



Overcoming Barriers to Electronic Health Record Adoption

**Results of Survey and Roundtable
Discussions Conducted by the
Healthcare Financial Management Association**



hfma
healthcare financial management association

© Copyright 2006
Healthcare Financial Management Association

For more information about this project, visit www.hfma.org/EHR.pdf
or contact Janice Wiitala, director of research and development, HFMA, jwiitala@hfma.org.

Contents

Overcoming Barriers to Electronic Health Record Adoption

Results of Survey and Roundtable Discussions Conducted by the Healthcare Financial Management Association

Key Findings	2
1. Introduction	3
2. How Are Hospitals Progressing in EHR Adoption?	5
3. What Are the Top Barriers?	6
4. What Are the Solutions?	7
<i>Standards and Interoperability</i>	7
Expectations for government	7
Hospital strategies	8
<i>Funding and Incentives</i>	10
Expectations for government	10
Hospital strategies	10
<i>Physician Acceptance</i>	11
Expectations for government	11
Hospital strategies	11
5. What's Best for Patients?	12
HFMA Statement on the Government's Role in Encouraging EHR Adoption	13

Key Findings

Where Are Hospitals Now in EHR Adoption?

Hospitals have a long road ahead to adoption of electronic health records. The EHR functions in which the greatest number of hospitals reported significant progress are:

- Order entry (38 percent)
- Results management (27 percent)
- Electronic health information/data capture (23 percent)
- Administrative processes (23 percent)

By comparison, relatively few hospitals reported significant progress in clinical decision support (13 percent), health outcomes reporting (13 percent), and patient access (2 percent). Larger hospitals were further along in EHR adoption than were mid-sized or small hospitals, and nonrural hospitals were slightly further along than were rural hospitals.

According to survey respondents, the most significant barriers to EHR adoption are:

- Lack of national information standards and code sets (62 percent)
- Lack of available funding (59 percent)
- Concern about physician usage (51 percent)
- Lack of interoperability (50 percent)

Only 28 percent of respondents cited insufficient financial return as a significant barrier.

Funding and ROI were greater concerns for hospitals indicating a low level of EHR adoption than for those indicating a higher level. Mid-sized hospitals were more concerned about funding as a barrier than were either large or small hospitals. Funding was a more significant barrier for rural hospitals.

Expectations for Government

The key desired actions of government are to:

- Facilitate development of national standards and code sets (57 percent cited as an “extreme” expectation; 22 percent cited as a “high” expectation)
- Provide grant funding (45 percent extreme; 35 percent high)
- Provide payment incentives (38 percent extreme; 32 percent high)
- Simplify the Medicare payment system (37 percent extreme; 26 percent high)
- Accelerate investment in regional networks (26 percent extreme; 37 percent high)

Survey findings, amplified by roundtable discussions with healthcare financial executives, indicate that hospitals are determined to implement EHR systems, but that government action in the areas of standard-setting and financial support would significantly speed adoption.

Hospital Strategies

Among the leading strategies of hospitals are to:

- Participate in formative or existing regional information networks
- Participate with vendors to explore connectivity and financing solutions
- Collaborate with other healthcare organizations to control costs
- Identify physician champions
- Start by providing physicians with electronic access to information that they most need to receive

1. Introduction

Electronic health record systems hold the promise to address the two most crucial challenges to the U.S. healthcare system: controlling costs and improving quality. Rising healthcare costs—now up to 16 percent of the nation’s GDP—create palpable hardship for patients, employers, and providers. At the same time, evidence such as the findings of the Institute of Medicine reports *Crossing the Quality Chasm* and *To Err Is Human* suggests that the quality of the nation’s health care is far less consistent or effective than providers and patients have a right to expect.

While no one believes a panacea exists for the ills of the U.S. healthcare system, EHR systems are a promising means to control costs and improve quality. “Reengineering the wobbly parts of this dysfunctional

system cannot be accomplished without a vitally important new tool: computerized physician support, including a comprehensive, automated medical record,” wrote George C. Halvorson, chairman and CEO of Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals, in the March 2005 issue of *hfm* (“Healthcare Tipping Points,” pp. 74-80). The federal government shares this view, and in April 2004, President Bush issued an executive order establishing the position of the National Health Information Technology Coordinator in the U.S. Department of Health and Human Services, charged with leading “nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care” within 10 years.

What Is an Electronic Health Record?

Ideally, a universal EHR will be a seamless patient record that crosses the continuum of care. The U.S. Department of Health and Human Services provides this definition: “An electronic health record is a digital collection of a patient’s medical history and could include items like diagnosed medical conditions, prescribed medications, vital signs, immunizations, lab results, and personnel characteristics like age and weight.” (“Secretary Leavitt Takes New Steps to Advance Health IT National Collaboration and RFPs Will Pave the Way for Interoperability.” HHS news release, June 6, 2005.)

