An Institute of Medicine report estimated that between 44,000 and 98,000 people die each year as a result of medical errors. It is argued that the number of errors could be significantly reduced if healthcare moved from the current paper-based medical record system to an electronic health record system. President George W. Bush has set a goal of implementing electronic health records within the next ten years. In order to reach this goal, President Bush established the Office of the National Coordinator for Health Information Technology under the Department of Health and Human Services which was given the task of implementing electronic health records for the federal government and providing incentives for private sector adoption. In addition to this executive action, there has been legislative action to require electronic health records for the federal government and give incentives for private sector adoption. Finally, there are several private sector entities which have arisen to help with the adoption of electronic health records. Although there are many benefits to electronic health record adoption, there are several legal and organizational barriers to reaching that goal. Interwoven throughout all of these issues is the need for privacy and security. Electronic health records will contain very sensitive patient data, and it is important that this data is protected.

I. BACKGROUND

Many transactions in today’s society are completed electronically, and most records are stored in an electronic form. As a result, information is easier and less costly to access. However, most healthcare records are still kept in paper form, especially in rural or underserved areas. Arguably, keeping health records in paper form is...
costly in terms of lives, money, and efficiency.\(^2\) In addition, there are several public health benefits to adopting electronic health records ("EHR").\(^3\)

One reason to move from paper records to electronic records is to save lives. In 1998, the Institute of Medicine initiated the Quality of Health Care in America project.\(^4\) The goal of the project is to increase the quality of care in the United States in the next ten years.\(^5\) The Institute of Medicine reported that in two studies conducted in 1984 and 1992, between 2.9% and 3.7% of hospital admissions resulted in an adverse event.\(^6\) Furthermore, between 53% and 58% of those adverse events were preventable.\(^7\) Extrapolated to 33.6 million hospital admissions, it is calculated that between “44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of

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\(^3\) See NEWT GINGRICH, SAVING LIVES & SAVING MONEY: TRANSFORMING HEALTH AND HEALTHCARE 34 (2003).

\(^4\) COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, TO ERR IS HUMAN 5 (Linda T. Kohn et al. eds., 2000).

\(^5\) Id.

\(^6\) Id. at 26 (an adverse event is “defined as injuries caused by medical management”).

\(^7\) Id. A preventable adverse event is the result of some error. An error is either “the failure of a planned action to be completed as intended […] or the use of a wrong plan to achieve an aim […]” Id. at 28 (emphasis omitted).
medical errors." Implementing EHRs could significantly decrease the number of preventable adverse events.

The cost of preventable adverse events is not only large in terms of the number of lives lost due to medical errors, but also the money spent to correct mistakes in those patients that survive. The Institute of Medicine estimates that the national cost of preventable adverse events is between $17 billion and $29 billion annually. Use of EHRs would reduce the number of errors and therefore reduce the cost.

It is also argued that it is inefficient to maintain the current paper-based system. For example, interoperable EHRs would prevent a physician from ordering the same test twice if another physician previously ordered the test. The economic benefit of this is clear; the patient or insurance company would only have to pay for one test.

In addition, there are public health benefits. First, EHRs would assist researchers by providing information that could be used to develop new healthcare technologies. Second, EHRs would allow for faster notification of public health threats, such as a disease outbreak or a bioterrorist event. Finally, EHRs would allow for the move from rewarding healthcare providers for volume-based healthcare to a

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8 Id. at 26. Although these numbers are relied on heavily in support of HIT and more specifically EHRs, it is important to note that these numbers are only extrapolations of a limited study. There is some debate as to the validity of these numbers. See Clement J. McDonald et al., Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report, 284 JAMA 93 (2000). But see Lucian L. Leape, Institute of Medicine Medical Error Figures Are Not Exaggerated, 284 JAMA 95 (2000).

9 See Gingrich, supra note 3, at 59, 116-18.

10 Committee on Quality of Health Care in America, supra note 4, at 27 (total national costs include lost income, lost household production, disability, and healthcare costs directly and indirectly resulting from the error).

11 This article will use the term electronic health record ("EHR") as this is the current term of art. The older term was electronic medical record ("EMR") or electronic patient record ("EPR"). An EHR is distinguishable from a personal health record ("PHR") discussed infra section VI.

12 See Gingrich, supra note 3, at 116-17, 230-31 (the Mayo Clinic in Jacksonville, Florida moved from paper records to EHRs and recognized an annual savings of between $2.8 and $7.1 million).

13 Id. at 34, 286-89.
pay-for-performance healthcare system, where healthcare providers are rewarded for providing quality healthcare.14

In response to these justifications, President Bush has set a goal of adopting EHRs within the next ten years.15 To reach this goal, the Office of the National Coordinator for Health Information Technology (“ONC”) was established under the Secretary of Health and Human Services (“HHS”). There has also been legislative action; both houses of Congress have developed bills to achieve EHR adoption.

Although the arguments for adopting EHRs are strong, there are several barriers to EHR adoption. These barriers can be divided into two categories: legal barriers and organizational barriers. The legal barriers include privacy, security, physician anti-kickback laws, antitrust laws, intellectual property rights, and medical professional liability. The organizational barriers are compatibility issues, the legacy of failed implementations, and financial burdens.

