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IS THERE A DOCTOR IN THE MOUSE? USING INFORMATION TECHNOLOGY TO IMPROVE HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON THE FEDERAL WORKFORCE AND AGENCY ORGANIZATION

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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IS THERE A DOCTOR IN THE MOUSE? USING INFORMATION TECHNOLOGY TO IMPROVE HEALTH CARE

WEDNESDAY, JULY 27, 2005

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON FEDERAL WORKFORCE AND AGENCY ORGANIZATION,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:02 p.m. in room 2154, Rayburn House Office Building, Hon. John C. Porter (chairman of the subcommittee) presiding.

Present: Representatives Porter, Davis of Illinois, and Norton.

Staff present: Chad Bungard, assistant staff director, chief counsel; Ronald Martinson, staff director; Chad Christofferson, clerk; Patrick Jennings, detailee from OPM serving as senior counsel; and Tania Shand, minority professional staff member.

Mr. PORTER. A quorum being present, the Subcommittee on the Federal Workforce and Agency Organization will come to order.

Good afternoon. I would like to thank everyone for being here today, especially our witnesses. The issue before us is an important one and something to which we can all relate. Every single one of us has gone to the doctor's office or the hospital or knows someone that has made such visits.

With both legislative jurisdiction over the Federal Employees Health Benefits [FEHB], program and oversight jurisdiction over health care policy, this subcommittee is poised to examine ways to achieve President Bush's goal for the majority of Americans to have electronic health records within 10 years.

Notwithstanding the fact that the United States is a world leader in health care science, its delivery and management of health care is often outmoded and inefficient. Over 90 percent of the activities that go into the delivery of health care are centered on information and information exchange. If this component is flawed in any way, the optimal delivery of care will not be achieved.

Health care costs are increasing at an alarming rate, rising 70 percent since 2000. The quality of care is riddled with preventable medical and administrative errors and burdened with inefficiency.

Information technology can help cure these ills. With the deployment of health information technology in a global fashion, no longer will patients have to be held captive to the brown padded envelopes in the bottom of their chest of drawers full of incomplete

medical records. No longer will patients have to track down personal health information from across the country.

No longer will a pharmacist misread a doctor's handwriting and prescribe the wrong medicine. No longer will medical errors occur caused by the lack of or incomplete health information. And, as Dr. David Brailer noted at a technology summit last year, "no longer will we spend up to $300 billion a year on inappropriate treatment or up to $150 billion on administrative waste."

The use of information technology has enormous potential to improve the quality of health care and is key to overall improved performance of the U.S. health system. Health care organizations are only beginning to apply technological advances. Patient information typically is dispersed in a collection of paper records, which often are poorly organized, illegible, and not easy to retrieve, making it nearly impossible to manage various chronic illnesses that require frequent monitoring and ongoing patient support.

In a world where our cars, our pets, our checking accounts have their own computerized record, is not it time for every American to benefit from the same technology? And I must emphasize the benefits are innumerable. The Institute of Medicine estimates that medical errors account for approximately 45,000 to 98,000 deaths each year in the United States, and 770,000 injuries due to adverse drug events, many of which could have been prevented through the use of health information technology.

In fact, more people die each year in the United States from medical errors than from highway accidents, breast cancer, or even AIDS. If death by medical errors were listed among the most deadly diseases, it would be among the top 10 leading causes of death in the United States each year.

The use of technology will reduce medical errors by making health information more accessible to both patients and providers, no matter where the patient is receiving that care. For example, the Boston Globe recently reported on the senseless, preventable death of a 79 year old retired chemist who died after doctors at the Massachusetts General Hospital treated him for a stroke when he really was having an insulin reaction. Tragic. It is easy to see how an electronic medical record could have assisted the physicians in correctly diagnosing this patient.

In addition, the use of automated medication order entry systems can reduce errors in prescribing drugs, and computerized reminders can help both patients and clinicians to identify needed services. The Journal of the American Medical Association reported in a recent study that computerized prescriptions resulted in an 81 percent decrease in errors. The National Center for Vital and Health Statistics reports that 20 percent of handwritten medical documents are illegible, and 24 percent are incomplete. Prescription errors can result in real catastrophes that easily could be prevented.

Recently, a 42-year-old male patient died 2 weeks after taking the wrong prescription drug. In that case the doctor who wrote the prescription wrote it for the wrong amount. It was actually eight times higher than what he should have been receiving.

The Department of Health and Human Services also reports that health information technology can significantly reduce cost by sav-

ing time, reducing duplication and waste, and improving efficiency. The Center for Information Technology Leadership estimates that a national health information technology system will result in annual savings of $132 billion. With national health care spending at a 15.6 percent share of the GDP, this is welcome news.

The benefits of computerizing health records are substantial. Health information technology will improve the quality of care, reduce the redundancy of testing and paperwork, virtually eliminating prescription errors, prevent adverse effects from conflicting courses of treatment, and significantly reduce medical errors and administrative costs.

In announcing his 10 year goal, the President admonished the Federal Government to take the lead. The FEHB program is no exception and should leverage its buying power of about 8½ million participants to support President Bush's goal and lead by example.

As the Institute of Medicine's president, Dr. Harvey Fineburg, stressed in testimony before this subcommittee this past March, the FEHB program could promote data standards and appropriate deployment of information technology providers. And since that hearing I am pleased to see that the Office of Personnel Management emphasized the importance of increase of health information technology for the first time in its April 2005, program carrier letter, offering guidance to insurance carriers for negotiating with the OPM.

The FEHB program can enhance its service to Federal employees and serve as a model for improving the performance of U.S. health care systems as a whole.

Progress is also being made on the national front. In June of this year HHS Secretary Mike Leavitt announced new efforts to help speed the President's 10-year proposal, stating that the HHS will establish a national health information infrastructure that will effectively be taken over by the public and private health sectors, eventually eliminating the need for extensive Federal involvement.

No one can claim that moving information technology into the health care industry is going to be easy. There are many challenges of implementing information technology, including financial, technical, cultural, turf. These are but a few of the challenges that we have.

As chairman of this subcommittee, I am committed to supporting the President's goal and guiding the implementation of health information technology in both the FEHB program and throughout the Nation. This subcommittee will hold additional hearings over the next several months to face the challenges head on and achieve meaningful improvement in America's health care system.

The individuals before the subcommittee today are vital players and leaders in achieving our goal and the President's goal, and I look forward to discussion from all the witnesses this afternoon.

I have had the opportunity to spend time in Nevada hospitals. I have had a chance to see first-hand. And yes, I have been sick in the hospitals before, but I have been very specific in spending time in the emergency rooms to see what I could do as a Member of Congress. University Medical Center, a major facility in southern Nevada, I have spent a couple of days just working hand in hand with the doctors—of course, staying out of the way—trying to

see what we could do. I am amazed at how well our delivery system does work, even in spite of some of the technological challenges. But I saw first-hand how technology could be such a lifesaver in many respects around the country, not only in Nevada but in every community across this great country.

Having said that, I would like to now recognize our ranking minority member of the subcommittee, Mr. Danny Davis. Mr. Davis.