In its survey, HFMA identified the following functions of EHRs (based on those identified by the Institute of Medicine in 2003):

- *Order entry/order management.* Clinical test, consults, and medication order entry are managed electronically.
- *Results management.* Physicians are able to access all information on patient care delivered at the hospital or health system.

- *Electronic health information/ data capture.*

All patient health records are contained in a computerized repository.

- *Administrative processes.* Scheduling, resource management, billing, and other administrative systems are interoperable.
- *Electronic connectivity.* There is fully effective electronic exchange of clinical data among the healthcare team and other care partners.
- *Clinical decision support.* Enhanced clinical performance is achieved through computerized tools (e.g., computer-assisted diagnosis and disease management.)
- *Health outcomes reporting.* The system can automatically extract information for quality indicator reporting.
- *Patient access.* Patients have remote access to their individual records.

The promises of EHRs are many: fewer adverse drug events, lower morbidity and mortality rates, seamless continuity of care, greater efficiencies, and lower costs. Unfortunately, the barriers are as formidable as the promises are alluring. Historically, hospitals have spent relatively small amounts on IT, and the proportion of paper in health care dwarfs the amount in other industries, so they do not have a strong foundation on which to build. EHR systems carry price tags high enough to make a CFO toss and turn, especially because high costs and inadequate payment have left many hospitals with a reduced ability to expend the capital necessary for routine maintenance, much less expensive technology. And EHR systems require a significant amount of change in clinical and administrative processes—and change has never been a core competency in health care.

“How are we ever going to get there from here?” asked David Brailer, MD, PhD, the person appointed to the position of National Health Information Technology Coordinator to spearhead the Bush administration’s drive toward national EHR adoption. “It’s a feat of culture, professionalism, and finance more than it is anything about technology.”

HFMA President and CEO Richard L. Clarke, DHA, FHFMA, noted, “Hospitals are doggedly determined to implement these systems as part of the mission of their organizations to improve quality and safety for their patients.”

National EHR adoption is “a feat of culture, professionalism, and finance.”

HFMA Involvement in Financial Aspects of IT

For many years, the Healthcare Financial Management Association has been delivering expert opinion on how to assess and realize the value of IT for the benefit of hospital operations and patient care. In 2004, HFMA’s *Financing the Future* project featured research showing that the three most commonly cited future capital projects all focused on technology: digital radiology systems, computerized physician order entry systems, and other major IT.* Further, *Financing the Future* research showed that hospitals planned to increase their capital spending by an average of 15 percent per year over the five years following the date of the findings, compared with average annual increases in capital spending of just 1 percent over the preceding five year—one indication of a capital crunch related to technology investment.

Later in 2004, HFMA held a CFO summit on EHRs, which yielded the paper *Making the Business Case for Electronic Health Records*. In 2005, David Brailer was a keynote speaker at HFMA’s Annual National Institute and began discussions with HFMA about collaborating to learn from healthcare finance professionals about the financial barriers to implementing EHR systems and how the government can help overcome those barriers.

As a result, in January 2006, HFMA conducted a survey of senior healthcare finance executives at hospitals and health systems of various sizes and regions to identify how healthcare financial executives view the barriers to EHR adoption and the actions government can take to encourage adoption. The survey yielded 176 responses.

In addition to the survey, HFMA, in collaboration with Brailer, met with 15 healthcare finance executives from across the country to identify ways that hospitals and the government can address some of the formidable challenges that stand in the way of a universal EHR.

* The *Financing the Future* project was a collaboration between HFMA and GE Healthcare Financial Services with research conducted by HFMA and PricewaterhouseCoopers.

2. How Are Hospitals Progressing in EHR Adoption?

Healthcare organizations have come a long way in EHR adoption, but they have an even longer way to go (see Exhibit 1). In none of the EHR functions did a majority of hospitals report making “significant progress.” The functions in which the greatest numbers of hospitals reported significant progress were order entry (38 percent), results management (27 percent), electronic health information/data capture (23 percent),

and administrative processes (23 percent). Relatively few hospitals reported significant progress in clinical decision support (13 percent), health outcomes reporting (13 percent), and patient access (2 percent).

Larger hospitals were further along in EHR adoption than were mid-sized or small hospitals, and nonrural hospitals were slightly further along than were rural hospitals. (See Exhibits 2 and 3.)