II. EXECUTIVE ACTION

In his 2004 State of the Union address, President Bush acknowledged the need for digital medical records.16 President Bush has set a goal of creating EHRs for most Americans within the next ten years.17 The purpose of establishing EHRs is to make the healthcare system more cost effective by reducing duplicative overhead costs in the current system and by improving healthcare


17 The White House, supra note 15.
quality. On April 27, 2004, President Bush promulgated Executive Order 13,335, which established the ONC. ONC was established under the Secretary of HHS and is given the task of “developing a nationwide interoperable health information technology infrastructure.” On May 6, 2004, David J. Brailer was named the first National Coordinator by HHS Secretary Tommy Thompson. Section 4 of Executive Order 13,335 required that within 90 days of the executive order, the Secretary of HHS must provide a report to the President of the ways to “promote the adoption of interoperable health information technology.” This section also required reports from the Director of the Office of Personal Management (“OPM”), the Secretary of Veterans Affairs, and the Secretary of Defense. These reports were compiled by ONC and produced on July 21, 2004. The report builds upon a report by Connecting for Health which “details specific actions the public and private sectors can take to accelerate the adoption of information technology in health care.”26 The ONC


20 Id. at 24,059.


22 Exec. Order No. 13,335, supra note 19, at 24,060.

23 Id. (The section required that the Director of OPM should give a report on how to adopt health information technology (“HIT”) in the Federal Employee Health Benefit Program; the Secretary of Veterans Affairs and the Secretary of Defense should give a report on how they can work with the private sector to make their “health information systems available as an affordable option for providers in rural and medically underserved communities.”).

24 NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY, supra note 14, at iv.


26 NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY, supra note 14, at iv (citing CONNECTING FOR HEALTH, ACHIEVING ELECTRONIC CONNECTIVITY IN HEALTHCARE: A PRELIMINARY ROADMAP FROM THE NATION’S PUBLIC AND PRIVATE SECTOR HEALTHCARE
A report creates four goals for improving healthcare through health information technology ("HIT"): (1) inform clinical practice (bringing EHRs into clinical practice); (2) interconnect clinicians (making EHRs interoperable among clinicians); (3) personalize care (putting the patient in control of personal healthcare decisions); and (4) improve population health (collecting and reporting data to improve healthcare).27

On November 15, 2004, ONC published a Request for Information ("RFI").28 The RFI requested comments from the public concerning the adoption of interoperable EHRs. The RFI contained twenty-four questions which ranged from the definition of the National Health Information Network ("NHIN") to implementation of NHIN. The responses were collected by ONC, and a report summarizing the responses was published on June 3, 2005.29

On June 6, 2005, HHS Secretary Mike Leavitt announced the creation of the American Health Information Community ("AHIC"), a public-private collaboration that provides guidance to HHS on the adoption of interoperable EHRs.30 Specifically, AHIC is charged with five tasks: (1) make recommendations on privacy and security, (2) prioritize health information technologies which will provide the greatest benefit to consumers, (3) make recommendations on a standards and certifications process, (4) make recommendations on a nationwide architecture, and (5) make recommendations on a private-

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27 NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY, supra note 14, at 9.
sector organization which will succeed AHIC. AHIC has a maximum of eighteen voting members with each member having a two-year term. Initially, AHIC will be chaired by HHS Secretary Leavitt and will have sixteen other members from both the public and private sectors. 

Also on June 6, 2005, HHS released four Request for Proposals (“RFP”). These RFP’s are: (1) a Standards Harmonization Process; (2) a Compliance Certification Process; (3) a Privacy and Security Assessment; and (4) a NHIN Demonstration. Three RFP contracts were awarded on October 6, 2005. The fourth was awarded on November 10, 2005.

The Standards Harmonization Process RFP was awarded to the American National Standards Institute, which will create the Health Information Technology Standards Panel (“HITSP”). HITSP will develop standards that will create “interoperability among health care software applications, particularly EHRs.”


32 UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, supra note 31, at 3.


38 Press Release, Contracts to Advance Nationwide Interoperable HIT, supra note 35.

39 Id.
The second RFP was for Compliance Certification. There are many EHR products on the market; however, there is no way to identify which products are interoperable and will work in a national system. This creates a great risk in investment for a healthcare provider. The provider may invest in an EHR product and later discover the product is not interoperable. Therefore, the provider would have to invest in another product in order to join the nationwide network. To reduce this risk, the Certification Commission for Healthcare Information Technology (“CCHIT”)\(^\text{40}\) was awarded a contract through the RFP process to develop criteria for EHR certification and an evaluation process for evaluating and certifying EHR products.\(^\text{41}\)

The third RFP, Privacy and Security Solutions, was awarded to RTI International.\(^\text{42}\) RTI will create the Health Information Security and Privacy Collaboration (“HISPC”), “a multidisciplinary team of experts ranging from privacy and security law and health care management, as well as the National Governors Association.”\(^\text{43}\) Differences in privacy and security business practices and laws present a barrier to interoperability. HISPC will address those variances and


\(^{41}\) The Certification Commission for Healthcare Information Technology (“CCHIT”): Certification Handbook (May 1, 2006), available at http://www.cchit.org/files/certification%20process%20narrative.pdf (CCHIT and AHIC will develop “use cases” which will create the standards of functionality to certify software. A “use case” is “a laymen and a clinical description of a patient care encounter or episode in a step-by-step form, a description of EHR and interoperability functions needed to support each step.”).


create recommendations on how to deal with laws and business practices that create a barrier to interoperability.\textsuperscript{44} The fourth RFP, to develop a prototype of a NHIN, was awarded to four different consortia led by: Accenture\textsuperscript{45}, Computer Science Corporation (“CSC”),\textsuperscript{46} International Business Machines (“IBM”),\textsuperscript{47} and Northrop Grumman.\textsuperscript{48} Each consortium will develop a network prototype that will share healthcare information among three healthcare providers within the same region.\textsuperscript{49} The four consortia will also work together to make their four networks interoperable. The Accenture collaboration will work with the Eastern Kentucky Regional Health Community, CareSpark,\textsuperscript{50} and the West Virginia eHealth Initiative.\textsuperscript{51} The CSC consortium will connect the Indiana Health Information Exchange,\textsuperscript{52} MA-SHARE,\textsuperscript{53} and the Mendocino

\begin{footnotesize}
\begin{enumerate}
\item Press Release, RTI International to Support National HISPC, \textit{supra} note 43.
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HRE in California. IBM will work with Taconic Health Information Network and Community\(^{54}\) and the North Carolina Healthcare Information and Communications Alliance.\(^{55}\) Northrop Grumman will connect Santa Cruz RHIO, HealthBridge,\(^{56}\) and University Hospitals Health System.\(^{57}\)

