Transforming Health Care: The Role of Health
Navigating the Future: Sixth Annual South Dakota Health IT Summit
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BIPARTISAN POLICY CENTER

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About the Bipartisan Policy Center

Established in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole and George Mitchell
The only Washington, D.C.-based think tank that actively promotes bipartisanship
Works to address the key challenges facing the nation, including those related to democracy, economic policy, energy, housing, national security, and health care.
BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.
See www.bipartisanpolicy.org
Bipartisan Policy Center Health Innovation Initiative

Former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN) serve as co-chairs of BPC’ Health Project

What We Do: conduct research and collaborate with experts and stakeholders to develop recommendations that improve the cost, quality, and patient experience of care

Areas of Focus:

– Creating the information foundation for delivery system and payment reforms and population improvement strategies that promote higher quality, more cost-effective care

– Assuring patient safety in health IT, while preserving an environment that fosters the innovation for a rapidly changing health care system

– Advancing innovation through personalized and genomic medicine.

– Identifying and advancing innovative employer-driven strategies to improve health and wellness, and improve the quality and cost-effectiveness of care.
Current Challenges in the U.S. Health Care System
Rising Health Care Costs: 18 percent of GDP

Figure 2: U.S. National Health Expenditures as a Share of GDP, 1960-2021

Source: Centers for Medicare and Medicaid Services.
Rising Health Care Costs: Primary Driver of Debt

Chart 2. Health Care Costs are the Primary Driver of the Debt

Source: Congressional Budget Office’s Alternative Fiscal Scenario (February 2013), additionally assuming that combat troops overseas decline to 45,000 by 2015 and that Hurricane Sandy funding is not allocated in future years; Bipartisan Policy Center extrapolations
Average Health Care Spending per Capita, 1980–2009
Adjusted for differences in cost of living

Source: OECD Health Data 2011 (June 2011).
## Quality Indicators in Select OECD Countries, 2009

<table>
<thead>
<tr>
<th></th>
<th>Asthma mortality among ages 5 to 39 per 100,000 population</th>
<th>Diabetes lower extremity amputations per 100,000 population</th>
<th>In-hospital fatality rate within 30 days of admission per 100 patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Acute myocardial infarction</td>
</tr>
<tr>
<td>Australia</td>
<td>0.13</td>
<td>11.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Canada</td>
<td>0.17&lt;sup&gt;b&lt;/sup&gt;</td>
<td>9.5</td>
<td>3.9</td>
</tr>
<tr>
<td>Denmark</td>
<td>0.08</td>
<td>18.1</td>
<td>2.3</td>
</tr>
<tr>
<td>France</td>
<td>—</td>
<td>12.6&lt;sup&gt;b&lt;/sup&gt;</td>
<td>—</td>
</tr>
<tr>
<td>Germany</td>
<td>0.17&lt;sup&gt;b&lt;/sup&gt;</td>
<td>33.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Japan</td>
<td>—</td>
<td>—</td>
<td>9.7&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Netherlands</td>
<td>0.09&lt;sup&gt;a&lt;/sup&gt;</td>
<td>12.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>5.3&lt;sup&gt;b&lt;/sup&gt;</td>
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<tr>
<td>New Zealand</td>
<td>0.43&lt;sup&gt;b&lt;/sup&gt;</td>
<td>7.0</td>
<td>3.2</td>
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<tr>
<td>Norway</td>
<td>0.27</td>
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<td>2.6</td>
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<tr>
<td>Sweden</td>
<td>0.01&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>2.9&lt;sup&gt;b&lt;/sup&gt;</td>
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<td>Switzerland</td>
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<td>7.4&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.5&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>United Kingdom</td>
<td>0.27</td>
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<td>5.2</td>
</tr>
<tr>
<td>United States</td>
<td>0.40&lt;sup&gt;b&lt;/sup&gt;</td>
<td>32.9&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.3&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>OECD Median</strong></td>
<td><strong>0.09</strong></td>
<td><strong>9.9</strong></td>
<td><strong>4.6</strong></td>
</tr>
</tbody>
</table>

Note: Rates are age–sex standardized.
<sup>a</sup> 2008.
<sup>b</sup> 2007.
<sup>c</sup> Figures do not account for death that occurs outside of the hospital, possibly influencing the ranking for countries, such as the U.S., that have shorter lengths of stay.

Source: OECD Health Data 2011 (Nov. 2011).
Prevalence of Chronic Disease Among Americans

In 2000, 125 million Americans had one or more chronic conditions.