[The prepared statement of Hon. Jon C. Porter follows:]

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Opening Statement of Chairman Jon Porter

Hearing of the House Government Reform
Subcommittee on Federal Workforce and Agency Organization

"Is There a Doctor in the Mouse?: Using Information Technology to Improve Health Care"

July 25, 2005

The issue before us today is an important one and one to which we can all relate. Every single one of us has gone to the doctor's office or the hospital or knows someone that has made such visits. With both legislative jurisdiction over the Federal Employee Health Benefits ("FEHB") Program and oversight jurisdiction over health care policy generally, this Subcommittee is poised to examine ways to advance efforts to achieve President Bush's goal for the majority of Americans to have electronic health records within ten years.

Notwithstanding the fact that the United States is a world leader in health-care science, its delivery and management of healthcare is often outmoded and inefficient. Over 90% of the activities that go into the delivery of healthcare are centered on information and information exchange. If this component is flawed in any way, the optimal delivery of care will not be achieved. Healthcare costs are increasing at an alarming rate – seventy percent since 2000, while the quality of care is riddled with preventable medical and administrative errors and burdened with inefficient practices. Information technology can help cure these ills.

With the deployment of health information technology in a global fashion, no longer will patients have to be held captive to the brown padded envelopes in the bottom of their chest of drawers full of incomplete medical records; no longer will patients have to track down personal health information from across the country; no longer will a pharmacist misread a doctor's handwriting and prescribe the wrong medicine; no longer will medical errors occur caused by the lack of or incomplete health information; and as Dr. David Brailer noted at a technology summit last year, "no longer will we spend up to $300 billion a year on inappropriate treatment or up to $150 billion on administrative waste."

The use of information technology has enormous potential to improve the quality of health care and is key to overall improved performance of the U.S. health system. Health care organizations are only beginning to apply technological advances. Patient information typically

is dispersed in a collection of paper records, which often are poorly organized, illegible, and not easy to retrieve, making it nearly impossible to manage various chronic illnesses that require frequent monitoring and ongoing patient support. In a world where our cars, pets, and checking accounts have their own computerized record, it is time for every American to benefit from the same technology; and, I must emphasize - the benefits are innumerable.

First, the Institute of Medicine estimates that medical errors account for approximately 45,000 to 98,000 deaths each year in the United States and 770,000 injuries due to adverse drug events, many of which could have been prevented through the use of health information technology. In fact, more people die each year in the United States from medical errors than from highway accidents, breast cancer or AIDS and if death by medical errors were listed among the most deadly diseases, it would be among the top ten leading causes of death in the United States each year.

The use of technology will reduce medical errors by making health information more accessible to both patients and providers no matter where the patient is receiving care. For example, the Boston Globe recently reported a senseless preventable death of a 79 year-old retired chemist who died after doctors at Massachusetts General Hospital treated him for a stroke when he really was having an insulin reaction. It is easy to see how an electronic medical record could have assisted the physicians in correctly diagnosing this patient.

In addition, the use of automated medication order entry systems can reduce errors in prescribing drugs, and computerized reminders can help both patients and clinicians identify needed services. The Journal of the American Medical Association reported in a recent study that computerized prescriptions resulted in an 81% decrease in errors. The National Center for Vital and Health Statistics reports that 20% of handwritten medical documents are illegible and 24% are incomplete. Prescription errors can result in real catastrophes that can easily be prevented. Recently, a 42 year-old male patient died two weeks after taking the wrong drug. In that case, the doctor who wrote the prescription intended for 20 mg of Isordil but the pharmacist who filled the prescription reasonably read the order for 20 mg of Plendil, which is eight times higher than the maximum recommended dosage.

The Department of Health and Human Services also reports that health information technology can also significantly reduce costs by saving time, reducing duplication and waste, and improving efficiency. The Center for Information Technology Leadership estimates that a national health information technology system will result in an annual savings of $132 billion. With national healthcare spending at a 15.6% share of the GDP, this is welcomed news.

The benefits of computerizing health records are simply substantial. Health information technology will improve the quality of care, reduce the redundancy of testing and paperwork, virtually eliminate prescription errors, prevent adverse effects from conflicting courses of treatment, and significantly reduce medical errors and reduce administrative costs. In announcing his ten-year goal, the President admonished, "The Federal Government has got to take the lead." The FEHB Program is no exception and should leverage its buying power of about eight and a half million participants to support President's Bush's goal and lead by example. As the Institute of Medicine's President, Dr. Harvey Fineberg, stressed in testimony

before the Subcommittee last March, "the FEHB Program could promote data standards and appropriate deployment of information technology providers."

Since that hearing, I am pleased to see that the Office of Personnel Management emphasized the importance of increased use of health information technology for the first time in its April 2005 FEHB Program Carrier Letter, which offers guidance to insurance carriers for negotiating with OPM. The FEHB Program can enhance its service to Federal employees and serve as a model for improving the performance of the U.S. health care system as a whole. Progress is also being made on the national front. In June of this year, HHS Secretary Mike Leavitt announced new efforts to help speed the President's ten-year proposal along stating that HHS will establish a National Health Information Infrastructure that will effectively be taken over by the public and private health sectors eventually eliminating the need for extensive Federal involvement.

No one can claim that moving information technology into the health care industry is going to be easy. There are many challenges to implementing information technology, including financial, technical, and cultural challenges. As Chairman of this Subcommittee, I am committed to supporting the President's goal and guiding the implementation of health information technology in both the FEHB Program and throughout the nation. This Subcommittee will hold a series of hearings over the next several months to face the challenges head on and achieve meaningful improvement in America's healthcare system.

The individuals before the Subcommittee today are vital players in achieving the President's goal and I look forward to the discussion from all of the witnesses this afternoon.

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Mr. DAVIS OF ILLINOIS. Mr. Chairman, I do not know what Representative Kennedy's time piece is, but if he would have a problem returning after the votes then I would defer to him and let him give his testimony. If not, then I will go ahead.

Mr. KENNEDY. No problem. That would be appreciated. If you are having another hearing down the road, I would be willing to testify at that, as well. If you want me to make brief comments now, I would be happy to come back at the next hearing.

Mr. PORTER. Without objection.

Mr. DAVIS OF ILLINOIS. I am prepared to yield to the Representative.

Mr. PORTER. Thank you. Without objection, please. Welcome.

STATEMENT OF HON. PATRICK KENNEDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND

Mr. KENNEDY. Thank you. Thanks, Mr. Chairman, Representative Davis.

Mr. Chairman, you just outlined essentially the problem and possibly the direction for us to go in terms of the solution. But I think what is important here is that this is not a hearing about technology. This is a hearing about saving lives.

You hit it on the head at the outset, Mr. Chairman, when you said that roughly 48,000 to 100,000 people in this country die of medical errors. It is the equivalent of a jumbo jet crashing every 3 days in this country. If the American people really understood the degree to which they are in jeopardy of being a victim of a medical error when they go to the hospital, Mr. Chairman, I know this Capitol would be awash with people from all over the country demanding that we would do something.

Mr. Chairman, I think people are learning about this and they are expecting us to begin to reform this system. Technology can be a big part of that. Mr. Chairman, Representative Murphy and myself have offered a piece of legislation that suggests a way to go about implementing IT in our medical system in this country. Everybody has recognized the need to do this, but now we have to actually do it, Mr. Chairman. That I think is our challenge here.