Exhibit 1

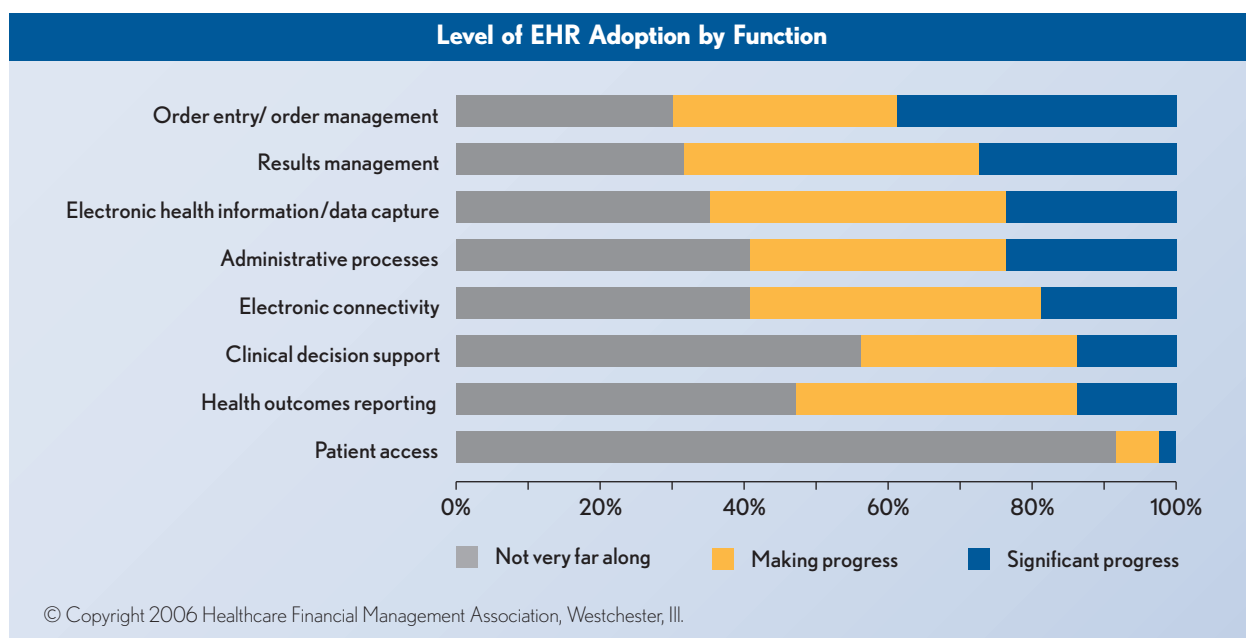


Exhibit 2

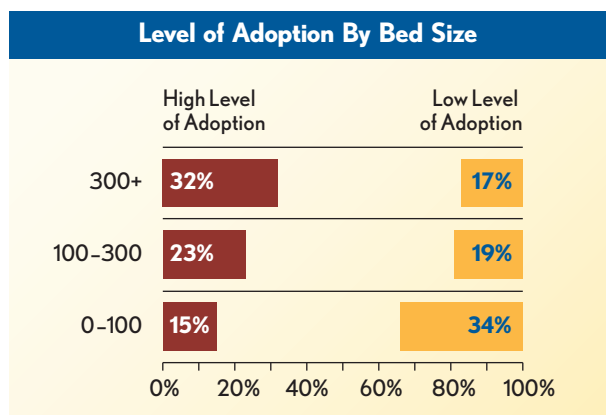
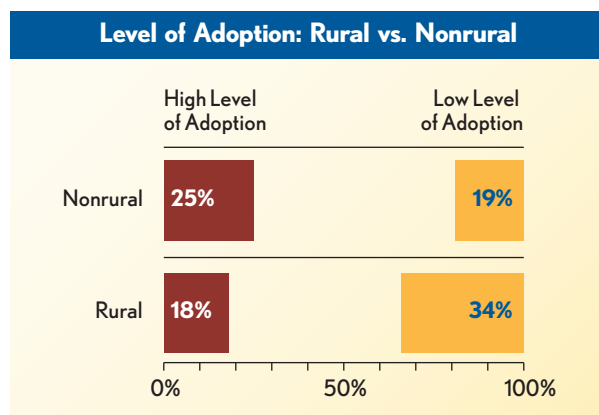


Exhibit 3



3. What Are the Top Barriers?

Perhaps not surprisingly, survey respondents and roundtable participants focused on issues of standardization, funding, and acceptance. The survey results showed the following as the most significant barriers (see Exhibit 4):

- Lack of national information standards and code sets (62 percent)
- Lack of available funding (59 percent)
- Concern about physician usage (51 percent)
- Lack of interoperability (50 percent)

