Costs of an Electronic Medical Record

Healthcare policymakers have pressured hospitals to adopt electronic medical records (EMR) (Ginn, Shen, & Mosely, 2011). The Bush administration, by executive order, established the position of National Coordinator for Health Information Technology in the Department of Health and Human Services to help launch the broad implementation of health information technology. Later, in the Obama administration, Congress passed the American Recovery and Reinvestment Act of 2009, which set a goal of near-universal application of EMR's by the end of 2014 and provided $19.2 billion for health information technology (Ginn et al., 2011). As a result, hospitals and physician offices are dealing with intense pressure to implement health information technology systems in order to have certified EMRs that fulfill the federal government's definition of meaningful use and therefore avoid substantial financial penalties (Ginn et al., 2011).

Even with intense pressure and claims of significant financial benefits only a small percentage of hospitals have adopted this technology so far (Ginn et al., 2011). The most frequent reported obstacle is financial. The capital requirements are substantial, the positive effect on return of investment is unclear, maintenance costs are high, and the increase in budget for information technology staff is daunting (Ginn et al., 2011). Hospitals in healthier financial shape have the resources to finance the implementation of the EMR. Larger hospitals with a high acuity case mix would benefit more than a smaller hospital with lower acuities and less complex patients (Ginn et al., 2011). According to Ginn et al., (2011) smaller hospitals may not benefit clinically, operationally, or financially from adopting EMRs. For these smaller hospitals, the capital outlay needed to adopt an EMR may actually degrade financial outcomes.

There are also unintended consequences for hospitals implementing EMR's. In January, 2012 the University of Mississippi Medical Center (UMC) laid off 115 employees and did not fill another 90 positions (Shaw, 2012). According to Shaw (2012) UMC's finances were in the red for 2011; one reason for the layoffs. Additionally, the hospital cited the fact they must spend $80 million over the next five years to establish EMRs to comply with a federal mandate. UMC may get much of the money back from the government if the system is implemented by 2016. However, getting most of the money back in four years is not much comfort to the facilities running in the red currently (Shaw, 2012). They are not the only facility laying off workers due in part to the financial costs of the EMR; the Nassau University Medical Center in New York also laid off workers. They are citing not only the EMR but concerns regarding reduced Medicare reimbursement going forward. It seems financial outlays for a computerized EMR is replacing some needed human staff in these hospitals.

Financial issues concerned EMRs, including adoption and implementation costs, ongoing maintenance costs, loss of revenue associated with temporary loss of productivity, and declines in revenue, are not strictly hospital concerns, they are also physician concerns (Menachemi & Collum, 2011). Even though costs have come down as the technology becomes more commonplace, the financial costs can be tremendous for a physician office. Acccording to Manachemi and Collum (2011), research estimates hardware, software, services, and telecommunication costs range from $14,000 to $32,409 per physician in the initial year of implementation, depending on the size of the practice. In addition, maintenance costs can be expensive. Hardware must be replaced and software upgraded on a regular basis. Providers must have ongoing training and

support for the end uses of an EMR. Menachemi & Collum (2011) state research shows ongoing maintenance costs after the first year of implementation range from $8,412 to $17,100 per provider. Physicians often site the costs of adoption and ongoing maintenance and licensing as the largest barrier to EMR implementation (Menachemi & Collum, 2011).

Another disadvantage of the EMR is disruption of workflow for staff and providers, which results in a temporary loss of productivity. This loss of productivity may come from end users learning the new system and could lead to loss of revenue (Menachemi & Collum, 2011). Again, larger physician practices would be able to finance the EMR implementation easier than small or solo practices.

The government is forcing the use and implementation of the EMR with monetary incentives. Physicians and hospitals should be able to choose whether the EMR is a financially sound system for their particular situation.

References

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