### III. LEGISLATIVE ACTION

In response to mounting political pressures for adopting health information technology (“HIT”) in the healthcare industry, several legislative measures have been introduced.\(^{58}\) This article will focus on the Wired for Health Care Quality Act\(^{59}\) (“WHCQA”), which was passed by the Senate on November 18, 2005. Under WHCQA, Congress codifies certain executive actions, establishes standards for HIT, creates incentives for private sector adoption, creates a demonstration program to integrate HIT into medical professional

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\(^{56}\) HealthBridge, http://www.healthbridge.org/ (last visited Mar. 3, 2006) (HealthBridge is a collaborative network of health care providers serving the greater Cincinnati healthcare community).


curricula, mandates healthcare quality reporting, reports on the
variation between the states on medical professional certification, and
ensures the privacy and security of HIT.60

A. LEGISLATIVE ADOPTION OF EXECUTIVE ACTION

WHCQA first codifies the Office of the National Coordinator and
the American Health Information Collaborative.61 The bill would add
Section 2902 to the Public Health Service Act62 which legislatively
establishes the ONC under the Secretary of HHS.63 The ONC is
charged with coordinating among relevant federal agencies and private
entities the development of “a nationwide health information
technology infrastructure.”64

WHCQA also codifies the American Health Information
Community established by HHS Secretary Leavitt.65 The name would
be changed to the American Health Information Collaborative
(“Collaborative”). The operation of the Collaborative would be
similar to AHIC. The Committee Report states that “the Collaborative
[would] serve the dual purpose of recommending standards for the
electronic exchange of health information . . . and recommending
uniform national policies facilitating the widespread adoption of
interoperable health information.”66 The Collaborative would
recommend standards to the Secretary of HHS.67 The Secretary of

60 Id.

61 See supra Part II (the Office of the National Coordinator currently exists through executive
order).


63 S. 1418, 109th Cong. § 2.

64 Id. For a description of the current American Health Information Community (“AHIC”),
see supra Part II.

65 See supra Part II.

bin/useftp.cgi?IPaddress=162.140.64.21&filename=sr111.109&directory=/diskb/wais/data/10
9_cong_reports.

67 S. 1418, 109th Cong. § 2.
HHS could then provide for adoption of the standards by the federal government.68 Once adopted, federal agencies could only purchase HIT systems in compliance with the standards.69 Although the Secretary of HHS adopts mandatory standards for the federal government, they are voluntary for private entities.70 Members of the Collaborative are chosen by the Secretary of HHS from the public and private sectors.71 Members are chosen for two year terms.

Finally, WHCQA creates a Health Information Technology Resource Center (“Center”) under the Agency for Healthcare Research and Quality (“AHRQ”).73 The purpose of the Center is to provide technical assistance in the adoption of HIT as well as developing effective methods for adopting, implementing, and effectively using HIT.74 Already existing under AHRQ is the National Resource Center for Health Information Technology, which is intended to “advance[] the use of health IT . . . and stimulate investment in health IT.”75 WHCQA allows the Secretary of HHS to modify the currently existing

68 Id. at § 2 (Subsection 2903(e) is added to the Public Health Services Act (“PHSA”) to provide procedures for federal action. Additionally, the adoption of standards by the Secretary of HHS is discussed in greater detail in subsection 2903(b)).

69 Id. (§ 2903(f)(1)).

70 Id. at § 2 (subsection 2903(h) is added to PHSA to address voluntary adoption).

71 Id. at § 2 (subsection 2903(b) is added to address the composition of the American Health Information Collaborative). The bill as reported out of committee required that the committee be chaired by the Secretary of HHS and comprised of the National Coordinator, the Secretaries of Defense, Veterans Affairs and Commerce, and other members chosen by the Secretary of HHS. An amendment on the Senate floor replaced the entire text of the bill, and therefore, the value of the committee report is questionable. See 151 Cong. Rec. S13247 (daily ed. Nov. 17, 2005) (proposed amendment by Sen. Frist).

72 Id. at § 2 (subsection 2903(b)(3) is added to address the term length for members of the Collaborative).

73 S. 1418, 109th Cong. § 3 (for more on the AHRQ see United States Department of Health and Human Services: Agency for Healthcare Research and Quality, http://www.ahrq.gov/ (last visited Mar. 4, 2006)).

74 Id.

National Resource Center for Health Information Technology to create the Health Information Technology Resource Center required by the bill.\textsuperscript{76}

B. \textsc{Establishment of Standards}

Once the Collaborative makes recommendations to the Secretary of HHS, he will develop standards for the certification of hardware and software.\textsuperscript{77} The purpose of these standards is to allow the interoperability of healthcare information between healthcare providers. Therefore, when a healthcare provider purchases HIT hardware or software, the provider will be sure that the hardware or software will work with other healthcare providers’ systems. According to the Committee Report, “[t]he adoption of standards is an important component of establishing consistent and common content and communication between health information technology systems . . . [and is] vital [to] establishing a nationwide interoperable health information system.”\textsuperscript{78} After the Secretary of HHS adopts the standards, a federal agency cannot spend federal funds for HIT that is not in compliance with the standards.\textsuperscript{79} The standards are voluntary for private-sector healthcare providers; however, grants or loans under the bill are conditioned on the healthcare provider using the grant or loan to purchase HIT systems compliant with the standards.\textsuperscript{80}

\textsuperscript{76} S. 1418, 109th Cong. § 3.