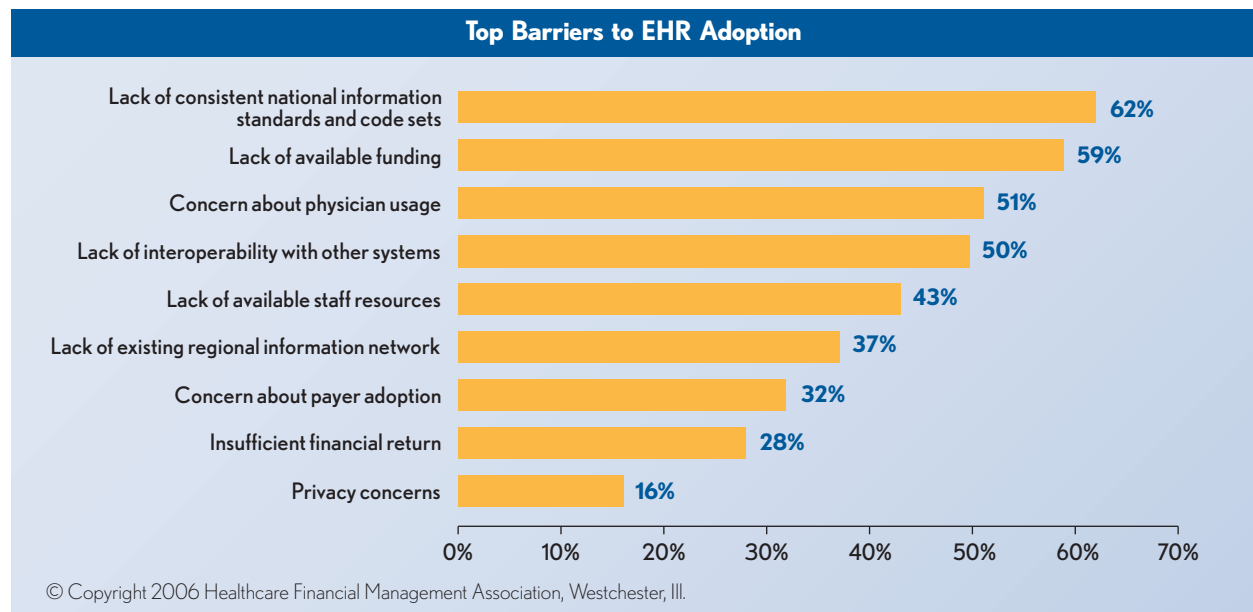
Surprisingly (for a group of financial executives), only 28 percent cited insufficient financial return as a significant barrier, suggesting a faith in the promise of EHRs and a determination to implement them that transcends traditional financial thresholds.

The significance of the barriers varied depending on the stage in EHR adoption and other site-specific factors. Predictably, funding was a greater concern (64 percent) for hospitals indicating a low level of adoption, but of less concern (44 percent) for those

Only 28 percent of those surveyed cited insufficient financial return as a significant barrier.

further along in adoption. Financial return was a greater concern (38 percent) for hospitals indicating a low level of adoption, but of less concern (19 percent) for those further along in adoption. Mid-sized hospital financial leaders were more concerned about funding as a barrier to adoption than were either large hospital or small hospital leaders. Funding was a less significant concern for nonrural hospitals than for rural hospitals.

Exhibit 4



4. What Are the Solutions?

Government has an important role to play in fostering EHR adoption, according to both HFMA survey respondents and roundtable participants. The following sections outline expectations for government involvement, as well as hospital-focused strategies, for the key concerns of standardization, funding, and physician acceptance.

Standards and Interoperability

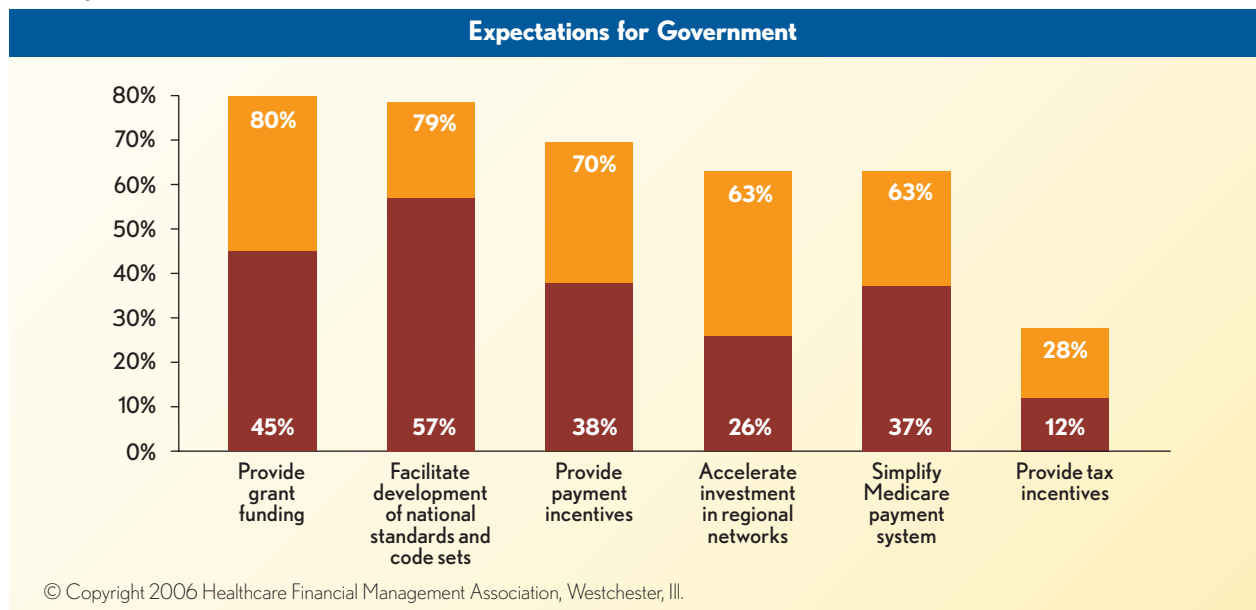
More than 60 percent of respondents to the HFMA survey were worried about the lack of consistent standards and code sets—in other words, the informational architecture that would facilitate the sharing of patient information among providers, payers, and others. The federal government foresees a national health information network consisting of regional health information organizations that freely exchange information. But the architecture to realize this national vision is uncertain, according to roundtable participants.