As you all are able to do this through showing how Government can be a model for the rest of the country, I think it is an important role that you will play in this debate, because the Federal Employees Health Benefits program is going to be a program that will be looked to as a model. And so I encourage you to continue to talk about how you are intending to do that. I look forward to coming back when you have successive hearings to be able to comment further about ways that you might do that.

I thank you for holding this hearing and focusing the attention that you are focusing on this very important subject.

[The prepared statements of Hon. Patrick Kennedy And Hon. Tim Murphy follow:]

Testimony of Congressman Patrick J. Kennedy
Committee on Government Reform
Subcommittee on the Federal Workforce and Agency Organization
"Is There a Doctor in the Mouse? Using Information Technology to Improve Healthcare"
2154 Rayburn House Office Building
July 27, 2005, 2:00 p.m.

Mr. Chairman, Congressman Davis, thank you for inviting me to testify today. It's an honor to be with you and with my partner in crime, Tim Murphy.

The subject you are exploring today is, I think it can be said without hyperbole, critical to our country's long-term economic competitiveness, not to mention to hundreds of thousands of Americans who will be needlessly killed and seriously injured if we do not act.

We politicians love to say that we have the best health care system in the world. We generally do this while we're helping break ground for a new cardiac care facility or speaking to an audience of doctors.

And we're half right. We undoubtedly have some of the best health care in the world. Our practitioners are superb. Our medical technology is unsurpassed. Our facilities are state-of-the-art. But the system in which they exist fails.

You probably are aware that if an airliner crashed today and tomorrow and every day this week, it would approximate the number of our constituents who are losing their lives to preventable medical errors. Double that number to include all of the people who die as a result of hospital-acquired infections that are largely preventable but rarely prevented.

The costs of these system failures are borne not only by those directly affected; they impact us all. We all know what is happening with health care costs and the burden they are putting on families and businesses. We all know about the scourge of the uninsured and how that problem is growing.

Our system just is not set up to get the best care to people as efficiently as possible. So nearly half the time, according to a RAND study, patients fail to receive recommended care. We have some regions of the country spending 60% more than others on an adjusted basis, yet getting worse patient outcomes and satisfaction. Faxing, copying, filing, coding, and moving paper and other administrative costs eat up thirty cents of each health care dollar. Probably any person in this room can tell a story of duplication in the system, whether it's filling out that clipboard for the fifth time or repeating a battery of tests because this doctor doesn't have the results handy.

Information technology is emphatically not the panacea that will automatically solve these problems. But it's also hard to imagine these problems being solved without IT. In a digital health care system, providers can have the information they need right at the point of care. Computer algorithms can catch mistakes and prompt to ensure consideration of latest scientific developments. Public health officials can be alerted nearly immediately of unusual patterns that

might indicate a natural or bioterror infectious outbreak, or to catch the next Vioxx before tens of thousands are put at risk. Researchers would have vast new databases to learn more about what works.

The vision is compelling, but of course getting from here to there is no easy task. I see four key components to achieving this vision:

First, privacy and security are absolutely paramount. People will pass up the enormous benefits that IT could provide to them individually and to society if they believe their health privacy may be compromised. Theoretically, I am convinced that digital health care can be made more secure that paper, which is difficult to secure and nearly impossible to monitor access to. But we need to ensure that the technical solutions are ready for prime time and that the regulatory structures are in place to ensure rigorous adherence to the privacy and security requirements.

Second, we need to get technology into providers' and consumers' hands. There have been all sorts of analyses of the obstacles to IT adoption, but certainly high on the list are the costs, not only of the hardware and software, but of the process of integrating these systems into practice. These costs are, by all estimates, recouped many times over, but not necessarily by the people who incur them. The cost-benefit mismatch, where employers and plans realize many of the gains of provider investments, is a key dynamic that we need to address.

Third, we need to create the interoperable networks that allow information to be shared seamlessly among physicians, individuals, public health agencies and other authorized users. Under David Brailer's leadership, we have taken important steps towards creating the predicates of interoperable health information networks. We need to continue this work towards standards while also beginning to invest in the infrastructure that will allow information to flow. Who will create and maintain these networks, what data will flow into and through them, who will own that data, how will it be financially sustained, how will access be governed? There are many questions and, I'm sure, many possible answers. We need to support the development of models that are flexible and innovative but uniform enough to ensure interoperability.

Finally, we need to be building this information infrastructure with an eye towards the real goals of improving quality, safety, and efficiency. The promise of health IT is in what the new data can allow us to do. If we simply do what we've been doing a little bit faster, we do not address the coming health care crisis. We need to use the data to help us deliver the right care to the right people at the right time as efficiently as possible by learning what works best and by improving the use of that knowledge.

The bill Congressman Murphy and I wrote, the 21st Century Health Information Act, attempts to address all of these tasks. We believe that Congress needs to pass legislation that begins to change the systemic dynamics that have hindered the development of the digital health care system. It's not just about plowing federal dollars into IT systems, it's about strategically using our resources to start the ball rolling, and then making sure the federal government doesn't get in the way. We believe that a coordinated regional approach is the best way to simultaneously drive both adoption and development of networks, provided that it's done within a framework of national standards and criteria. Our bill leverages the private sector involvement and leadership

this task requires and offers systemic solutions to systemic problems on a pilot basis. It respects the learning we need to do but is scalable.

I would be happy to discuss at greater length with any of the committee members my thoughts about what our legislative priorities should be. We introduced our bill to begin that conversation and are pleased that the discussion has taken off. There are a number of other bills, including the very strong Senate bill reported out of the HELP Committee last week, which add important improvements.

But given your jurisdiction, I'd like also to say a few words specifically about the Federal Employees Health Benefits Program, and how I think it can be a force for driving improvements in our health care system.

I have been speaking to business audiences in Rhode Island and around the country trying convince them that they are not getting their money's worth for their health care dollar and that we need their leadership. I would make the same argument to you as the committee overseeing federal employee health spending. Employers, including the FEHBP, need to invest in improving the value of the health care system.

There are numerous creative ways that FEHBP could help drive the digital revolution and spur higher quality and efficiency. I'm sure these conversations are going on within OPM. But I would offer a few concrete suggestions:

- The FEHBP should provide a personal health record to every beneficiary. These records are owned by the individual and contain key data. They can make that clipboard obsolete and ensure that emergency room physicians aren't trying to figure out somebody's status by digging through a paper bag full of the contents of a medicine cabinet. They can provide a structured way for patients to get meaningful reminders pertinent to their particular needs, like prescription refill reminders or patient education materials.

- If you wanted to go one step further, the FEHBP could pilot a personal health record fed by claims data. Much of a person's relevant health information is included in claims data, such as which prescriptions they have filled. This information could automatically feed a personal health record to increase its value and accuracy.

- I also believe that FEHBP should lead other employers by example by participating in regional efforts to spur provider adoption and develop information sharing networks. Particularly in the Washington area, where there is such a high concentration of federal employees, it makes good sense for the FEHBP to financially and morally support these efforts. Ultimately, those who pay the health care bills are going to have to help capitalize these IT efforts. FEHBP could do that in many ways, for example by encouraging plans to bump up reimbursement rates for providers who meet certain criteria for IT use in the provision of care.