Between 2000 and 2030 the number of Americans with chronic conditions will increase by 37 percent, an increase of 46 million people.

People With Chronic Conditions Account for 84% of Spending

Source: Medical Expenditure Panel Survey, 2006

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U.S. Also Lags in Health and Wellness
Obesity (BMI > 30) Prevalence Among Adult Population, 2009

Approximately $147B in direct medical costs can be attributed to obesity alone


Source: OECD Health Data 2011 (June 2011)
*2008, **2007
Note: Body-mass index (BMI) estimates based on national health interview surveys (self-reported data) are usually significantly lower than estimates based on actual measurements.
## Strategies to Address Rising Costs (and Uneven Quality)

<table>
<thead>
<tr>
<th>Drivers of Higher Costs and Uneven Quality</th>
<th>Strategies to Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misaligned incentives in the current fee-for-service reimbursement system</td>
<td><strong>Realign health care delivery and payment incentives and systems</strong> to encourage greater accountability and coordination</td>
</tr>
<tr>
<td>Fragmentation in care delivery</td>
<td><strong>Promote systems that coordinate care delivery</strong> for all patients across different settings and effectively meet the needs of individuals with chronic and co-morbid conditions</td>
</tr>
<tr>
<td>Limited information and incentives for consumer decision-making</td>
<td>Improve consumer cost-sharing incentives and increase transparency of cost and quality of care to promote <strong>patient engagement</strong></td>
</tr>
<tr>
<td>Legal barriers to more cost-effective, coordinated care delivery</td>
<td><strong>Reform laws and regulations</strong> that impede care coordination and cost-effective care delivery</td>
</tr>
<tr>
<td>Increasing prevalence of chronic disease and comorbidities</td>
<td>Promote <strong>prevention</strong> and healthful lifestyles and <strong>wellness</strong> programs in the work place</td>
</tr>
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</table>

Common Attributes of High-Performing Organizations and New Models of Care
Bipartisan Policy Center Task Force on Delivery System Reform and Health IT
Led by BPC Health Project Co-Leaders and former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN) and comprised of leaders across every sector of health care
Informed by research and interviews with 40 high-performing organizations
Focus of Task Force and Report:
  – What are the common attributes of high performing organizations and new models of care?
  – What are the information needs and capabilities of these new models of care?
  – How do current investments align with those information needs and capabilities?
  – What actions are needed to close the gaps?
New Models of Care are Rapidly Emerging Across U.S.

Among Provider Organizations:
One study identified 227 provider organizations that had established ACO contracts with Medicare, Medicaid, private payers, or some combination thereof¹

Among Health Plans:
One study identified 30 accountable care arrangements within 22 health plans²

Among States:
A majority of states are now advancing medical home or other accountable/coordinated care arrangements³

Funding From Federal Government is a Catalyst

Center for Medicare and Medicaid Innovation:

Accountable Care
- Advanced Payment ACO Model Initiative
- Pioneer ACO Model Initiative
- Rural Community Hospital Demonstration

Bundled Payments for Care Improvement
- Retrospective Acute Care Hospital Stay Only Model
- Retrospective Acute and Post Acute Care Episode Model
- Retrospective Post Acute Care Only
- Prospective Acute Care Hospital Stay Only

Primary Care Transformation
- Comprehensive Primary Care Initiative
- FQHC Advanced Primary Care Initiative
- Independence at Home Demonstration
40 High-Performing Organizations Interviewed

Banner Health
Better Health Greater Cleveland, MetroHealth
Billings Clinic
Blue Cross Blue Shield of Massachusetts
Colorado Beacon Consortium, Quality Health Network,
Rocky Mountain Health Plans
Community Care Physicians
Dartmouth-Hitchcock Clinic
Dean
Denver Health
Eastern Maine Medical Center
Everett Clinic
Fallon Community Health Plan
Fairview Health Services
Geisinger Health System
Group Health Cooperative
Hampden County Physician Associates, Accountable Care Associates
HealthPartners
Indiana Health Information Exchange/Quality Health First Program