Also missing is a solution for identifying and tracking patients in a regional or national database. Privacy concerns make using social security numbers problematic. Solutions being discussed include an algorithm-like approach like that used by credit bureaus when consumers inquire about their credit history. A patient would answer several questions to verify his or her identity.

Expectations for Government

HFMA survey respondents' highest-ranked expectation for government facilitation of EHR adoption was to create standards and code sets, cited by 57 percent as an "extreme" expectation, and by 22 percent as a "high" expectation (see Exhibit 5). Healthcare financial executives also expressed the hope that the government will require private payers to adhere to any national IT standards that are developed. But healthcare executives are understandably wary of federal intervention in

Exhibit 5



standards setting, especially after HIPAA has caused so many compliance problems.

“As the largest purchaser of health care, the government should have some input [into standards setting],” notes one survey respondent. “But providers need to drive the design, implementation, and adoption of the system.”

Hospital Strategies

It is, of course, too early to see how the federal plans will play out. Rather than sitting on the sidelines, many hospitals and health systems are going forward with efforts to collaborate with other local providers to share data.

Winona Health Services, a small community hospital in Winona, Minn., shares an electronic record and database with three local physician offices/clinics. “To get that done in a small setting like ours, we went with integrated systems, not interfaces,” says Michael Allen, FHFMA, CPA, vice president and CFO. “We don’t have

separate lab systems and radiology systems; we have one integrated system.

As a result, Winona’s referring physicians can now access hospital information about their patients. “You could have a patient who went to two local clinics and our emergency room, and all that information would be available to the physician,” says Allen.

Another collaborative effort is under way in Kalispell, Mont. It began when there was a shortage of local radiologists in the rural communities, and the rural facilities approached KRMC and the local radiologists in Kalispell for their services utilizing a picture archiving communication system. “The rural hospitals used to have to wait up to seven days for radiology reports. Now, our radiologists get a voice clip in two hours and a written report in ten hours,” says Candy Deruchia, director of computer information services at Northwest Healthcare.

Providers around Kalispell have also collaborated to improve the electronic exchange of information among regional hospitals and physician offices. A purchased

The Government’s Approach to EHR Adoption

The Bush administration is emphasizing public-private collaboration to encourage EHR adoption. Last year, HHS chartered a commission of public and private experts—called the American Health Information Community—to recommend a market-based approach for making health records digital and interoperable. HHS has also awarded contracts to private, not-for-profit groups to begin creating four of the stepping stones needed for a national patient record (*see Exhibit 6*).

Data standards. The American National Standards Institute is developing a process for harmonizing the data standards that will be used to exchange health information across the United States.

Certification of EHR products. The Certification Commission for Health Information Technology is creating a process for certifying EHR products. To become certified, IT vendors will need to meet criteria related to functionality, interoperability, security, and reliability. HHS has put this on the

fast track: Certified ambulatory EHR products are scheduled to be on the market by June 2006. Criteria for inpatient EHR products are also in the works.

Architecture for the NHIN. Four health IT organizations (Accenture, Computer Science Corporation, IBM, and Northrop Grumman) have developed consortiums with healthcare providers to develop an architecture and a prototype network for information sharing among hospitals, laboratories, pharmacies, and physicians. These four consortiums will work together to ensure that information can move seamlessly among the four networks to be developed. The consortiums are scheduled to have prototypes completed by fall 2006.

Privacy and security issues. RTI International is overseeing a multidisciplinary team called the Health Information Security and Privacy Collaboration. The team’s goal: to address the variances in privacy policies and laws that prevent the sharing of information.

enterprise medical record and physician practice IT solutions allow for tracking of patient encounters through out various facilities, electronic signatures, tracking of reports and lab and radiology orders and results, and other tasks to be completed electronically between the acute inpatient and outpatient arenas.

Next on the agenda: Kalispell providers are hoping to hook up other disparate IT systems in their region, such as those used for home health and long-term care. A regional health information network is in the plans, as well as a master patient index that will help providers track patient information across the continuum of care.