\textsuperscript{77} Id. (section 2940 discusses the implementation and certification of health information standards).


\textsuperscript{79} S. 1418, 109th Cong. § 2 (referring to amended § 2903).

\textsuperscript{80} Id. (referring to the following subsections of amended § 2905: (a)(2)(D), (b)(3)(E), and (c)(2)(F)).
C. INCENTIVES FOR PRIVATE SECTOR ADOPTION

One barrier to the adoption of HIT is the high cost of implementing an HIT system.\textsuperscript{81} In addition to the cost of implementation, there are also the costs associated with maintaining the HIT system.\textsuperscript{82} Although there are benefits, both in cost and quality, to adopting HIT, the benefits are hard to compare against the costs of implementing HIT.\textsuperscript{83} Therefore, healthcare providers have chosen to forgo the risk and keep their paper-based method. Grants by the federal government would help defray the costs of HIT adoption. WHCQA allows for three types of grants: grants to healthcare providers,\textsuperscript{84} grants to States to create state loan programs,\textsuperscript{85} and grants for regional or local health information technology plans.\textsuperscript{86} Each of the grants requires matching funds provided by the recipient.\textsuperscript{87} Additionally, each of the grant recipients will have to adhere to the standards adopted by the Secretary of HHS.\textsuperscript{88}

\textsuperscript{81} S. REP. NO. 109-111, at 8 (“The committee recognizes that . . . [a] major barrier to widespread adoption of health information technology in the U.S. health care system is the high cost of such technology.”).

\textsuperscript{82} Id.

\textsuperscript{83} Id. (The Committee Report suggests that while the provider will bear the cost of adopting a HIT system, the savings will be realized by insurers and large healthcare systems and not small healthcare providers such as physicians practices or small community hospitals.).

\textsuperscript{84} S. 1418, 109th Cong. § 2 (§ 2905(a)).

\textsuperscript{85} Id. (§ 2905(b)).

\textsuperscript{86} Id. (§ 2905(c)). In addition to these three types of grants, the bill extends the grants created by § 330L(b) of the Public Health Service Act. S. 1418, 109th Cong. § 4.

\textsuperscript{87} S. 1418, 109th Cong. § 2 (§ 2905(a)(4); (b)(8); and (c)(5)).

\textsuperscript{88} S. 1418, 109th Cong. § 2 (§ 2905(a)(2)(D); (b)(3)(E); and (c)(2)(F)). In general, the standards are optional for private sector healthcare providers; however, making adoption of the standards a condition of receiving grants facilitates adoption of the standards in the private sector. See section III(B), supra.
D. DEMONSTRATION PROGRAM TO DEVELOP ACADEMIC CURRICULA

The bill also allows the Secretary of HHS to award grants for the development of academic curricula “integrating [HIT] systems in the clinical education of health professionals.” The Committee Report explains that the purpose of this provision is to address a cultural barrier to adoption. According to the report, one reason that healthcare providers continue to use a paper-based system is because they have always used paper-based systems and adopting an electronic system might be intimidating. By including HIT in academic curricula, healthcare providers would be more comfortable adopting HIT systems.

E. HEALTHCARE QUALITY

A major reason to adopt HIT is to improve healthcare quality. To this end, WHCQA directs the Secretary of HHS to develop quality measures to be used in quality reporting. The quality information collected will eventually be disseminated to the public to allow the public to make choices on healthcare providers partially based on quality. In addition, the information will allow researchers and public health officials to evaluate the effectiveness of the healthcare system and to make appropriate changes.

89 S. 1418, 109th Cong. § 2 (§ 2906(a)).
91 Id.
92 Id. (“The committee believes that exposing students and residents to effective everyday uses of health IT will lead to a greater adoption by these students and residents when they graduate and begin practicing on their own.”).
93 See supra Part II.
94 S. 1418, 109th Cong. § 2 (§ 2908).
95 Id.
96 Id.
F. MEDICAL PROFESSIONAL CERTIFICATION BARRIERS

Another barrier to adopting HIT is the differences between the states on certification of medical professionals. 97 WHCQA directs the Secretary of HHS to perform a study of state laws to determine the variation of the laws with respect to licensure, registration, and certification of medical professionals and how that variation affects the secure electronic exchange of health information. 98

G. PRIVACY AND SECURITY

According to a survey by the Markle Foundation, 99 although most Americans favor the creation of a national health information network and EHRs, the biggest concern is privacy of their information. 100 Section four of WHCQA specifically states that nothing in the bill is intended to affect the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) § 264, 101 the Social Security Act §§ 1171-1179, 102 or any regulations under those sections. 103 In addition,

97 This is particularly important for determining whether a physician can render advice to a patient or physician in another state. For a more detailed analysis of this barrier, see infra Part V.A.4.b.

98 S. 1418, 109th Cong. § 2.

99 Markle Foundation, http://www.markle.org (last visited Mar. 4, 2006) (The Markle Foundation works to accelerate the use of emerging information and communication technologies “to address critical public needs, particularly in the areas of health and national security.”).


103 S. 1418, 109th Cong. § 2. The Committee Report explains that the purpose of the section is to ensure that HIPAA is applied to health information stored or transmitted in electronic format. S. REP. NO. 109-111, at 12 (2005).
entities receiving grants or loans are required to “agree to notify patients if their individually identifiable health information is wrongfully disclosed.” One additional privacy provision not contained in WHCQA but in another proposed bill is the ability for individuals to opt-out of the nationwide health information network created under the bill.