Inland Northwest Health Services (INHS)
Intermountain Health Care
Kaiser Permanente
Louisiana Health Care Quality Forum, Medical Home Initiative
Marshfield Clinic
Mayo Clinic
Memorial Sloan-Kettering Cancer Center
Monarch HealthCare
MyHealth Access Network, Greater Tulsa Beacon Community
New York-Presbyterian Hospitals
North Texas Specialty Physicians
Park Nicollet Health Services
Partners HealthCare
Seton Healthcare Family
Sharp HealthCare
Taconic IPA
Texas Health Resources
Greater Cincinnati Beacon Community, TriHealth
University of Michigan Faculty Group Practice and University of Michigan Health System
Vermont Blueprint for Health
Focus of Task Force and Report:

- What are the common attributes of high performing organizations and new models of care?
- What are the information needs and capabilities of these new models of care?
- How do current investments align with those information needs and capabilities?
- What actions are needed to close the gaps?
Attributes of High Performance in Health Care

1. Strong Organizational and Clinical Leadership
2. Access to Information to Support Efficient, Coordinated Care
3. Timely Access to Care
4. Emphasis on Prevention, Wellness and Healthy Behaviors
5. Accountability, Alignment of Incentives and Payment Reform
6. Organization-Wide Focus on the Needs of the Patient
First Attribute:  
Strong Organizational and Clinical Leadership

Leaders of high-performing organizations set goals purposefully and implement plans to achieve them

These leaders support the pursuit of clear, shared aims derived from the organization’s mission, vision and values

They promote a top-to-bottom organizational culture that focuses on the needs of the patient, values trust and respect, encourages learning and innovation, and adapts to change

Physician leaders serve as role models and play a key role in the development of interventions that improve care delivery
High performing organizations work hard to coordinate care across providers, settings, conditions and time

Multi-disciplinary teams communicate effectively and deliver integrated, collaborative care

Access to patient information from across a range of settings, along with clinical decision support tools, helps clinicians and care teams provide coordinated, patient-centered, evidence-based care

Patient access to their own health information helps them manage their health and participate in decision-making
Third Attribute: Timely Access to Care

High-performing organizations provide multiple avenues for patients to receive timely care.

Care and consultation are not limited to face-to-face visits.

Such organizations make it easy for patients to access care.
Fourth Attribute: Emphasis on Prevention, Wellness and Healthy Behaviors

High-performing organizations recognize that better health outcomes have as much to do with prevention as they do with delivering higher quality, more coordinated care.

Prevention activities:

- Health promotion activities that encourage healthy living and limit the initial onset of diseases
- Early detection efforts, such as screening at-risk populations, and
- Strategies for appropriate management of existing diseases and related complications
Fifth Attribute: Accountability, Alignment of Incentives, Payment Reform

High-performing organizations continuously measure their performance against clinical and cost metrics.

They take responsibility for populations of patients by accessing and analyzing data to:

- Identify gaps in care and opportunities for improvement
- Match resources to patients’ needs
- Create incentives that promote better outcomes instead of just higher volume
Patients are “at the center” of high-performing organizations

High-performing organizations recognize that more activated and engaged patients are associated with:

- Better health outcomes
- Lower costs
- Better patient experiences
The Role of Health IT in High-Performing Organizations and New Models of Care
Health IT Capabilities Needed for High Performance and New Models of Care

Focus of Task Force and Report:
- What are the common attributes of high performing organizations and new models of care?
- **What are the information needs and capabilities of these new models of care?**
- How do current investments align with those information needs and capabilities?
- What actions are needed to close the gaps?
Health IT Plays a Critical Foundational Role

Achieving the attributes of high-performance and new models of care is not possible without the strong information foundation that health IT provides.

The work in which you are engaged could not be more important.

You are laying the foundation for the future of health care.
# The Role of Health IT in High-Performing Organizations and New Models of Care

<table>
<thead>
<tr>
<th>Attributes of High Performance</th>
<th>Role of Health IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong Organizational and Clinical Leadership</td>
<td>1. Access to and analysis of clinical, administrative, community, and patient-generated data to set goals, monitor progress, and improve performance</td>
</tr>
<tr>
<td>Access to Information to Support Efficient, Coordinated Care</td>
<td>1. Electronic access—for all members of the care team—to clinical decision support and information about the patient from the multiple settings in which care and services are delivered</td>
</tr>
<tr>
<td>Timely Access to Care</td>
<td>1. Electronic, secure “email” communications between clinicians and patients</td>
</tr>
<tr>
<td></td>
<td>2. Virtual visits or online consultations</td>
</tr>
<tr>
<td></td>
<td>3. Online health care transactions</td>
</tr>
<tr>
<td>Emphasis on Prevention, Wellness and Healthy Behaviors</td>
<td>1. Online, electronic educational resources</td>
</tr>
<tr>
<td></td>
<td>2. Interactive tracking and self-management tools</td>
</tr>
<tr>
<td></td>
<td>3. Online communities</td>
</tr>
</tbody>
</table>
# The Role of Health IT in High-Performing Organizations and New Models of Care