Without nationally sanctioned data standards, healthcare providers that want to build a regional information network must adopt one of the existing data standards available in the marketplace. For example, Oregon Health and Sciences University in Portland has adopted, to the extent possible, the standard used by the vendor that supports Portland's Oregon Computerized Health Information Network and the

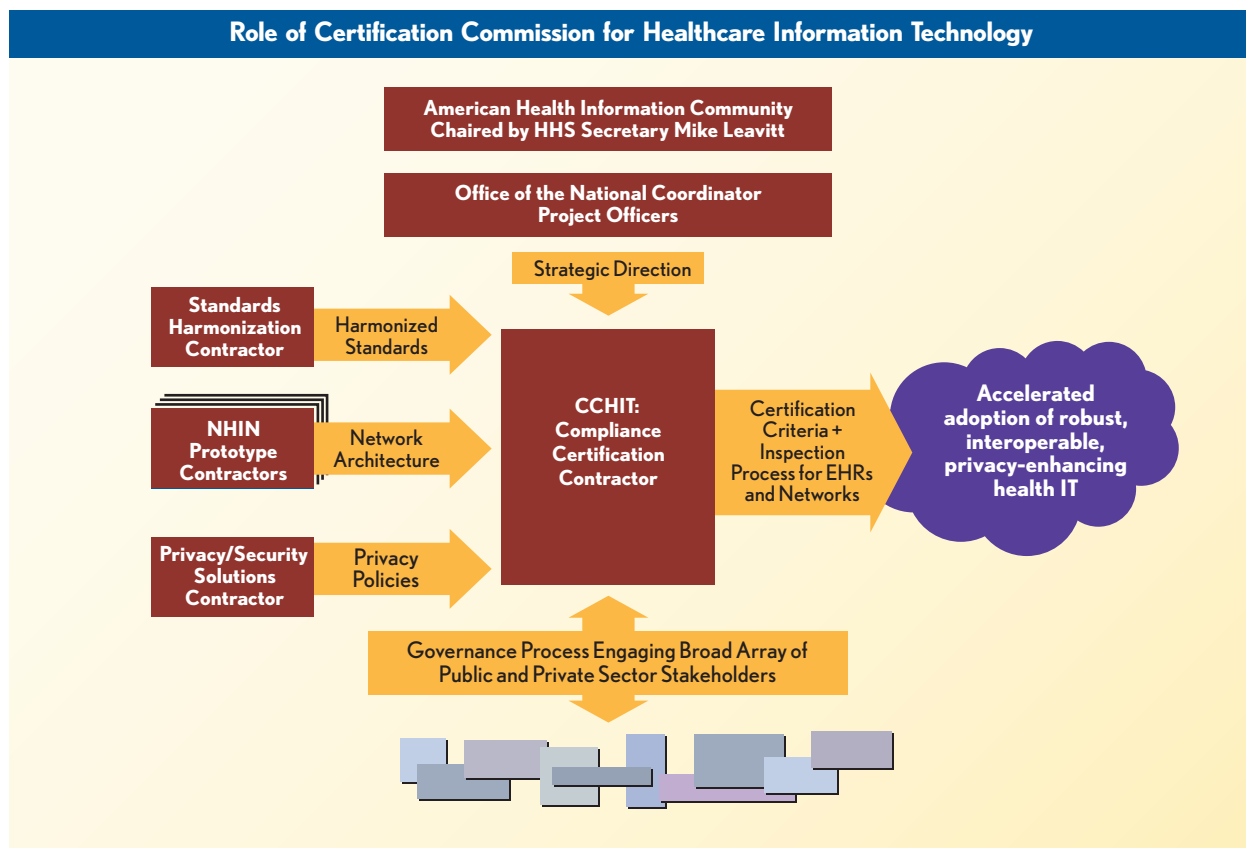
Kaiser Permanente Network, which is a large referrer of patients to OHSU. Now, many of the providers hooking up to that network are also adopting that standard.

"This has helped things in terms of interoperability," says Bradley N. King, CPA, vice president and CFO at OHSU. Eleven months into implementation, OHSU is electronically connected with about 400 referring physicians, and within several months, OHSU expects to be connected with about 800 physicians and 70 practice sites.

Patient identifiers are also being created at a regional level. For example, Massachusetts is hoping to create a master patient identifier that can be used to track patients. Current plans involve identifying patients by a series of personal facts.

"Surveys show that the federal government is the last entity that the American people want touching their identity," Brailer told roundtable participants. "That's why we're pushing for regional projects to keep doing this."

Exhibit 6



Source: Department of Health and Human Services.

Funding and Incentives

A 2005 RAND analysis predicted that implementation of a nationwide EHR network would cost more than \$100 billion over 15 years—\$6.5 billion per year for hospitals and \$1.1 billion annually for physicians (*Extrapolating Evidence of Health Information Technology Savings and Costs*). A study sponsored by the Commonwealth Fund and the Harvard Interfaculty Program for Health Systems Improvement, published in the August 2005 *Annals of Internal Medicine*, estimates that \$156 billion in capital investment will be necessary over five years along with \$48 billion in annual operating costs.

