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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.

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. 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.

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 projects for providing EHR systems to small, independent primary care practices serving low- and moderate-income Vermonters. The legislation sets a goal of raising \$1 million, and asks for voluntary contributions from payers, hospitals, and others to fund this activity, while leaving somewhat open-ended the long-term funding for this project. As mentioned previously, a recent study indicates that only 11% of savings from EHR system deployment accrue to the provider – the remainder goes to the payers through a reduction in unnecessary tests and more automated record handling. This savings should serve as a foundation for contributions by payers in this project.

The project has several specific purposes, including:

- Improve the adoption rate by providers of certified EHR systems, 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

99 See Lohr, Steve, "Risks and Rewards: Who Pays for Efficiency?" New York Times, June 11, 2007 < http://www.nytimes.com/pages/business/businessspecial3/index.html >

The "foundation for contributions by payers in this project" is a study mentioned in an interview in the New York Times?

Moreover, this directly contradicts "Bending the Curve," the study used to quantify the "savings," which says that the savings for the first ten years do NOT go to private payers.

The process would work like this:

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

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