<table>
<thead>
<tr>
<th>Attributes of High Performance</th>
<th>Role of Health IT</th>
</tr>
</thead>
</table>
| Accountability, Alignment of Incentives and Payment Reform | 1. Access to, analysis of, and presentation of reports which aggregate clinical, administrative, community, and patient-generated data to:  
Measure outcomes in cost, quality, and patient experience of care  
Identify gaps and duplications in care to support clinical decision-making  
Identify and predict areas requiring innovation and improvement |
| Organization-Wide Focus on the Needs of the Patient | 1. Patient-centric information to support care coordination  
2. Consumer access to information contained in their EHRs  
3. Education, engagement, and support of individuals through online, electronic, and mobile tools |
Key Issues that Must be Addressed to Create an Information Foundation for New Models of Care
Where are the Gaps Today? What Strategies are Needed to Address Them?

Focus of Task Force and Report:
- What are the common attributes of high performing organizations and new models of care?
- What are the information needs and capabilities of these new models of care?
- **How do current investments align with those information needs and capabilities?**
- What actions are needed to close the gaps?
Addressing Gaps: Information Foundation for High Performance and New Models of Care

1. Misaligned incentives
2. Limited levels of electronic health information sharing
3. Limited level of consumer engagement using electronic tools
4. Limited levels of EHR adoption in some sub-groups
5. Some concerns about privacy and security
6. Multiple federal priorities requiring focus and attention
Predominant method of payment in U.S. health care system today provides reimbursement for volume—or the number of visits, tests, or procedures performed, as opposed to rewarding outcomes or value
Addressing Misaligned Incentives

1. Accelerate the shift away from fee-for-service payment toward new, value-based payment models

2. One recommendation from BPC’s Report: A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment
   Improve upon the current accountable care organization (ACO) model
   – Stronger incentives for providers to participate
   – Providers share in both savings and excess cost growth
   – Better tools to engage patients in their care: patients given choice and incentives to enroll
   – Shared savings with beneficiaries
Levels of Adoption
- 30 percent of hospitals and 10% of ambulatory practices are participating in operational health information exchange efforts

Barriers to Adoption:
- Lack of a business case: predominant method of payment rewards volume over outcomes
- Lack of standards adoption and interoperability of systems
- Lack of access to or cost of infrastructure to support exchange
- Some concerns about privacy
- Some concerns about liability
## Stage 1 vs. Stage 2 Meaningful Use: Provider Requirements for Information Sharing

<table>
<thead>
<tr>
<th>Stage 1 Requirements</th>
<th>Stage 2 Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals and eligible professionals (EPs) are required to provide a summary of care</td>
<td>Hospitals and EPs are required to provide a summary of care record for more than 50 percent of</td>
</tr>
<tr>
<td>record for more than 50 percent of transitions of care or referrals (which need not</td>
<td>transitions of care or referrals (which need not be transmitted electronically)</td>
</tr>
<tr>
<td>be transmitted electronically)</td>
<td>Hospitals and EPs are required to electronically transmit a summary of care record for more than 10</td>
</tr>
<tr>
<td></td>
<td>percent of transitions of care and referrals.</td>
</tr>
<tr>
<td>Hospitals and EPs must also send at least one summary of care record electronically</td>
<td>Hospitals and EPs must also send at least one summary of care record electronically to a recipient that</td>
</tr>
<tr>
<td>to a recipient that uses a different EHR vendor or a CMS-designated test EHR</td>
<td>uses a different EHR vendor or a CMS-designated test EHR</td>
</tr>
<tr>
<td>Summary of care document has no required elements</td>
<td>Summary of care document must include the following:</td>
</tr>
<tr>
<td></td>
<td>Current problem list</td>
</tr>
<tr>
<td></td>
<td>Current medication list</td>
</tr>
<tr>
<td></td>
<td>Current medication allergy list</td>
</tr>
</tbody>
</table>
## Stage 1 vs. Stage 2 Meaningful Use: Certified EHR Requirements for Information Sharing

