their health history and care, to record systems in which the key data is automatically fed from other data sets in the health care system (e.g., those of a health plan). Because they are internet-based, PHRs can be viewed from any location and, in compliance with security and privacy protections, can be seen by anyone who is required to see them.

What all PHRs have in common is their summary nature and unique ability to be used universally. The simplest way to think about a PHR is as an outline of your health care history, or your health résumé. Certain types of PHRs provide a comprehensive view of the patient, which currently is not available from any other type of record. Unlike today's hospital- and physician-based medical records, which contain information only from affiliated locations (at best), the payer-based PHR can provide a comprehensive overview of all diagnoses, procedures, testing, and treatments, across all locations and practitioners. This digital record does not necessarily contain specific test results or detailed notes on treatment, although it can. Rather, it lists the types of tests performed, their dates, and the names of the providers by whom they were ordered and performed. This summary-level information can act as a prompt for doctors to get more detailed information if necessary. It is easy to see how the breadth of the payer-based PHR can help physicians and others throughout the health care supply chain identify potential drug interactions, avoid duplicate testing, make comparative evaluations and cross-check the care one receives from multiple treatment centers.

Another important advantage of the payer-based PHR is that it can be understood easily by consumers and providers alike. All of the physicians, nurses and therapists involved in one's care (and even family members, with the patient's permission) are capable of using it. Because it is in summary form, the PHR is useful in a wide variety of settings, including the home, the doctor's office and when a patient first arrives at a hospital for treatment.

One Size Doesn't Fit All

Just as retailers use different models for organizing and managing supply chains, the U.S. health care system likely will require differing electronic record solutions to handle the full range of health care benefits and delivery methods across the system. Simply put, a one-size-fits-all approach to clinical electronic records will not deliver the system-wide cost, quality and access improvements we seek.

Having been behind the firewalls and in the shoes of many different health care constituents, I can personally attest to the need for multiple, integrated health record models. I was involved in the implementation of the earliest electronic medical records and physician records in integrated delivery networks. I've been a patient on the receiving end (both good and bad) of the in-

formation in these records. I have accompanied primary and specialty physicians going about their daily work. And, as a board member of a hospital, I remain current with health record implementation initiatives. Given the wide spectrum of information needs across health care constituents and the differences in how their workflows and computer systems are designed, we need to employ multiple types of records. But we must make sure these various record types are linked and coordinated within the construct of IHM. We cannot lose sight of our ultimate, broader objective: better coordination of benefits and care at the right time and place during the consumer (patient) and provider interaction.

PHRs: Getting There Faster, Cheaper, and Better

The health care dollar flows through the health care payer organization and is distributed to the “supply side” of the supply chain—that is, to clinicians, hospitals, pharmacies and labs, among others. In order to get reimbursed for their portion of the dollar, the supply-side constituents submit claims to the health plan, which then has a record of all this activity at the individual consumer (patient) level. This data is close to 100 percent digitized, as the industry has had electronic submission incentives for many years.

Health care payers’ benefits and care data is a rich source of information that can be used in a health record to show the health history (i.e., diagnoses and treatments) for a particular patient. Let’s consider an additional element that goes to the heart of the PHR’s advantages.

If you are like most Americans—some 80 percent—you receive your care from a virtual delivery network rather than an integrated delivery network, such as Kaiser Permanente. You see multiple clinicians in different group practices. You receive care at multiple medical facilities. You get blood work at still other locations, and you fill prescriptions at one or more pharmacy locations. Your health plan is, quite simply, in the best position to create your PHR. It gathers digitized data from the multiple doctors, hospitals, diagnostic testing centers and pharmacies and aggregates the data on your behalf to share with you, your physician(s) and other caregivers. And considering that most people have only one health plan in a given year and that so much data flows through that health plan, the absence of a payer-based PHR is a waste of good, digitized data.

Considering, too, that people change health plans, the standardized claims and administrative data that populate PHRs must be transportable. Significantly, PHR transportability is quicker and more financially practical than EHR interoperability. This is because payers are accustomed to adding populations of consumers along with claims history to their information systems due to years of industry consolidation; the data in payer systems lives in an already highly standardized mode.

