I am writing this editorial while participating in the American Medical Informatics Association (AMIA) Annual Fall Symposium in Washington DC. I see many differences on this side of the Atlantic: in understanding of what primary care informatics actually is, in the types of electronic health records (EHRs) available to family practice/primary care, and in the coverage of EHRs.

The USA is the richest nation in the world – and yet fewer than 20% of primary care providers use an EHR (compared with 98% in the UK, and comparable figures in Australia and many European countries). One of the reasons for this disparity is the structure of the health system: family practitioners operate in a variety of different health organisations, from privately owned practices through Health Maintenance Organisations (HMOs), hospital clinics, academic medical centres and so on. This fragmentation, alongside the financial constraint of having to demonstrate return on investment (ROI), does not provide an environment conducive to the rapid uptake of the EHR without some incentives to the physicians themselves, to the organisations within which they work, to the organisations that pay for care.

The view from across the Pond
Sheila Teasdale MMedSci Comp BCS
Editor, Informatics in Primary Care, and Service Director, Primary Care Information Services (PRIMIS), University of Nottingham, UK

Working towards wider uptake of EHRs across the nation, were also presented: I will mention just two of them.

The National Alliance for Primary Care Informatics (NAPCI) initiative was conceived around three years ago, in response to a challenge from Moon Mullins and John Zapp:

A serious problem exists in the use of information technology in caring for patients by primary care practitioners in the United States of America. There is currently no identifiable national strategy for the use of information technology and management in primary health care addressing this problem, and there is a critical need to establish and fund a centralised, co-ordinating group to provide strategic leadership in its development.

The vision of NAPCI is that every primary care provider will use information technology that includes electronic health records, with the ability to access and communicate needed clinical information to achieve high-quality, safe, and affordable health care.

NAPCI has succeeded in bringing together a number of organisations with an interest in primary care informatics, including the AMIA PCIWG, the clinical professional societies, and the Agency for Healthcare Research and Quality (AHRQ). It is expected that NAPCI will shortly be formally incorporated, having developed bylaws, articles of incorporation, a business plan and a strategic vision. Its objectives are to promote the creation of a national health information infrastructure that identifies and supports the unique needs of primary care providers, to document and report on the use of informatics and IT in primary care, to promote primary care informatics research, and to educate primary care providers in the use of informatics and IT. I hope we will be publishing more news about NAPCI and its activities in a future issue of the journal.

The second initiative is the American Association of Family Physicians (AAFP) Open Source EHR Project. Its original goal was to make available to all primary care physicians a free open source EHR; for a variety of reasons this did not succeed, but the goal has been modified now to providing an EHR that passes
the ‘ACID’ test (affordability, compatibility, interoperability, data stewardship). As well as presentations, the PCIWG held a number of breakout sessions, considering the definition of primary care informatics (this will form the topic of a consensus conference planned to run alongside the Medinfo 2004 conference – see page 241), clinical practice issues, and the research agenda for primary care informatics. There were also a number of informal demonstrations given by members in the PCIWG hospitality suite.

Other presentations

A very well-attended panel session discussed both NAPCI and the AAFP Open Source initiative; this panel included a talk by Dr Mike Bainbridge on the English National Programme for IT and the Integrated Care Records Service (ICRS), which is conceptually somewhat similar to the US projects but is to be implemented across the whole of the NHS by 2008, at a cost of £2.3 billion (US$4 billion), which caused some sharp intakes of breath in the auditorium!

Another presenter at that session was Dr John Zapp, who was given an AMIA Award at the Opening Plenary Session in recognition of his longstanding work in primary care informatics, and particularly his vision and championship for the creation of NAPCI.

The final presentation to mention is that given by Dr David Bates, Chair of NAPCI. He confessed to being somewhat envious of what is happening in European health systems in the rapid adoption and development of the EHR. He is an advocate for the implementation of the EHR in order to support better patient care, and particularly its role in enhancing patient safety and reducing medical error. He recognised the need for integration of medical record elements, not separate modules, and also for standards for coding, messaging, etc, but felt that the way forward was actually to start doing something now even if it is not perfect, and even if formal standards have not yet been adopted on a national level. He is leading a Massachusetts-wide proposal for implementation of EHRs for primary care providers from a limited number of ‘approved’ vendors, and recognises the need for education in information management and the importance of good change management processes in implementation, especially in small practices with few resources.

A number of concerns were expressed by attendees at this session, about ‘cookbook medicine’ in use of templates and conditional branching protocols, about how to encode or otherwise record the existing paper record, about large amounts of text-based information inaccessible to population data uses, and about workflow redesign during and after implementation (and the associated change management skills). I am honoured to say that Dr Bates called on Dr Glyn Hayes, Dr Mike Bainbridge and myself to answer some of these concerns, with 20 years’ experience of implementation in primary care in the UK.

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