<table>
<thead>
<tr>
<th>Stage 1 Requirements</th>
<th>Stage 2 Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified EHR technology must be able to electronically receive, display, create, and transmit a summary record that includes the following:</td>
<td>Certified EHR technology must be able to receive, display, create, and transmit a summary of care record that includes the following:</td>
</tr>
<tr>
<td>Diagnostic test results*</td>
<td>Care plan fields</td>
</tr>
<tr>
<td>Medication allergies</td>
<td>Care team members</td>
</tr>
<tr>
<td>Medications*</td>
<td>Cognitive status (create and transmit only)</td>
</tr>
<tr>
<td>Problems*</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Procedures*</td>
<td>Discharge instructions (create and transmit only, inpatient setting only)</td>
</tr>
<tr>
<td></td>
<td>Encounter diagnoses* (create and transmit only)</td>
</tr>
<tr>
<td></td>
<td>Ethnicity*</td>
</tr>
<tr>
<td></td>
<td>Functional status (create and transmit only)</td>
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<tr>
<td></td>
<td>Immunizations* (create and transmit only)</td>
</tr>
<tr>
<td></td>
<td>Laboratory tests*</td>
</tr>
<tr>
<td></td>
<td>Laboratory test results</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Medication allergies</th>
<th>Medications*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name</td>
<td>Preferred Language*</td>
</tr>
<tr>
<td>Problems*</td>
<td>Procedures*</td>
</tr>
<tr>
<td>Race*</td>
<td>Reason for referral (create and transmit only, ambulatory only)</td>
</tr>
<tr>
<td>Referring or transitioning provider’s name and contact information (create and transmit, ambulatory only)</td>
<td>Sex</td>
</tr>
<tr>
<td>Smoking status*</td>
<td>Vital signs</td>
</tr>
</tbody>
</table>
Addressing Lack of Electronic Information Sharing

1. Align payment incentives with higher quality, more cost-effective care
2. Prioritize information sharing in payment policy: inside and outside of Meaningful Use
3. Gain agreement on strategy:
   - Develop a long-term data strategy for interoperability and standards that aligns with health and health care priorities
   - Gain agreement on a path forward for health information exchange
   - Gain agreement on and accelerate the execution of common methods for both directed exchange and query-based exchange
   - Build awareness of and understanding of federal strategy and programs
4. Clarify policies for information sharing
5. Improve accuracy of matching of patient data
Use of Electronic and Mobile Tools on the Rise for Every Aspect of American Life

The use of online, electronic, and mobile tools has revolutionized the way that Americans live, work and play

– 85% of adults use the Internet¹
– 91% of American adults have a cell phone, 56% have a smartphone, and 34% have a tablet computer¹,²

These tools can be leveraged to improve engagement of individuals in their health and health care

– Easy-to-access online, general educational resources
– Self-monitoring or tracking tools
– Online communities
– Electronic communications (e.g., secure email) between consumers and their clinicians

### Adoption of Electronic Tools Specifically for Health and Health Care is Increasing

<table>
<thead>
<tr>
<th>Electronic Tools to Support Engagement of Individuals</th>
<th>Rates of Adoption</th>
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<tbody>
<tr>
<td>Electronic educational resources</td>
<td>72% of internet users have looked online for health information</td>
</tr>
<tr>
<td></td>
<td>31% of cell phone owners, and 52% of smartphone owners have used their phone to look up health or medical information</td>
</tr>
<tr>
<td>Interactive electronic tools</td>
<td>69% of U.S. adults have tracked a health indicator like weight, diet, exercise routine, or symptom. Of those, 21 percent used some form of technology to track their health data</td>
</tr>
<tr>
<td>Online communities</td>
<td>Among online health information seekers, 16% have tried to find others who might share the same health concerns</td>
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</tbody>
</table>

### Adoption of Electronic Tools Specifically for Health and Health Care is Increasing

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</thead>
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<tr>
<td>Electronic communication between individuals and their clinicians</td>
<td>While 53% of patients believe that being able to email their doctors is important or very important, only 12% say that their doctors provide these capabilities.¹</td>
</tr>
<tr>
<td>Online care or telemedicine</td>
<td>45% of employers expect to see new access points for health care delivery, such as telemedicine, e-visits, and data-enabled kiosks.²</td>
</tr>
<tr>
<td></td>
<td>Increasingly, health plans are providing reimbursement for online care</td>
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</tbody>
</table>

¹ Harris Interactive. (September 10, 2012). *Patient choice an increasingly important factor in the age of the "healthcare consumer"*. New York: Harris Interactive.

