developing an interface *once* and then encouraging its replication at all applicable sites. These interfaces can cost anywhere from $5,000 to $150,000 a piece depending on the systems involved and the transactions to be supported. A fund should be designated, either earmarked by the General Assembly or carved out of VITL's operating or contract revenues, of no less than $500,000 per year to support this work. It is common for interfaces to need periodic adjustments to stay in operation, so some funds may need to be allocated for this maintenance.

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VITL can be seen as part of a "safety net" for those provider sites that are either too small or too remotely located to warrant investment in HIT/HIE on their own. VITL will provide leadership to help ensure over time that all relevant stakeholders can participate in the HIEN since everyone benefits from universal participation.

10.3.2 Funding for Physician EHR System Deployment

One widely-cited study estimates that "initial EHR costs were approximately $44,000 per FTE provider per year and ongoing costs were about $8,500 per FTE provider per year" and that revenue losses from reduced patient visits during training and implementation averaged $7,473 per FTE provider.[97] Further, studies show use of EHR systems is directly related to the size of the practice. Compared with solo practices, practices with 10 to 19 physicians were more than twice as likely to use EHR systems, and practices with 20 or more physicians were three times as likely to use them.[98]

In order to help address the barriers to EHR system adoption, Act 70 of the 2007 session of the Vermont General Assembly (H.229) establishes an Interim Technology Fund to finance pilot ... ary care practices serving low- and ... ing $1 million, and asks for voluntary ... vity, while leaving somewhat open- ... eviously, a recent study indicates that ... he provider – the remainder goes ... e automated record handling.[99] This savings should serve as a foundation for contributions by payers in this project.

See next page, which is the Executive Summary of this "widely-cited study." You'll note that only ONE bullet from the list --- the cost of an initial EHR, and a figure about revenue loss, are quoted from that study. The HIT Plan does NOT quote the other key findings (see next page) which include $17,000 in increased revenue and ***a 2 1/2 year return on investment.***

The project has several specific purposes, including:

- Improve the adoption rate by providers of certified EHR systems,[100] especially by those providers least likely to adopt systems on their own;
- Encourage the acceptance of EHR systems by patients as part of a larger education campaign surrounding the benefits of health information technology to their overall health and quality of care;
- Lower some of the most difficult barriers to adoption (see Section 4.2.3), especially cost and perceived risk;
- Position Vermont to be able to better test interoperability between provider sites, especially sites which would otherwise not be able to participate but represent an important venue for care and an important source for health records. These pilots allow Vermont to understand the assumptions and implications of these activities before committing to more full-scale implementations.

The process would work like this:

- Use a structured evaluation process to identify two or three EHR systems that comply

Solo and Small Group Physician Practices Can Reap Benefits from Electronic Health Records, But Face Challenges

September 14, 2005

New York City, September 12, 2005 - Two Commonwealth Fund-supported studies in the September/October issue of *Health Affairs* examine the potential benefits and challenges for solo and small-group physician practices in adopting electronic health records (EHRs), and highlight the greater difficulties smaller practices face in implementing health information technology (HIT), compared with larger health care institutions.

In "The Value of Electronic Health Records in Solo or Small Group Practices," lead author Robert H. Miller of the Institute for Health and Aging at the University of California, San Francisco and colleagues detail findings from case studies of fourteen solo and small group practices in twelve states. Highlights of their findings include:

- Small physician practices on average recoup the cost of investing in electronic health records in two-and-a-half years.
- Start-up costs average $44,000 per physician (or nurse practitioner); annual maintenance costs average $8,400 per physician per year.
- More than half of the financial benefits of implementing electronic health records for small physician practices come from improved billing for services, which increases physician practice revenues by $17,000 per physician per year
- Efficiency savings and gains from greater physician productivity averaged $15,800 per physician per year.

Challenges included difficulty in obtaining adequate training and changing practice processes to adapt to EHR capabilities, pointing to the need for better technical and practice redesign support services. Further, despite the fact that electronic health records are viewed by policymakers as an important investment to improve quality of care, the study found limited use of EHR quality-improving

capabilities that remind physicians and patients of needed chronic or preventive care services, or that show physicians how well they're doing in providing quality care. This points to the need for pay-for-performance incentives for quality improvement.

"With almost three-quarters of physicians in solo or small-group practice settings, it is critical to recognize not only the financial barriers, but the greater need for technical assistance in implementing electronic health records, compared with physicians in larger health care settings with existing support systems," said Anne-Marie Audet, M.D., vice president at The Commonwealth Fund. "Health care leaders and policymakers must also address the significant difficulties physicians in solo or smaller practice settings face in using electronic health records to improve quality. We cannot forget that the primary purpose of these new technologies is to improve quality of care for patients."

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