- Finally, I would urge FEHBP to reinforce CMS's efforts by adopting the same goals and performance metrics so that we start learning which providers are doing the best job.

This step would not only begin explicitly making providers accountable for quality, but would help drive IT adoption because data reporting is difficult without technology.

We are standing on the edge of a monumental change in health care. We have come far in so short a time. I applaud the subcommittee's pursuit of this important topic and look forward to working with you to make our health care system truly the best in the world.

Thank you.

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Is There a Doctor in the Mouse: Using Information Technology to Improve Healthcare
Testimony delivered to the
U.S. House Subcommittee on the Federal Workforce and Agency Organization
Wednesday July 17, 2005, 2:00pm
Congressman Tim Murphy (R-PA)

Thank you, Mr. Chairman.

Almost a year ago as Acting Chairman of this subcommittee, I convened a hearing on how the federal government could drive improvements in our nation's health care system. A year later, over 45 percent of our nation's mandatory spending is going towards health care and while these numbers continue to climb[1], the federal government has yet to provide interoperable Electronic Medical Records and Electronic Prescribing to its employees. As the largest purchaser of health care, any steps that the federal government takes to improve the quality of care has the power to transform the health care culture in this country from one of "who pays," to one of "what we are paying for."

When most people hear the phrase 'health information technology,' they think of wires, hardware, software, PDAs and computers, when in reality it means fewer errors, less infections and mistakes, lower cost, better quality and a higher standard of care. It's as simple as that.

Imagine this scenario. You are on a vacation in Colorado and you lose your luggage. You can simply go to a local ATM, put in your credit or debit card, immediately access your home account and get the money to buy what you need. You can also transfer

[1] Heffler, Stephen. U.S. Health Spending Projections For 2004–2014. Office of the Actuary, enters for Medicare and Medicaid Services. February 2005.

money from one account to another, check your balance to make sure that you have enough money to pay for your expenses, or check your account history for mistakes. Now, imagine the same scenario but instead of losing your luggage, you have an auto accident and are unconscious. You are taken to a hospital and the doctor needs to treat you immediately but they do not have access to your medical records or history. Your spouse has your insurance information but they are stuck filling out forms while the doctors rushes you in for an MRI. Minutes count. But the doctor does not have the information needed including your medications, allergies or past problems such as heart disease. So precious time is lost and doctors have to act without important information and mistakes are made.

What if we could prevent these mistakes through the successful implementation of health information technology? What if your medical information was as instantly accessible as your money? As part of a National Health Information Network, this information would be accessible wherever you are to ensure that your doctor has the information necessary to avoid a preventable medical error and save your life.

President Bush has stated that when it comes to Health IT, "We want to lead. We're not interested in following."[2] The Federal Employees Health Benefits (FEHB) program is no exception and should leverage its buying power to support the President's goal for every American to have interoperable health records within 10 years.

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[2] President Bush. President Bush Touts Benefits of Health Care Information Technology. White House Remarks by the President in a Conversation on the Benefits of Health Care Information Technology. Department of Veterans Affairs Medical Center. April 27, 2004.

Historically, the FEHB program often serves as a model for improving the overall quality of our nation's health care system. Whether it is offering mental health coverage on an equal basis with other medical care or bringing affordable prescription drugs to its members; the FEHB program has the opportunity and the responsibility to drive these changes to improve the nation's health care system.

Plans to bring health information technology to the FEHB program are already underway. Dr. David Brailer, the President's National Coordinator for Health Information Technology, has cited the Framework for Strategic Action on Health IT report to President Bush from the Office of Personnel Management to provide incentives and regulatory changes in the FEHB Program to promote the adoption of interoperable health information technology for the program's over 8 million beneficiaries.[3] However, the train for health information technology has already left the station. In fact, 32 states and the District of Columbia are already developing and financing the implementation of private health information initiatives across the country.[4] While I am pleased with the leadership from U.S. Department of Health and Human Services (HHS) Secretary Michael Leavitt to establish a uniform process for determining interoperable standards for Health IT, every day that we delay implementation is costing lives and money to the tune of over $100 billion dollars,[5] and 195,000 lives[6] per year.

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[3] Fyffe, Kathleen. Office of the National Coordinator for Health Information Technology. Staff Presentations. Markle Foundation, Connecting for Health. March 2005.
[4] Marchibroda, Janis. American Health Quality Foundation eHealth Initiative Advisory Panel. February 24, 2005.
[5] Walker, Jan. et. al. The Value of Health Care Information Exchange And Interoperability. Center for Information Technology Leadership. January 2005.: eHealth

Despite the urgent need for the immediate deployment of health information technology, there remain a number of obstacles which the federal government needs to address. Often small physician practices do not have the financial resources to make this a reality with only 13% of solo physicians implementing Electronic Medical Records, compared to 57% of large group practices of 50 or more physicians.[7] Furthermore, under current Stark anti-kickback laws, it is illegal for hospitals and health care providers to offer this technology to their patients. While HHS has taken proactive steps with the recent creation of Secretary Leavitt's Health IT advisory group, the American Health Information Community (AHIC) and the release of the Requests For Proposals for standards, security, privacy and prototypes of a National Health Information Network, without certified uniform standards across the federal and private sector, doctors, patients and insurers are left without any guidance as to how to make the vision of interoperable health records a reality. This situation creates a 'Tower of Babble,' where various regional health information technology projects can not talk to one another.

Let me give you an example of success. The University of Pittsburgh Medical Center (UPMC), which is ranked No. 1 in health care by InformationWeek 500 of the most innovative users of information technology in the United States and 5th among all U.S. companies has already committed $500 million to developing an interoperable Electronic Medical Record between its 20 hospitals. In addition, UPMC has recently

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Initiative. Electronic Prescribing:Toward Maximum Value and Rapid Adoption. April 2004. : Center for Information Technology Leadership 2004.

[6] HealthGrades. Second Annual Patient Safety in American Hospitals Report. May 2005.

[7] Brailer, David. Remarks by David Brailer, MD. PhD. National Coordinator for Health Information Technology. HIMSS 2005. July 2005.

formed a partnership with IBM for $402 million over the next 8 years to develop and commercially market medical technologies and information systems,[8] while the federal government is still on the sidelines studying this issue. Meanwhile, people are dying.

To ensure that the federal government can bridge this adoption gap with private industry, I have introduced, H.R. 2234, the *21st Century Health Information Act* along with my colleague Rep. Patrick Kennedy from Rhode Island, a bill cosponsored by the Chairman of this full committee, the Honorable Rep. Tom Davis of Virginia. This legislation will provide $50 million in grants and loans to regional Health IT projects with a preference for small providers, calls for interoperable standards to be established by private industry with certification from the Secretary of HHS and removes the current Stark barriers for providers to supply their doctors with Health IT. It will also leverage the federal resources of Medicare and Medicaid to reward providers who show improvements in the quality and performance of care through the successful implementation of information technology. This legislation has been emulated in the U.S. Senate, which recently passed a version out of the Senate Health, Education, Labor and Pensions Committee. As the Co-chair of the 21st Century Health Care Caucus, I am currently working with House Ways and Means Health Subcommittee Chair Nancy Johnson (R-CT) and House Energy and Commerce Health Subcommittee Chair Nathan Deal (R-GA) to ensure that the House also passes Health IT legislation this year.