Beyond Just Being the “Right Thing to Do”, There’s a Business Case for Patient Engagement

There is a growing body of evidence that shows that patients who are more activated and engaged in their care have better health care outcomes and experiences. There is also some evidence that indicates that more activated or engaged patients are associated with lower health care costs.
Barriers to Adoption of Consumer e-Health Tools

For Individuals
- Lack of awareness about the availability of tools
- Limited or no Internet access
- Concerns about usability and benefit
- Lack of computer skills
- Low health literacy
- Unmet technical- or information-support needs
- Concerns about the privacy and security of their online health information
- Lack of provider adoption

For Providers
- Concerns about privacy and security
- Concerns about receiving an unmanageable number of messages from patients and the impact on workflow
- Lack of reimbursement for time spent
Addressing Low Levels of Consumer Engagement

1. Build awareness of availability and benefits among consumers
2. Educate providers on the benefits and support them in making the transition
3. Continue to improve usefulness and usability of such tools
4. Develop and disseminate best practices
5. Raise awareness of the “business case” and further align federal, state and private sector incentives with engagement of consumers
EHR Adoption Rates

**EHR Adoption Rates: At Least a Basic System**

- Adoption of at least a basic EHR system among office-based physicians increased from 17 percent in 2008 to 40 percent in 2012.
- The share of hospitals that have adopted at least a basic EHR system increased from 9 percent in 2008 to 44 percent in 2012.

**Differences in Subgroups**

- Primary care physicians are more likely to adopt EHRs than non-primary care specialists.
- Physicians in small practices are less likely to adopt than those who deliver care in larger practices.
- Small, non-teaching, and rural hospitals tend to adopt EHRs more slowly than other hospitals.
### Medicare and Medicaid EHR Incentive Programs are a Catalyst

<table>
<thead>
<tr>
<th>Types of Providers</th>
<th># Paid Incentives Through August 31, 2013</th>
<th>$ Amounts Paid Through August 31, 2013</th>
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<tbody>
<tr>
<td>Eligible Professionals</td>
<td>316,143</td>
<td>$6.5 billion</td>
</tr>
<tr>
<td>Hospitals</td>
<td>4,098</td>
<td>$9.7 billion</td>
</tr>
<tr>
<td>Total</td>
<td>320,241</td>
<td>$16.2 billion</td>
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</table>
Addressing Low Levels of EHR Adoption

1. Expand the business case for EHR adoption and electronic information sharing
2. Build awareness and expand implementation assistance for EHR adoption and meaningful use, particularly among small physician practices and rural and community hospitals
3. Address needs of those not eligible for Meaningful Use incentives, including home care and long-term care providers and behavioral health care providers
4. Evaluate and leverage lessons from federally-funded programs to advance progress
5. Accelerate sharing of strategies and best practices for more challenging components of meaningful use
6. Improve usability of EHRs
Addressing Continued Concerns about Privacy and Security

1. Issue comprehensive and clear guidance
2. Require consistent protections for personal health information
3. Improve ability to accurately match/link patient data
4. Disseminate “common sense” security practices
1. Align and coordinate IT requirements across federal programs
2. Align federal health IT programs with the needs of new models of care
3. Align clinical quality measurement activities within the federal government and across the public and private sectors
4. Further alignment between clinical quality measures and methods for electronic capture and reporting
A Strong Professional Workforce is Needed to Support Health System Transformation

Changes in the incidence and prevalence of disease in U.S. population
Changes in the clinical delivery of care reflecting personalized medicine
Changes in the structure and organization of delivery systems—alignment of physicians and hospitals in clinically integrated systems which adopt new models of care
Changes in payments and incentives
Changes in consumer expectations; greater consumer access to information
Increased use of electronic health records, electronic information sharing, “big data”, and analytics
Changes in education, licensing and regulatory oversight of health professionals, as liability, error reporting, outcomes and cost information become more transparent

Nearly a fifth of all U.S. spending is devoted to health care. Despite such high spending, the quality of health care is uneven; often wasteful, uncoordinated, and inefficient. U.S. health care should be value-driven and coordinated, rather than volume-driven and fragmented. Innovations in both health care delivery and payment, which promote accountability, coordination, competition, and patient choice, are needed to reduce costs and improve quality in the U.S. health care system.

Such innovations cannot be accomplished without a strong information foundation, which health IT can provide. These changes will require public and private sector collaboration and leadership. We must act now, to begin the transformation to a higher quality, more sustainable, health care system.
Thank You!

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