Experiencing Your Personal Health Record in an IHM World

By example, let’s see how the use of a payer-based PHR can optimize benefits and care for both the consumer (you) and clinician.

You call a new doctor’s office to make an appointment. When you arrive, you needn’t complete all the

forms about you, your health conditions, your medications and your insurance carrier and emergency contact; the office already has that information. By the time you arrive for your appointment, the staff has sent a standard eligibility verification request to your health plan. Along with the eligibility verification, the health plan sends a neatly formatted copy of your health résumé.

As a result, when the nurse checks your blood pressure and temperature, she is able to verify that the recently filled prescriptions on your health résumé are accurate; there’s no need for you to recollect the medication names and doses. With your health résumé at her fingertips, the nurse is better able to complete the initial interview with you about the reason for your visit. As the physician enters your examination room, he is leafing through your PHR, which was printed when your eligibility was confirmed, or he’s reviewing your record on his computer, quickly gleaned the diagnoses and treatments of other clinicians you’ve seen, as well as medications you’ve been prescribed. He sees that you’ve come with concerns about your right knee, and an X-ray of that knee last year at the ski resort provides a baseline of comparison for new diagnostic images. The physician asks his nurse to see if that image is electronically retrievable. Indeed, the ski resort clinic has an EMR that can e-mail the image to your doctor in a matter of minutes.

Seeing no severe knee injury on the prior image, the doctor examines you and suggests exercise and physical therapy, as well as a prescription to reduce the pain and inflammation around your knee. He comments that without that image from the ski resort clinic, he would have sent you for a CT scan or perhaps an arthroscopic procedure by an orthopedic surgeon. You confide that the time and expense of either would have been taxing. Later, at the instruction of the doctor, you make an appointment with a physical therapist who the doctor’s staff has already verified is within your approved network of providers. They also “clicked” the contact information for the physical therapist into your PHR. When you schedule the appointment with the physical therapist, the front desk tells you exactly how much you will owe for this service. Behind the scenes, your insurance company already had informed the imaging center of your financial responsibility when the physical therapist’s office checked your eligibility, based on a calculation that included your covered benefits (in this case, the number of physical therapy visits you are allowed) and your deductible status.

As part of your recovery and rehabilitation, the doctor requests that you log in to your health record and indicate your daily rehabilitation and exercise activities, which are based upon evidence-based protocols, for future review. At your follow-up visit, your physician scans your PHR and sees how well you have done, as will other doctors you visit subsequently. In other words, the PHR helps the doctor see, and you track, how well you are complying with the recommended course of treatment. This provides information that enables both value-based benefits and value-based reimbursement.

Moving Ahead Now

Now imagine that the systems that made all this happen so smoothly were available today at no additional cost to consumers or providers. That vision is not a dis-

tant reality. It can be, and is being, prepared and delivered in select regional markets through PHRs powered by health plan information. Is it the *perfect* answer? No. But it's a powerful start, and that's what is most important.

There are two final points to understand about payer-based PHRs. First, on a relative time-and-expense-basis, PHRs largely could be in place and adopted much sooner and for a fraction of the cost of EMRs and EHRs, at least for the more than 200 million people whose benefits are managed by private payers (and for fee-for-service Medicare beneficiaries as well). Second, the aggressive pursuit of PHRs will actually improve the usefulness and "interoperability" of EMRs and EHRs. This is so because the claims data in the payer-based PHR contains the date-of-service, the place (location) of service and the treating physician, as well as the diagnoses

and treatments, essentially creating the search engine parameters to track down and connect otherwise disparate data sources.

The time for the PHR is now. It presents a tremendous opportunity to improve health care dramatically in the near term, while the physician practice-based EHR and hospital-based EMR become more widely implemented. Advancing PHRs at this time in no way impedes those other record systems; rather, it helps all three models grow together toward fully integrated health care management—IHM—in the United States. The imperative heard often in Washington from everyone on up to President Barack Obama, says it all: "When it comes to addressing our health care challenge, we can no longer let the perfect be the enemy of the essential."