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[8] Duffeild, Jane. IBM and UPMC in $402 Million On Demand Agreement to Drive Health Care Transformation. April 2005.

Congress can no longer ignore the benefits of health information technology. If we accomplish one thing during this session of Congress, we need to ensure that the federal government takes advantage of the substantial benefits of information technology to improve the quality of care. These benefits include but are not limited to reducing the redundancy of testing and paperwork, virtually eliminating prescription errors, preventing adverse effects from conflicting courses of treatment while significantly reducing medical errors and administrative health care costs.

For example, Electronic Prescribing will ensure that patients receive the lowest generic prescription drugs available. However, it does not matter how much the drug costs when it is the wrong drug, for the wrong patient, at the wrong dosage for the wrong condition, at the wrong time. We need to follow the President's advice and lead by example to establish standards for Health IT and to help doctors acquire electronic prescribing software before preventable errors take the lives of those whom we hold most dear. With over 150 million phone calls made each year by pharmacists to clarify illegible doctors' handwriting, [9] and 1 out of every 12 seniors receiving the wrong medications,[10] there are no excuses for a congressional gap in leadership on this issue.

Thank you Mr. Chairman for allowing me to testify today on the benefits of health information technology. It is important to remember that Health IT is only one

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[9] Institute for Safe Medication Practices. Electronic Prescribing Can Reduce Medication Errors. 2000.

[10] Goulding, Margie. Inappropriate Medication Prescribing for Elderly Ambulatory Care Patients. Archives of Internal Medicine. 2004.

piece of the puzzle to improving the quality of care. The federal government needs to continue to expand and enhance high value services such as comprehensive care management, coordination of care and preventive services. In addition, the federal government needs to continue pay-for-performance measures, such as the demonstration projects currently underway in Medicare, as well as creating legal protections and incentives to empower employees to improve medical hygiene and to stop medical procedures and recommend improvements when they see a chance for medical mistakes without a fear of punitive actions to improve the quality of our nation's health care system.

Patients must also fulfill their responsibilities by adhering to doctors' orders, following prescription regimens, keeping updated medical information and improving their lifestyle choices to help decrease the cost of medical care in this country. I would like to applaud Chairman Porter for having this hearing today and I look forward to working with the Members of this committee to guarantee that the federal government leads by example to lower heath care costs to ensure the American taxpayer receives the quality of health care that they are paying for.

Mr. PORTER. Thank you, Congressman. We appreciate your leadership in a bipartisan nature with Congressman Murphy, who is sick today.

Mr. KENNEDY. That is right.

Mr. PORTER. Here we are talking about health care, and my friend Tim decides to be ill. But certainly we appreciate what you are doing and we look forward to working with you and applaud you for your leadership. Thank you very much.

Mr. KENNEDY. Thank you very much, Mr. Chairman.

Mr. PORTER. We will now go into recess until our votes are concluded.

Thank you.

[Recess.]

Mr. PORTER. I would like to bring the meeting back to order.

For those that have attended a few of our subcommittee hearings in the past, I have been promising to hold our hearings in Las Vegas. Well, I think I am not sure whether it is cooler here or in Las Vegas today. We will be having a hearing in Las Vegas some time in August, so you are welcome to join us around the 12th. If you are looking for a reason to come to Nevada, we are going to be having a hearing in the dry, wonderful southwest.

Thank you for your patience. We will bring the meeting back to order.

I would like to turn to Mr. Davis for any opening comments.

Mr. DAVIS OF ILLINOIS. Thank you very kindly, Mr. Chairman. Let me thank you for calling this hearing. This is a very timely subject for the subcommittee to be considering.

The utilization of information technology to improve the Nation's health care system has gained a great deal of momentum since the Institute of Medicine released its 1996 report on health IT: "To Err Is Human: Building a Safer Health System."

As a matter of fact, health IT is featured in the August 1, 2005, issue of Health and Medicine section of U.S. News and World Report. One of the articles in the magazine, "Can High Tech Save Your Life?," listed 47 hospitals that earn two impressive distinctions: first, the hospitals were listed among America's best hospitals, U.S. News and World Report's ranking of hospitals that is based on expertise, ability to save lives, reputation among specialists, commitment to nursing excellence, and several other factors.

Those hospitals also made the 100 Most Wired List compiled by hospitals and health networks and published by the American Hospital Association. It is a list that identifies the hospitals and health systems that have the most complete information technology. It would appear that those hospitals have successfully used health IT, the technology used to collect, store, retrieve, and transfer health information electronically to improve the quality and safety of health care for their patients.

When compared to other institutions, the mortality rate of the 100 Most Wired Hospitals was 7.2 percent lower on average. While there seemed to be a connection between improved patient outcomes and health IT, matters of patient privacy, continued human care, and the accessibility of online medical data should be addressed by health care providers as they adopt IT policies and systems.

I might just add, Mr. Chairman, that you really appreciate our looking into this matter. I have had a long and intimate association with health care, representing more hospital beds than any other Member of Congress in the United States, having many of the finest hospitals in the country and medical schools in my Congressional District. As a matter of fact, there are four of them—Northwestern University, University of Illinois at Chicago, Rush Presbyterian, St. Luke's Medical Center, Loyola University—as well as a number of smaller community hospitals threaded throughout the area.

I have also spent a great deal of my personal career involved in health care. As a matter of fact, I have sat on the boards of hospitals, I have worked in community health centers, I have been an active member of the American Public Health Association. As a matter of fact, I wrote my doctoral dissertation on the health care needs of black Chicago. I have worked with doctors and hospitals and been on a couple of Federal commissions that I was appointed to, one by President Carter and some other people. So health has been pretty much my life, and the most exciting part of my life.

So as we try and find ways to improve the quality of care and find new ways to protect our public, it is exciting and challenging, and so I certainly thank you for delving into this arena and look forward to the testimony of our witnesses.

I yield back.

Mr. PORTER. Thank you, Mr. Davis.

Mr. DAVIS OF ILLINOIS. And the medical center that you are talking about out in Vegas, my good friend is the director, a fellow named Lacy Thomas, who used to work for me.

Mr. PORTER. You trained him very well. He is doing a great job.

Mr. DAVIS OF ILLINOIS. I am glad to know that he is doing well.

Mr. PORTER. He is doing real well. So maybe when you are out for the meeting in August we can stop and see him.

Mr. DAVIS OF ILLINOIS. Absolutely.

[The prepared statement of Hon. Danny K. Davis follows:]

STATEMENT OF CONGRESSMAN DANNY K. DAVIS AT THE SUBCOMMITTEE ON FEDERAL WORKFORCE AND AGENCY ORGANIZATION ON HEALTH INFORMATION TECHNOLOGY

Wednesday, July 27, 2005

Chairman Porter, this is a very interesting and timely subject for the Subcommittee to be considering. The utilization of information technology (IT) to improve the nation's health care system has gained a lot of momentum since the Institute of Medicine released its 1996 report on health IT, *To Err is Human: Building a Safer Health System*. As a matter of fact, health IT is featured in the August 1, 2005, Health and Medicine section of *U.S. News and World Report*.