IV. NON-GOVERNMENTAL PLAYERS

Outside the governmental action to adopt EHRs, there have been several organizations which have been working on EHR adoption. Three of the most influential organizations have been Connecting for Health, the eHealth Initiative, and the Center for Health Transformation. The work of these organizations has provided guidance for the work of public bodies trying to address the same issues.

A. CONNECTING FOR HEALTH

Connecting for Health is a public-private collaborative which was established in 2002 by the Markle Foundation. Connecting for Health, eHealth Initiative, and Center for Health Transformation have been influential in guiding the work of public bodies trying to address EHR adoption issues.

104 See supra Part III(C).

105 S. 1418, 109th Cong. § 2 (referring to the following subsections of amended § 2905: (a)(2)(F), (b)(3)(D)(iii), and (c)(2)(H)).


109 Center for Health Transformation, http://www.healthtransformation.net/home/ (last visited Mar. 4, 2006). This is by no means an exclusive list of private-sector organizations; rather, this list represents three of the most influential organizations whose work is frequently relied on by ONC and HHS.

Health was “designed to improve patient care by promoting the adoption of an initial set of standards for electronic medical information, in a way that protects patient privacy.”\textsuperscript{111} In the first phase, occurring from September 2002 to June 2003, Connecting for Health developed initial interoperable standards.\textsuperscript{112} The collaborative also “[d]eveloped case studies on systems that could serve as potential models for privacy and security.”\textsuperscript{113} Finally, they defined the role of the “consumer/patient . . . in an interconnected healthcare system.”\textsuperscript{114} Three working groups were established to reach the goals of Phase I: the Data Standards Working Group,\textsuperscript{115} the Privacy and Security Working Group,\textsuperscript{116} and the Personal Health Working Group.\textsuperscript{117}

In January 2004, Connecting for Health began the second phase.\textsuperscript{118} The first part of Phase II was to create a “roadmap” to define objectives to implementing a health information infrastructure.\textsuperscript{119} A

\textsuperscript{111} Id.


\textsuperscript{113} Connecting for Health, Achieving Electronic Connectivity in Healthcare, supra note 112, at 5.


\textsuperscript{115} Connecting for Health - Data Standards Working Group, supra note 112.


\textsuperscript{117} Connecting for Health - Personal Health Working Group, supra note 114.

\textsuperscript{118} Connecting for Health, Achieving Electronic Connectivity in Healthcare, supra note 112, at 5.

preliminary roadmap was released in July 2004.\textsuperscript{120} Four working groups were established to address current barriers to health information sharing: \textsuperscript{121} the Expert Panel on Organizational and Sustainability Models for Community-Based Health Information Exchange, \textsuperscript{122} Working Group on Policies for Coordination Across the EHR and the PHR, \textsuperscript{123} Working Group on Accurately Linking Information of Health Care Quality and Safety, \textsuperscript{124} and the Expert Panel on Uniform Data Exchange Standards for Health Information. \textsuperscript{125} The culmination of Phase II is the implementation of a demonstration project “to test and evaluate the working groups’ products in real-world settings.”\textsuperscript{126}

On June 1, 2005, Connecting for Health announced that it was launching a “prototype of an electronic national health information exchange.”\textsuperscript{127} The prototype will connect the regional health

\begin{footnotesize}
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\item Connecting for Health, Achieving Electronic Connectivity in Healthcare, supra note 112. This preliminary roadmap states that a final roadmap will be published at some point. \textit{Id.} at 5 (“the final version of the Roadmap . . . is set for release in September, 2004”). However, there is no indication that a final version was published or that there is intent to publish a final version.
\item Press Release, Connecting for Health, supra note 119.
\item Connecting for Health - Expert Panel on Uniform Data Exchange Standards for Health Information, http://www.connectingforhealth.org/workinggroups/epuniformwg.html (Although this website is given as the address of the working group, the website merely informs the visitor that more information will be forthcoming) (last visited Mar. 4, 2006).
\item Press Release, Connecting for Health, supra note 119.
\end{enumerate}
\end{footnotesize}
information networks in Massachusetts, California, and Indiana.\textsuperscript{128} Connecting for Health was part of the consortia that was awarded an RFP contract to create a prototype for the NHIN.\textsuperscript{129}

B. eHEALTH INITIATIVE

The eHealth Initiative is a group of healthcare organizations that want to improve healthcare through technology.\textsuperscript{130} The eHealth Initiative was created to address the obstacles to HIT adoption.\textsuperscript{131} The overall goal of the eHealth Initiative is “to drive improvement in the quality, safety, and efficiency of healthcare through information and information technology.”\textsuperscript{132} Related to the eHealth Initiative is the Foundation for the eHealth Initiative which is a non-profit 501(c)(3) organization which “was created to serve as a national forum for the discussion of the policy issues” of HIT.\textsuperscript{133}

One project of the eHealth Initiative is the Connecting Communities for Better Health (“CCBH”) program.\textsuperscript{134} CCBH is a

\textsuperscript{128} Id.

\textsuperscript{129} See Press Release, Statement of HHS Announcement of Contract to the Connecting for Health Team to Develop Nationwide Health Information Network (Nov. 10, 2005), available at http://www.connectingforhealth.org/assets/cfh_111005.pdf; see also Press Release, Contracts to Develop NHIN, supra note 36; see also supra section II.


\textsuperscript{131} eHealth Initiative – About: Why eHI Was Created, http://www.ehealthinitiative.org/about/why.mspx (According to eHealth Initiative, the barriers to adoption are “lack of health care system interoperability and widespread adoption of clinical data standards, outdated policies related to reimbursement, concerns about privacy and security, and lack of investment in innovation and technology.”) (last visited Mar. 4, 2006).

