

Personal Health Records—Barriers and Benefits, Real and Imagined



KAISER PERMANENTE
HEALTH+CONNECT™

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Andrew M. Wiesenthal, MD, SM

Associate Executive Director, The Permanente Federation

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- **Kaiser Permanente (KP) is the "bi-directionally exclusive" partnership of the Kaiser Foundation Health Plan and Hospitals and the Permanente Medical Groups**

- **Kaiser Permanente is**
 - 8.3 million members (6.3 million in California)
 - 140,000 employees
 - 12,000 physicians
 - 30 hospitals, 431 medical offices
 - Operations in 9 states and D.C.
 - Annual operating revenue of \$27 billion

- **Kaiser Foundation Health Plan and Hospitals**
 - Single, national, not-for-profit entity with operations in in 9 states and the District of Columbia
 - Develops insurance products
 - Prices, markets, and enrolls members
 - Operates facilities, employs majority of staff except physicians

- **Eight Permanente Medical Groups – one in each KP region**
 - Self-governing, integrated, multi-specialty group practices
 - Range in size from 250 (Ohio) to 5300 (Northern California) physicians from all medical specialties and subspecialties

In the KP Context, What is a PHR?

- We are in the middle of a multiyear deployment of an electronic health record (ambulatory, and inpatient where applicable) and practice management system
- From the clinician perspective, capabilities to be deployed in 2005-6 include review of problem lists, lab results, drug profiles, immunizations, care plans and physician instructions, member addenda to their record, and secure messaging
- From the member perspective, kp.org currently allows them to schedule appointments, refill prescriptions, request advice, access a health encyclopedia, and do many other things. Over the next few years, members will gain web-based automated access to much of the information within that electronic health record
- From the perspective of health plan administration, members will be able to conduct a variety of benefits management and financial transactions via kp.org. These capabilities are not ordinarily part of a PHR, but they represent important conveniences for our members
- The KP PHR will be “tethered”—in an integrated delivery system such as KP, it is integral to the entire patient record, not a free-standing entity. Other aspects of our software will enable members to move data to other health care entities should they desire, but the PHR itself is not freely moveable

- **There are no important barriers any longer to the adoption of a PHR within my organization, so my thinking represents educated speculation on the state of affairs outside of fully integrated multi-specialty group practices like the Permanente Medical Groups**
- **The PHR will never be a substitute for true integration of the delivery system**
 - Some people will take the time and make the effort to aggregate information from all of their caregivers, but most will not
 - If all caregivers in a locale do not participate in a local health information collaboration that feeds a PHR, then no one will have confidence in the completeness of the PHR
 - Even if caregivers do participate broadly, it is important that they be encouraged to use PHRs to improve the care they deliver. Such encouragement could come from pay-for-performance incentives under consideration in public health financing programs such as Medicare and Medicaid

Barriers to PHR Adoption from a Physician Perspective

- **Vital information that physicians need to contribute to a PHR is still not digitized**
 - Problem list
 - Patient instructions/plans of care
 - In-office testing
- **No technical or business infrastructure exists to provide for the routine maintenance of physician-contributed information**
 - What liability is associated with the persistence of outdated information?
 - If a physician posted information to a PHR that was accurate at the time but is no longer accurate, can they be held accountable for any harm to the patient that arises because someone else relied on that inaccurate data?
 - The rules for what goes into the PHR, what form the information takes, and who should have access to it must be consistent across all physicians
- **Is there an economic basis for the contribution of FFS physicians?**
 - Contributing data to a PHR and maintaining it should be part of a pay-for-performance incentive policy directed at improving the quality of care
- **When these barriers are addressed, physicians see value**
 - They believe that quality of care will improve when a full set of information is available to both patients and other care givers whenever care is being rendered
 - Proper reimbursement for the activity will assure that they allocate the appropriate time and resources to it

- **Digitization**
 - Short term solutions include adapting practice management data for routine inclusion into PHRs
 - Standard vocabularies for diagnosis, procedures, orderables, and plans must be used by these often-proprietary systems
 - Long term solution is the widespread adoption of an electronic health record that routinely feeds and maintains standardized data in a PHR
 - Physicians should be responsible for maintaining timely, accurate data in PHRs, but they cannot be held accountable until the software tools to do so routinely are widely available
- **Most physicians cannot build this infrastructure themselves**
 - They have neither the expertise nor the capital
 - Reimbursement must include increment for system acquisition and maintenance for all physicians who demonstrate quality improvement using the system
 - Hospitals and other “conveners” will need to host PHR databases within LHIs
 - Physicians may need reimbursement for the time and effort required to feed data to PHRs, again, directed at paying for improved quality

- **Patients can have routine access to information they need to take care of themselves**
- **The physician and their office staff are relieved of the unwanted responsibility of being information brokers in situations where they add no additional value to that information**
- **A well-designed PHR will have decision support tailored to the requirements of each specific patient, not just passively transfer data or boilerplate information**
 - People will contact their physician when the physician can add value to their decision making—“my peak flow has dropped below the lower level we agreed on, I’ve used my inhaler twice in the last 30 minutes, according to your instructions, and I’ve shown no improvement. What should I do next?”