One of the articles in the magazine, "Can High Tech Save Your Life?" listed 47 hospitals that earned two impressive distinctions. First, the hospitals were listed among America's Best Hospitals, *U.S. News & World Report's* ranking of hospitals that is based on expertise, ability to save lives, reputation among specialists, commitment to nursing excellence, and several other factors. Those hospitals also made the "100 Most Wired," list. Compiled by the Hospitals and Health Networks and published by the American Hospital Association, it is a list that identifies the hospitals and health systems that have the most complete information technology.

It would appear that those hospitals have successfully used health IT – the technology used to collect, store, retrieve, and transfer health information electronically – to improve the quality and safety of health care for their patients. When compared to other institutions, the mortality rate of the "100 Most Wired" hospitals was 7.2 percent lower, on average.

While there seems to be a connection between improved patient outcomes and health IT, matters of patient privacy, continued human care, and the accessibility of online medical data should be addressed by health care providers as they adopt IT policies and systems.

Thank you for taking the time to testify and educate the Subcommittee about this very important issue.

Mr. PORTER. With that, I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the record, and the answers to written questions provided by the witnesses also be included in the record.

Without objection, so ordered.

I ask unanimous consent that all exhibits, documents, other materials referred to by Members and witnesses may be included in the hearing record and that all Members be permitted to revise and extend their remarks.

Without objection, so ordered.

It is also the practice of this subcommittee to administer the oath to all witnesses. If all witnesses would please stand, I would like to administer the oath.

[Witnesses sworn.]

Mr. PORTER. Let the record show that the witnesses have answered in the affirmative.

We have four panels today. As you know, we started with one, which was very brief for politicians. We appreciate Congressman Kennedy for his leadership and we certainly will have him a part of our additional hearings and will also have Congressman Murphy joining us.

So what I would like to do now is move into our second panel. Our second panel, we will hear from Linda Springer, the Director for Office of Personnel Management. In fairness, Ms. Springer and I have met numerous times over the past month or so, but we note that this is her first hearing with our committee. We are honored to have her.

I know that in the brief amount of time that you have had on the job you have been getting a lot of things together, and I know that even prior to being in a new position you were aware of a lot of these issues. We welcome you and understand that, in your long term of serving the business community and the public sector, you have had a very distinguished career, and we appreciate your being here today.

You have 5 minutes. We look forward to having you come back.

STATEMENT OF LINDA M. SPRINGER, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT

Ms. SPRINGER. Thank you, Mr. Chairman. It is a privilege to be here with this committee today with you and Representative Davis on what we consider at OPM to be a very important issue, and that is the efforts of OPM particularly in helping the community to adopt the provisions of the health information technology, particularly in the FEHB program.

I want to provide a little context for my remarks about that adoption and in the way of background of the FEHB program and OPM's role as the administrator.

There are approximately 8 million Federal employees, retirees, and dependents who are covered by that program. The program allows OPM to offer competitive health benefits for Federal workers in a similar fashion that large employers are able to procure that in the private sector.

We administer the program by contracting directly with private sector providers, but not with the doctors, themselves, so we do not

have specific oversight there, but indirectly we do through the health programs.

Now, with that background I would like to talk a little bit about the direct subject of this hearing and our related activities with the FEHB program.

Under the Executive order issued by President Bush related to the health information technology, there were several areas where OPM was directed to provide information and to work closely to promote its enactment. The order underscored really the importance that the President places on the development of this type of capability nationwide and to have health information technology infrastructures in place that will improve quality, safety, and efficiency of health care.

In order to help fulfill the President's vision, OPM, working also with the Veterans Affairs Department and also Department of Defense, was directed to submit a report within 90 days of the Executive order on various options and incentives that we could put into place in the FEHB program to try and promote adoption of these health information technology opportunities.

In July 2004 OPM fulfilled that requirement and issued a report to the President outlining various options to provide incentives in the FEHB program. Among those options were the following: Encouraging health plans to provide incentives for the adoption of interoperable health information technology systems under the FEHB contracts. Consider basing part of the service charge or profit for the fee for service plans and other experience rated plans and consider introducing performance goals for health maintenance organizations—this is where you really are putting your money where your mouth is when you start talking about their service fees. Introducing incentives and other performance goals for plans that contract with networks of providers to make records accessible through secure—and I want to underscore secure—and other HIPPA compliant interoperable HIT systems. Introducing incentives and performance goals for plans that integrate their provider networks with local and national health information infrastructure initiatives. Also encouraging and rewarding carriers that contract with pharmacy benefit managers that are providing incentives for e-prescribing and health information technology linkages.

Earlier this year OPM staff met with Dr. Brailer, HHS' national health information technology coordinator, and his staff on how we could work closely with them to help promote and to move forward the agenda that they have. In April 2005, Dr. Brailer was the keynote speaker at our annual FEHB carrier conference. His staff also had a followup workshop at the conference to provide more in-depth information for the plans that are participating in the FEHB program. Again, the idea there was to have direct contact without any intermediary for the members of the FEHB program and Dr. Brailer.

Following this conference, OPM issued the annual Call Letter to the carriers that are in the FEHB. This carrier letter provides guidance and negotiation objectives for benefit and rate proposals for the FEHB program for the next contract term. I have a copy of that Call Letter here, but if you look at the Letter you will find that about a page, a solid page of this is in the Letter this year

that would not have been here in the past were it not for the new initiatives on HIT. So clearly OPM is taking some very concrete actions with respect to our carriers.

The Call Letter requested that plans describe their HIT initiatives, including any currently in place for the doctors and pharmacies to use e-prescribing and for contracting hospitals to use electronic registries, electronic records, and e-prescribing. We have received responses from the FEHB plans, and we are in the process of reviewing them right now to establish a baseline from which we can measure progress on how they are doing.

OPM's Web site is another important vehicle for communicating with all of the members of the FEHB program. On that Web site page for participating plans there are links to HIT-related information such as regional health organizations, and the focus on HHS' HIT initiatives and technology groups.

OPM has affiliated itself with a variety of other organizations so that we can stay current on the efforts that are undertaken to again develop this technology capability. We are members of the e-health initiative, Employer and Purchaser Advisory Board, and we are on other various public/private partnership organizations that are focused on quality assurance and quality forums that are focused on patient safety, health care quality, and privacy issues.

With regard to current privacy protections, FEHB enrollees have the same privacy protections as all Americans do in their private plans. All program contracts require health plans to be in complete compliance with HIPPA requirements, and as new interoperable systems are developed OPM will ensure that FEHB plans comply with any Federal requirements with respect to privacy of health information.

We look forward to continuing to work with HHS and with our FEHB participating health plans on our initiatives. We are strongly committed to working forward alongside of the industry and private partners in accomplishing this important objective.

This concludes my testimony, but I appreciate the opportunity to answer any questions that you may have, Mr. Chairman.

Mr. PORTER. Thank you very much.

[The prepared statement of Ms. Springer follows:]

STATEMENT OF THE HONORABLE
LINDA M. SPRINGER
DIRECTOR
OFFICE OF PERSONNEL MANAGEMENT

before the

SUBCOMMITTEE ON THE FEDERAL WORKFORCE
AND AGENCY ORGANIZATION
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

on

Health Information Technology

July 27, 2005

Chairman Porter, Representative Davis, and distinguished Members of the Subcommittee:

I am pleased to be here today to discuss the role of the Office of Personnel Management (OPM) in promoting the adoption of health information technology (HIT) in the Federal Employees Health Benefits (FEHB) Program.