\textsuperscript{132} eHealth Initiative – About: Strategic Priorities, http://www.ehealthinitiative.org/about/priorities.mspx (last visited Mar. 4, 2006).


program which provides funding to healthcare providers within a community “who are using IT and health information exchange to address quality, safety, and efficiency goals.” The funding is provided by the Health Resources and Services Administration ("HRSA") and the Office of Advancement of Telehealth ("OAT") and is distributed by the Foundation. The goals of the program are: (1) to provide funding for communities to adopt HIT; (2) to provide an information exchange for the adoption of HIT learned through these programs; and (3) to help create a nationwide health information infrastructure. The eHealth Initiative is also involved in creating a prototype of a NHIN with Connecting for Health.

C. CENTER FOR HEALTH TRANSFORMATION

The Center for Health Transformation ("CHT") was started in 2003 by the Gingrich Group. The purpose of CHT is to create

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136 Health Resources and Services Administration, http://www.hrsa.gov/ (The Health Resources and Services Administration ("HRSA") is an agency in HHS that focuses on “people who are uninsured, isolated or medically vulnerable.”) (last visited Mar.4, 2006).

137 Within HRSA is the Office for the Advancement of Telehealth ("OAT"). OAT is responsible for the coordination and promotion of telehealth technologies with HRSA as well as creating partnerships with other federal and state agencies. Office for the Advancement of Telehealth – Services, http://www.hrsa.gov/telehealth (last visited Sept. 9, 2006).

138 CCBH Resource Center – FAQ, supra note 135.

139 This allows for the evaluation of the cost/value of HIT.

140 CCBH Resource Center – FAQ, supra note 135.

141 See Press Release, Contracts to Develop NHIN, supra note 36; see also supra Part II.

142 About CHT, http://www.healthtransformation.net/about/History/ (last visited Mar. 4, 2006) (The Gingrich Group is a consulting firm established by former House of Representatives
solutions and policies that will lead to better healthcare. Some strategies to reaching this purpose are: development of EHRs “to maximize accuracy, minimize errors, reduce inefficiencies and improve care;” development of a research database to improve research and decrease the amount of time from discovery by researchers to use by healthcare providers; and development of a network to protect the public against natural outbreaks and bioterrorism.

While Connecting for Health and eHealth Initiative focus on working with healthcare providers to adopt HIT, CHT attempts to drive the adoption of HIT at the policy level. To reach the adoption of HIT, CHT is working with politicians to develop legislation that would help modernize healthcare, pushing for the reform of the Stark Law and the Anti-kickback Statute, and create interoperability standards.

V. BARRIERS TO ADOPTION

There are two categories of barriers to adoption of EHRs: legal barriers and organizational barriers. The legal barriers are privacy, security, physician anti-referral and anti-kickback laws, and professional liability. Other legal barriers to EHR adoption that are

Speaker Newt Gingrich); About CHT: Mission, http://www.healthtransformation.net/About/Mission/ (last visited Feb. 9, 2006).

141 About CHT: Mission, supra note 142.


not discussed in detail in this article include intellectual property rights, \textsuperscript{149} federal income taxes, \textsuperscript{150} and antitrust issues. \textsuperscript{151} All of these are particularly important when forming Regional Health Information Organizations ("RHIOs").\textsuperscript{152} The organizational barriers include funding and financial risk of HIT adoption, the legacy of failed implementations, and compatibility issues.

In addition to these specific barriers to adoption, there is a general barrier to adoption that is significant. The transformation from paper records is not only expensive, but it can require significant expertise.\textsuperscript{153} It requires legal knowledge to determine applicable laws,
technical knowledge for the actual implementation, and medical knowledge to make the system practical.

A. LEGAL BARRIERS TO EHR ADOPTION

1. PRIVACY

In a survey by the Markle Foundation, researchers found that 72% of Americans were interested in the establishment of a nationwide health information system. However, their greatest concern was privacy of their health information. Although it is clear that protecting privacy is very important, it is a great barrier to adoption for reasons including the difficulty in determining the applicable state and federal laws.

a. FEDERAL LAW

First, an EHR system will have to comply with federal privacy law. For example, it is clear that any system adopted would have to...
comply with HIPAA. In addition, the system would have to comply with two rules promulgated under HIPAA: the Privacy Rule and the Security Rule. HIPAA was enacted to reduce administrative costs in the healthcare industry and allow for the easy exchange of healthcare information, while protecting that information. The Privacy Rule is a “‘federal floor’ of privacy protection for health information in the United States.” The Privacy Rule “define[s] and limit[s] the circumstances in which an individual’s protected health information may be used or disclosed by covered entities.” The Security Rule provides security standards for the maintenance and exchange of electronic health information. It is clear that the information contained in an EHR would clearly fall within the scope of protected health information covered by the Privacy Rule. Therefore, an EHR system would have to comply with the requirements of the Privacy Rule.

b. State Law

In addition to complying with federal privacy law, an EHR system will have to comply with the applicable state privacy laws. This

160 Hutton & Barry, supra note 101.
163 68 Fed. Reg. 8334, 8334 (Feb. 20, 2003) (the purpose of the Security Rule is to provide “national standards for safeguards to protect the confidentiality, integrity, and availability of electronic protected health information.”).
becomes even more complicated when designing an interoperable nationwide network for the exchange of health information between healthcare providers in different states because the transfer will have to comply with the state laws of both states.

2. SECURITY/INTEGRITY

Related to the issue of privacy are the issues of security and integrity. The privacy and accuracy of the health information stored on a system depends on the security of the system.\textsuperscript{165} Assuming the healthcare provider adopting the EHR system is a covered entity under HIPAA,\textsuperscript{166} the HIPAA Security Rule will apply.\textsuperscript{167} Security is important for several reasons. First, security protects the privacy of the health information maintained within the system. Second, security is one element in guarding the integrity of the system.\textsuperscript{168} The integrity of the system is important for making sure that the information is practically useful\textsuperscript{169} as well as legally useful.\textsuperscript{170}

Security will become even more important if a nationwide interoperable health information network is implemented. In order to maintain the security of the entire system, each member of the network will have to maintain a minimum level of security because the security of the entire network is based on the security of the weakest member.