Hardware and software costs are only part of the equation. Providers also have to pay implementation costs and systems maintenance. There are also significant costs related to lost time and revenue. Yet it is possible to demonstrate a positive ROI with implementation of such a system, says OHSU's Bradley King, with major savings occurring in transcription, coding, and medical records filing costs.

Wall Street is starting to question whether hospitals are making major investments in IT. But Moody's and other bond examiners want to see that these investments are leading to a clinical transformation that will bring improved quality and lower costs. In other words, if hospitals don't make it work, they might see their future ability to garner capital dissolve.

"I think a lot of us will get there in terms of building our respective electronic medical records," says Michael P. Freed, CPA, executive vice president, corporate resources, and CFO, Spectrum Health, Grand Rapids, Mich. "But we're trying not to waste a lot of time and effort getting down a path, spending a lot of money, and finding out that that was not a path that was going to take us where we want to go."

HFMA research shows that financial leaders from mid-sized hospitals are more concerned about EHR funding than are financial leaders from large and small hospitals. Small, independent hospitals that don't have the financial pockets of a large hospital system also face major funding challenges. But paying for this behemoth is, obviously, a concern for everyone.

What should government do? Many say allocate funding for EHR development.

Expectations for government. Many healthcare executives surveyed expect the federal government to allocate funding for EHR development. Some executives saw a role for grant funding. Some also thought that tax incentives would help. Another favorable idea: provide financial incentives for investing in IT in the form of provider payments through Medicare and Medicaid. Private payers might follow suit once they saw the federal government offering such incentives.

The federal government can also help hospitals by easing regulatory barriers. For instance, simplifying the Medicare payment system could help hospitals lower their administrative costs, freeing up monies that can be used for IT investments.

HFMA's survey showed the following expectations for government related to funding and creating financial incentives for EHR adoption:

- Provide grant funding (45 percent extreme; 35 percent high)
- Provide payment incentives (38 percent extreme; 32 percent high)
- Simplify Medicare payment system (37 percent extreme; 26 percent high)
- Accelerate investment in regional networks (26 percent extreme; 37 percent high)

Hospital strategies. Some larger hospitals are finding ways to finance the equipment and software-related costs of an EHR. However, almost 70 percent of health executives surveyed plan to use cash from operations as their primary funding source. So keeping costs down is a priority.

Working with a single vendor can help, says Guy Alton, FHFMA, CPA, CFO at St. Bernard Hospital in Chicago. “We decided to look for one vendor who could basically take care of everything. We’ve tried very hard not to stray from that. It reduces our overhead. The systems, the modules all talk to each other, and we’re not having to maintain interfaces on our own.” St. Bernard has also saved about \$250,000 by building some of its hardware internally.

In Montana, Kalispell providers are finding that collaboration can bring costs savings. “A driving force in our collaboration has been dollars,” says Northwest Healthcare’s Candy Deruchia. “To do these things independently would be much more costly than if we collaborate and purchase together or share common information.”

Some roundtable participants expressed an interest in creating state loan pools for small providers who are having trouble financing an EHR. These pools might provide low-cost funding for IT with less stringent financial requirements than private lenders typically offer.

Gary Vogan, FHFMA, CPA, senior vice president and CFO, Holy Cross Hospital, Silver Spring, Md., emphasizes that it is important that management communicate effectively to the board why this investment is necessary. “Quality and safety are the big drivers,” he says. “And relatively close to that is efficiency.” For Vogan’s organization, an EHR will help distinguish the organization as a high-quality provider, and will eliminate significant expense associated with “shuffling paper back and forth.”

Physician Acceptance

“Our version of a computerized physician order entry system is a physician handing an order to somebody next to him saying, ‘You do it, because it’s taking too long for me to sit there and do it myself,’” says Spectrum Health’s Michael Freed. “The struggle we’ve run into is getting physicians to actually operationalize this because of concerns about their own productivity.”

Time, after all, is money to the independent physician. These same physicians are also being asked to lay out immense sums of money to computerize their own practices in anticipation of an EHR.

“I actually had a physician group tell me they’re waiting for the Yahoo version,” says Freed. “They’re a small business, and they’re saying, ‘This is a huge expenditure per doctor. How do I know a web-based version won’t suddenly come out of nowhere and cost next to nothing.’ So a lot of physicians hold back and say, ‘I’m waiting till the last possible moment on this.’”

Many hospitals are considering covering some or all of the costs of digitally connecting physician offices. “When you look more closely at availability of technical resources, it would be the hospitals that would be in the best position to transition this kind of technology to community physicians; however, regulatory approvals and funding incentives would need to be established to enable hospitals to successfully accomplish this EHR technology transfer,” says William Lammers, CPA, senior vice president, finance, and CFO, Sisters of St. Francis Health Services, Mishawaka, Ind.