In order to provide a context for my remarks, I'd like to offer some background about the FEHB Program and the role of OPM as the Program administrator. About 8 million Federal employees, retirees and their dependents are covered by this Program. The Program allows OPM to offer competitive health benefits products for Federal workers much like large employer purchasers in the private sector. OPM administers the Program by contracting with private sector health plans. OPM does not contract directly with health care providers and does not generally mandate specific program initiatives. However, in our oversight of the Program, we have consistently encouraged participating plans to be responsive to consumer interests. We have emphasized flexibility and consumer choice as very important features of a competitive health benefits program. With this background, I would now like to discuss the subject of this hearing and our related activities within the FEHB Program.

On April 27, 2004, President Bush issued Executive Order 13335, *Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator.* This Executive Order underscored the importance the President places on the development and implementation of a nationwide interoperable health information technology infrastructure to improve the quality, safety, and efficiency of health care. OPM is strongly committed to working with the FEHB participating health plans on furthering this objective which is to ensure that most

Americans have electronic health records within the next ten years. OPM is also committed to working with the U.S. Department of Health and Human Services (HHS), which is leading this initiative by developing policies and programs aimed at creating a nationwide interoperable health information technology infrastructure.

In order to help fulfill the President's vision, OPM, together with the Department of Veterans Affairs and the Department of Defense, was directed to submit a report within 90 days of the Executive Order on options to provide incentives in the FEHB Program to promote the adoption of interoperable health information technology. In July of 2004, OPM issued a report to the President outlining various options to provide incentives in the FEHB Program. This report emphasized OPM's opportunities as a large purchaser of health benefits to urge FEHB participant health plans to expedite the nationwide phase-in adoption of HIT as soon as practicable. It identified a number of options to support the President's initiative, designed to include incentives for FEHB plans to adopt electronic health records based upon national standards for health data and interoperability, and related practice changes. Below are the options identified in the report:

- Encourage FEHB plans to adopt systems based on generally accepted and certified standards.

- Encourage plans to indicate individual provider HIT capabilities in their provider directories.

- Encourage plans to link disease management and quality initiatives to HIT systems for measurable improvements.

- Encourage health plans to provide incentives for the adoption of interoperable health information technology systems by key providers under FEHB contracts.

- Consider basing part of the service charge, or profit, for fee-for-service and other experience-rated plans and consider introducing performance goals for health maintenance organizations (community-rated plans) that are linked to their developing incentives for:
  - Doctors and pharmacies to use paperless systems to fill prescriptions (ePrescribing);
  - Contracting with hospitals that use electronic registries, electronic records, and/or ePrescribing; and
  - Increasing the number of enrollees whose providers use electronic registries, electronic records, and/or ePrescribing.

- Introduce incentives and performance goals for plans that contract with networks of providers to make records accessible through secure and Health Insurance Portability and Accountability Act (HIPAA) compliant interoperable HIT systems.

- Introduce incentives and performance goals for plans that integrate their provider networks with local and national health information infrastructure initiatives.

- Encourage and reward carriers that contract with pharmacy benefit managers which are providing incentives for ePrescribing and health information technology linkage.

OPM is committed to using its position as the largest purchaser of employee healthcare benefits to contribute in the expansion and use of electronic health records, e-prescribing and other HIT related provisions. In September of 2004, OPM's Deputy Director Dan Blair testified before this subcommittee on the role of the FEHB Program in positively affecting the quality of health care services in the United States. His testimony summarized our findings in the report to the President and highlighted the importance of health information technology to not only improve quality in health care, but also to create cost savings.

Earlier this year, OPM staff met with Dr. David Brailer, HHS' National Health Information Technology Coordinator, and his staff on how we could move the information technology agenda forward. This discussion allowed us to collaborate with HHS and to focus our preliminary approach. In April 2005, Dr. Brailer was the keynote speaker at our annual FEHB Carrier Conference. His staff also conducted a follow-up workshop at the conference to provide more detailed information for the plans participating in the FEHB Program. During his keynote speech, Dr Brailer introduced FEHB plans to the Administration's Framework for Strategic Action in promoting HIT technology. The choice of the National Health Information Technology Coordinator as a featured speaker at our annual conference signaled the importance of the HIT initiative in OPM's agenda.

Following this conference, OPM issued the annual FEHB "Call Letter" to carriers. This carrier letter provides guidance and negotiation objectives for benefit and rate proposals from FEHB Program plans for the next contract term. OPM strongly encouraged plans to take steps to improve their health information technology.

In addition, the call letter requested that plans describe their HIT initiatives, including any currently in place for doctors and pharmacies to use ePrescribing, and for contracting hospitals to use electronic registries, electronic records, and ePrescribing. We have received responses from the FEHB plans and are in the process of reviewing them to establish a baseline on how HIT is currently being used in our health plans. This will allow us to determine where we should focus our next efforts to best further the President's initiative.

OPM's web site is an important vehicle for communication with all involved in the FEHB Program. Enrollees and plans can access information regarding all aspects of the program through the web. Our web site page for participating plans provides links to HIT related information, such as regional health organizations with a focus on HHS' HIT initiatives and technology groups.

OPM recognizes that in order to achieve shared health information technology goals there must be a collaborative effort from all organizations involved in the health care industry. OPM has undertaken and affiliated itself with a variety of organizations working toward the common goal of quality health care through available technology. For example, OPM is member of the eHealth Initiative Employer and Purchaser Advisory Board which is moving forward aggressively to create national and local collaborative effort in this area. OPM also participates on other public/private partnership organizations including the National Committee for Quality Assurance performance measurement workgroup, and the National Quality Forum, which are both focusing on patient safety and healthcare quality.

While the President's Executive Order established the importance of implementing a nationwide HIT infrastructure to improve the quality and efficiency of health care, it also required patients' individually identifiable health information to be secure and protected. OPM will ensure that any options it undertakes will conform to these and any additional Federal requirements that protect the privacy of individually identifiable health information.

With regard to current privacy protections, FEHB enrollees have the same privacy protections as all Americans. The Health Insurance Portability and Accountability Act (HIPAA) required the Secretary of HHS to adopt standards for health care transactions and to protect the privacy of individually identifiable health information. The final HIPAA privacy regulation compliance deadline was April 14, 2003. All FEHB Program contracts require health plans to be in complete compliance with HIPAA requirements. As new interoperable systems are developed, OPM will ensure that FEHB plans comply with Federal requirements on the privacy of individually identifiable health information.

Finally, according to a report entitled *Use of Computerized Clinical Support Systems in Medical Settings*, released in March of this year by the Centers for Disease Control and Prevention (CDC), less than a third of the nation's hospital emergency and outpatient departments use electronic medical records and less than one in five doctors use electronic medical records. The CDC stated that the use of electronic records in health care lags behind the computerization of information in other sectors of the economy. Electronic billing systems are used in three-quarters of physician office practices, but computerization of clinical records has been much slower. Currently, none of the FEHB plans have entirely electronic based information systems. Clearly, there is much more work to be done in the healthcare industry as a whole.