\textsuperscript{165} Security is one of the five core principles of privacy protection. Fair Information Practice Principles, supra note 156.

\textsuperscript{166} HIPAA § 1173.

\textsuperscript{167} See 45 C.F.R. § 164.

\textsuperscript{168} The other element, which is beyond the scope of this article, is the integrity of the system itself. This is left to the software engineers to make sure that the system properly stores the data.

\textsuperscript{169} For example, the system would not be very beneficial if the data was incorrect.

\textsuperscript{170} An unsecured system would probably not be considered trustworthy under the business record exception to hearsay; therefore, the record might not be admissible in court. Fed. R. Evid. 803(6).
Another legal barrier to EHR adoption is anti-kickback and anti-referral statutes. Under federal law, these are the Anti-kickback Statute\textsuperscript{171} and the Stark Law.\textsuperscript{172} In general, the Anti-kickback Statute provides for criminal liabilities to anyone who gets remuneration when referring patients under Medicare, Medicaid, or any federally funded health plan.\textsuperscript{173} The Stark Law is broader and prevents physicians from referring patients to other healthcare providers in which the physician has a financial interest.\textsuperscript{174} Under state law, it is significantly more difficult to determine what state laws are applicable.

Following the creation of Medicare and Medicaid in 1965, complicated schemes arose where physicians would refer patients to other healthcare providers in which the physician had a financial interest; therefore, the physician would benefit from the referral.\textsuperscript{175} In 1972, Congress enacted an anti-kickback statute to stop this practice.\textsuperscript{176} Violation of this statute is a felony and can result in up to five years imprisonment, a $25,000 fine, or both.\textsuperscript{177} There are several exceptions to this statute,\textsuperscript{178} referred to as “safe harbors.”\textsuperscript{179} The Stark Law is broader than the Anti-kickback Statute because it covers all physician referrals and is not limited just to referrals involving

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{171} 42 U.S.C. § 1320a-7b(b) (2000).
\item \textsuperscript{172} 42 U.S.C. § 1395nn (2000).
\item \textsuperscript{173} Alissa M. Nann, \textit{Health Care Fraud}, 42 AM. CRIM. L. REV. 573, 582 (2005).
\item \textsuperscript{174} Id. at 605.
\item \textsuperscript{176} Id. at 170 (citing Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972)). The current statute can be found at 42 U.S.C. § 1320a-7b(b).
\item \textsuperscript{177} 42 U.S.C. § 1320a-7b(b)(1).
\item \textsuperscript{178} Id. at § 1320a-7b(b)(3).
\end{enumerate}
\end{footnotesize}
Medicare or Medicaid.\textsuperscript{180} In addition, the Stark Law does not provide criminal liability, but rather civil liability.\textsuperscript{181} There are several exceptions to this law as well.\textsuperscript{182} Many scholars and private organizations have suggested that this is a barrier to the adoption of HIT, and they suggest that safe harbors or exceptions should be created to encourage HIT adoption.\textsuperscript{183} For example, physicians might be discouraged from joining a Regional Health Information Organization ("RHIO") with other healthcare providers in a region because doing so might create a financial relationship, and then they could not refer patients to providers within the RHIO without being subject to criminal or civil liabilities.\textsuperscript{184} In addition to the federal anti-kickback and anti-referral laws, it is necessary to determine applicable state laws.\textsuperscript{185} This can become even more complicated if the relationship involves entities in more than one state.

4. PROFESSIONAL LIABILITY

In adopting EHRs, there are several medical professional liability issues which need to be addressed. First is the effect of EHR adoption on the legal standard of care. Second, the adoption of EHR with relation to telemedicine has the potential to create liabilities for physicians.

\textsuperscript{180} See 42 U.S.C. § 1395nn.

\textsuperscript{181} Id. at § 1395nn(g).

\textsuperscript{182} Id. at §§ 1395nn(c)-(e).

\textsuperscript{183} See, e.g., Gulick, supra note 179, at 389-91 (2002) (The author explains that e-commerce uses the promotional tool of “per click” arrangements which reward websites for generating traffic through ads placed on their websites. This could not be implemented in the healthcare context because it would violate the anti-kickback statute.).

\textsuperscript{184} CONNECTING FOR HEALTH, ACHIEVING ELECTRONIC CONNECTIVITY IN HEALTHCARE, supra note 112, at 51.

\textsuperscript{185} For a comprehensive table of state statutes that are similar to the federal anti-kickback or Stark laws, see MICHAEL K. LOUCKS & CAROL C. LAM, PROSECUTING AND DEFENDING HEALTH CARE FRAUD CASES 575 (2001).
a. STANDARD OF CARE

Over the past two centuries, the legal standard of care for physician accountability has evolved. The “locality” standard was established by courts during the middle of the 19th Century as a solution to the variances in physician skill level caused by the vast differences in resources and access to new technology from area to area. The “locality” standard compared each physician to other physicians in the same community. After World War II, as travel and information sharing improved, the “locality” standard was replaced with a “national” standard. The “national” standard, which is the current standard, holds a physician to the same “degree of care and skill which is expected of a reasonably competent practitioner in the same class to which [the physician] belongs, acting in the same or similar circumstances.” With the recent exponential growth in medical knowledge, the use of EHRs and HIT will increase the standard of care required by physicians throughout the country. In addition to the dissemination of general information, EHRs will compile targeted information concerning the procedures and policies of physicians throughout the country, further increasing the “national” standard of care.

b. EHR AND TELEMEDICINE

Another potential issue in medical professional liability that poses a barrier to EHR adoption is through the use of EHRs in telehealth.  