But many gun-shy hospital lawyers are putting the brakes on these physician-hospital partnerships, out of fears of violating the Stark/anti-kickback laws. Hospitals and physicians can be penalized if physicians refer Medicare or Medicaid patients to a hospital with which they have a financial relationship.

Expectations for government. Hospital executives want clear guidelines from the federal government on how to provide computer support to physicians without violating the Stark/anti-kickback laws. At the HFMA roundtable, Brailer said discussions about this are well under way in Washington.

Once, again, the federal government should also be a leader in the development of positive payment incentives that encourage physicians to acquire and implement EHR systems.

Hospital strategies. Winona Health Services has found a way to not implicate the Stark/anti-kickback laws and is providing computer solutions to its physician offices. The hospital was able to set up a per-physician licensing deal through its IT partner. “It pretty much represents a monthly cost-per-physician for each

clinic,” says Winona’s Michael Allen. This agreement has worked pretty well. The physician offices could find enough value in the deal to pay the fee.”

But getting IT into the hands of physicians is only half the battle. How can hospitals get physicians to use it? Several executives who participated in the roundtable cited the importance of a physician champions who push their colleagues to adopt the technology.

Setting the stage for a successful physician roll out is also important for a successful clinical transformation. For example, before introducing computerized physician order entry, Adventist Health System in Winter Park, Fla, has asked its physician leaders to build the content of the system—the clinical guidelines and prompts—based on evidence-based medicine. “So when we do

get to a CPOE, it can be something that creates value for the doctor,” says Brent Snyder, FHFMA, senior vice president.

United Regional Health Care System in Wichita Falls, Texas, is trying a similar approach. “We’re trying to create a recognition for change among physicians,” says Phyllis Cowling, FHFMA, CPA, the system’s president and CEO, and past Chairman of HFMA. Hospital staff are presenting physicians with performance data that demonstrate the need to understand and improve clinical and operational processes.

Another way to create physician converts: providing electronic access to information that physicians would like to receive more rapidly. Many hospitals are starting with lab results.

5. What’s Best for Patients?

Despite the significant barriers, HFMA is finding dogged determination among hospital financial executives to invest in and implement EHRs. “The goal is to stay patient-centered,” says Deruchia. “What do you ultimately want for your community? As long as you stay patient-centered, you can make good decisions off of that philosophy, knowing that there are going to be drawbacks and pros and cons.”

There’s a long road ahead toward universal connectivity. But healthcare executives also need to take credit for how far the healthcare system has come in a short amount of time. “We’re all moving very rapidly when you realize that we are trying to change 100 years of paper in five years or so,” says Freed. “In our organization, just trying to get into the game of interoperability and CPOE was a mega-process unto itself. There’s all this sausage-making that no one is seeing unless they’re sitting in the kitchen like we are.”

HFMA Statement on the Government's Role in Encouraging EHR Adoption

Point 1. HFMA believes that universal implementation of EHRs will produce a profound societal return—improving care and reducing costs. The societal return of EHRs develops from enhanced quality and patient safety through improved continuity of care and clinical decision making, reduced clerical and administrative costs, and more effective use of health services.

Point 2. HFMA believes that government has a key role in facilitating the universal adoption of EHR systems. Government's role should be to:

- Work with the private sector to create a broad-based national vision of what these interoperable systems should accomplish, and define the standards, characteristics, and attributes of the components needed to achieve that vision
- Encourage development of innovative financing mechanisms—such as tax incentives, grants, and others—and provide relief from regulatory barriers
- Lead, as the major payer for healthcare services, in the development of positive payment incentives for providers to acquire and implement these systems, and to ensure private payers do likewise

Point 3. HFMA believes the true societal benefits of EHRs occur only through universal adoption. Organizations and physicians with limited access to capital must be able to avail themselves of these systems. HFMA will bring together thought leaders in capital finance to identify innovative solutions and facilitate the use of these solutions.

Point 4. HFMA believes the current system of paying for healthcare services is dysfunctional. Public and private payment systems are rife with deficiencies such as conflicting incentives, overly complex payment rules and techniques, and lack of standardized approaches, which inhibit effective use of technological solutions and drain resources away from patient care and necessary investments such as EHRs. Government, employers, payers, and providers must work together to find mutually beneficial solutions to these problems through a commitment to administrative simplification.

Overcoming Barriers to Electronic Health Record Adoption



hfma

healthcare financial management association

The Healthcare Financial Management Association is the nation's leading membership organization for more than 34,000 healthcare financial management leaders employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant. HFMA offers educational and professional development opportunities; information on key issues affecting healthcare financial managers; resources such as technical data, checklists, and research reports; and networking opportunities—all of which provide our members with the practical tools and ideas they need to ensure career and organizational successes. For more information, visit HFMA's web site at www.hfma.org.

For more information on this project, visit www.hfma.org/EHR.