187 Id. at 473-475.

188 Id. at 474.

189 Id. at 475.


191 Telehealth includes the term teledicine but telehealth is broader than teledicine. DEPARTMENT OF VETERANS AFFAIRS, REPORT ON APPROACHES TO MAKE HEALTH INFORMATION SYSTEMS AVAILABLE AND AFFORDABLE TO RURAL AND MEDICALLY UNDERSERVED COMMUNITIES 19 (2004), reprinted in NATIONAL COORDINATOR FOR HEALTH
Telehealth is “the provision of health care services [through electronic media] when patient and provider are separated in time and/or place.” Telehealth involves “the use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, public health and health administration.” A key component of telehealth is EHRs because for telehealth to be effective, it is necessary that the remote physician be able to look at the patient’s health record. Therefore, the use of telehealth would theoretically increase the adoption of EHRs. However, a barrier to the adoption of telehealth is physician licensure. Physicians are generally required to have a license in a state in which they practice, and it is unclear whether a physician is considered practicing in a state when the physician is in another state performing telehealth.

B. ORGANIZATIONAL BARRIERS TO EHR ADOPTION

In addition to the legal barriers to EHR adoption, there are several organizational barriers: compatibility issues, legacy of failed implementations, and financial risks.

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192 Id.

193 Office for the Advancement of Telehealth, supra note 137. The Office for the Advancement of Telehealth (“OAT”) was established by the Health Resources and Services Administration, which is under HHS, to lead the adoption of telehealth. Id.

194 Gulick, supra note 179, at 365.

1. Compatibility Issues

Compatibility is necessary so that healthcare providers can exchange records with one another.\textsuperscript{196} Much of the executive action, through the Office of the National Coordinator, and the legislative bills that have been proposed have focused on creating national standards for interoperable EHRs. Interoperable simply means systems are compatible with each other. The goal is to eliminate compatibility issues. Aside from establishing standards of interoperability, there is another potential compatibility issue. Many healthcare providers have already implemented an EHR system or are in the process of implementing a system. For these providers, there is no guarantee that their current system will be compatible with the standards that are yet to be adopted. Depending on the amount of money these providers have invested in their current system, it might not be financially feasible for them to move to a system which is interoperable until they can afford to replace their current system. This could mean that providers which are currently technologically advanced may end up being technologically behind.

2. Legacy of Failed Implementations

Successful EHR adoption will require overcoming the legacy of failed implementations. According to a Connecting for Health report, “[e]fforts to institute electronic medical records and clinical health information networks date back at least to the 1960s, but they have been unable to overcome formidable structural and financial barriers.”\textsuperscript{197} Organizations involved in failed attempts at implementing EHRs may be reluctant to try again. In order to overcome this barrier, it is necessary to look at the reasons the implementations failed and attempt to avoid those problems in the future.


\textsuperscript{197} Connecting for Health, Achieving Electronic Connectivity in Healthcare, supra note 112, at 1.
3. Financial Burden

There are also financial burdens which present a barrier to EHR adoption. First, “[m]any healthcare organizations . . . believe that EHRs are a poor investment.”\(^{198}\) In addition, several studies have found that EHR adoption is low because most healthcare providers lack adequate funding.\(^{199}\) This lack of funding is further exacerbated because providers do not see any current benefit in adopting EHRs that would make adoption worthwhile even if they did have adequate funding.\(^{200}\)

VI. PHR v. EHR

While the federal government and many private-sector entities work toward interoperable EHRs, some patients have already collected their medical records into a personal health record (“PHR”).\(^{201}\) A PHR, like an EHR, contains a patient’s entire health record; however, a PHR is collected and maintained by the patient whereas an EHR is collected and maintained by a healthcare provider.\(^{202}\) The justifications for creating a PHR are generally the same as for adopting EHRs, except there is no benefit to the public, such as through research and public health surveillance. Rather the benefits are personal to the patient creating the record.\(^{203}\) A PHR can be either digital or paper-based.\(^{204}\) There are a wide variety of software and

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198 CONNECTING FOR HEALTH, FINANCIAL, LEGAL, AND ORGANIZATIONAL APPROACHES TO ACHIEVING ELECTRONIC CONNECTIVITY IN HEALTHCARE, supra note 148, at 21.

199 Id.

200 Id. at 22.

201 CONNECTING FOR HEALTH, ACHIEVING ELECTRONIC CONNECTIVITY IN HEALTHCARE, supra note 112, at 27.

202 Id. at 25.


services available to help create and maintain a PHR. One advantage of PHRs over EHRs is that the patient could completely control the security of the PHR by regulating who has access to the record. In contrast, a patient could not control who had access to their EHR. Further, if the PHR was kept at an online PHR service provider, if the patient was unsatisfied with the service provider, including security considerations, the patient could change service providers. The patient would not have the same control over an EHR. However, an EHR in a hypothetical nationwide interoperable system would be available anywhere at the point of care in an emergency situation. A PHR would require the patient to grant consent for the physicians to use the PHR, which might not be possible in an emergency.

VII. CONCLUSION

Moving from paper-based healthcare records to EHRs would provide a great benefit by reducing preventable errors, lowering the cost of healthcare, and improving the efficiency and quality of healthcare. While there are many benefits to the adoption of EHRs, there are also many barriers to adoption. The barriers include both legal and organizational barriers that need to be addressed before adoption of EHRs can be effective. EHRs have the potential to transform the healthcare system; however, the path to EHR adoption will require hard work and collaboration among many public and private organizations.

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206 Of course, HIPAA places some limitations on who has access to a patient’s health information. See Hutton & Barry, supra note 101, at 350-51.