We are looking forward to continued work with HHS and with our FEHB participating health plans on this initiative. And, we are strongly committed to moving forward alongside industry public and private partners in accomplishing this significant objective for all Americans.

This concludes my testimony. I appreciate this opportunity to provide comments on this important initiative for the Federal Employees Health Benefits Program.

Mr. PORTER. I am going to forego my questions at this time because the element of time is limited. I know we communicate frequently, so I will save my questions.

Mr. Davis, do you have any questions?

Mr. DAVIS OF ILLINOIS. I only have one question.

How do you see patient privacy being handled with the development of the centralized data base?

Ms. SPRINGER. I think that patient privacy, first of all, is really the key to acceptance of this type of thing. If we could have all the technology in the world and all the information in the world, but if the privacy is not there we are really wasting our time because it will not be usable. People will not accept it. All of these things require, as I understand it, permission from the patient. They are optional. They are not a mandatory type of thing.

So we have to show that the privacy safeguards are in place, similar to any other type of thing where personal, private information is used electronically. I think, as the chairman mentioned in his opening statement, there are any number of capabilities that are in place today where information is available. Health care is one of the last frontiers, if you will.

So we have to look to those areas to find out what they are doing to ensure privacy and to make sure that it is there, whether it is technologically or the kind of oversight certification possibly that might be required. But I think it is clear that without the privacy protections these efforts will not be successful.

Mr. DAVIS OF ILLINOIS. Thank you.

Mr. PORTER. Thank you. Thank you, Ms. Springer. We appreciate it and look forward to working with you.

Ms. SPRINGER. Thank you.

Mr. PORTER. On panel three we have Dr. David Brailer, our newly appointed National Health Information Technology Coordinator at HHS; Dr. Carolyn Clancy, the Director for the Agency for Health Care Research and Quality, also a division of HHS. Thank you very much for being here.

It is going to help the subcommittee as well as Congress as we move forward. You each will have 5 minutes. We start with Dr. Brailer.

STATEMENTS OF DAVID BRAILER, M.D., PH.D., NATIONAL HEALTH INFORMATION TECHNOLOGY COORDINATOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND CAROLYN M. CLANCY, M.D., DIRECTOR FOR THE AGENCY FOR HEALTH CARE RESEARCH AND QUALITY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DAVID BRAILER

Dr. BRAILER. Thank you, Chairman Porter and Ranking Member Davis.

I have submitted my testimony in advance, and with your consent I will just give brief remarks and then answer any of your questions.

Efforts are well underway to advance health information technology. There are numerous initiatives across the United States in the Administration, which I will detail today, in many States driv-

en by Governors and legislatures, in local and regional grassroots projects, and in the private sector. We certainly welcome the interest of health IT in this subcommittee and elsewhere in Congress.

We have set the foundation for health information technology that is long-term, market-based, non-regulatory, and with a primary focus on attributes that America's consumers need: safety and quality, cost effectiveness, consumer management, and threat preparedness.

Briefly, the foundations of our efforts fall into three categories. First, clinically, we want to ensure that clinicians have access to the kinds of information they need to prevent errors and deaths, to make evidence-based treatment decisions, and to reduce redundant treatments and unnecessary treatments.

We want to bring disparate clinicians together because of the overwhelming evidence that team-based care and collaborative care improve patient's health status. We want to get information to consumers so they can make their own treatment decisions, be involved in critical management of their own health, and choose providers who suit their own needs.

There is a business foundation, as well, that arises from strong support in the private sector for the use of health information technology to improve the competitiveness of our industry, to improve health status of employees, and to bring productivity to the U.S. health care industry that is not unlike productivity improvements we have seen in other sectors of the economy, and, as an added benefit, to develop high-technology jobs in the health care industry across our providers in the United States.

The Federal Government has been called upon by private sector leaders to be a catalyst and convener of this change—and our actions reflect this orientation—and ultimately to use our purchasing power to drive results. To that end, we have had a very collaborative and positive relationship with OPM to be able to accomplish that goal.

The technology foundations have been set by a recent RFI that we have published which asks how do we accomplish the goals of the Administration. Some of the key findings were: it should be collaborative, with public and private players involved; information should ultimately be patient centric, about the patient, not about the doctor or the hospital; there should be very strong privacy safeguards; the information should be decentralized and regionally governed; and there should be a nationwide communication, architecture, and standards.

There are two fundamental aspects of our strategy. One is interoperability and the other is electronic health record adoption.

Interoperability is ultimately about getting information where it is needed and when it is needed. Most of the clinical value that we discuss is tied up in the ability to get information to clinicians when they need it and have it be full, complete, and accurate; yet, today there is very little sharing of information and most of it that is done is patchy and proprietary. There is very little portability of health information toward consumers, and we cannot empower them without getting their information together in a useful way.

The other component of our strategy is about electronic health record adoption, and later the adoption of other health information

technology. There is a large gap in adoption between large health care systems, large hospitals large physician offices, and small ones. Large providers have the know-how and resources to buy, develop, invest, implement, and use advanced health information technology, and they are driving most of the reported adoption. Smaller providers, small physician offices, small hospitals have substantial barriers to the adoption and use of health information technology. They are lagging behind.

We are placing our primary efforts on ensuring that health information is interoperable so that it can be seamlessly following the patient. We are doing this because many scientists and clinicians view that this is a key component of the health care of the future, and it is something that we believe has very strong support from the nearly unanimous recommendations from the respondents to our RFI.

There are several other reasons for this approach, however. It is a one-time chance. Before there is large-scale adoption of electronic health records in the United States, we have a chance today to put in the foundations for information sharing so we can overcome fragmentation of health care. We can enable portable health information and personal health records for our consumers, we can stimulate electronic health record adoption without subsidies, because interoperability lowers the cost and increases the benefits of electronic health records.

We can increase the industry's capacity to implement these tools by eliminating the labor-intensive and risky components of implementation to make products more plug and play. And we can promote innovation and fundamental research by developing new areas where technology can have promise for our clinicians.

We have allocated $86½ million to achieve these goals in fiscal year 2005, and we have requested $125 million to advance this work further in 2006.

I appreciate your interest in the topic and I look forward to further discussion and answering your questions. Thank you.

Mr. PORTER. Thank you, Doctor. We appreciate it.

[The prepared statement of Dr. Brailer follows:]

Testimony
Before the Committee on Government Reform, Subcommittee on Federal Workforce and Agency Organization
U.S. House of Representatives

Activities of the Office of the National Coordinator for Health Information Technology

Statement of

David J. Brailer, M.D., Ph.D.

National Coordinator for Health Information Technology
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 9:30 a.m.
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Chairman Porter and Members of the Subcommittee, I am Dr. David Brailer, the National Coordinator for Health Information Technology. The Office of the National Coordinator for Health Information Technology is a component of the Department of Health and Human Services (HHS). Thank you for inviting me to testify today on health information technology activities underway in the Department.

Setting the Context

On April 27, 2004, the President signed Executive Order 13335 (EO) announcing his commitment to the development and nationwide implementation of an interoperable health information technology infrastructure to improve efficiency, reduce medical errors, raise the quality of care, and provide better information for patients, physicians, and other health care providers. In particular, the President called for widespread adoption of electronic health records (EHRs) within 10 years so that health information will follow patients throughout their care in a seamless and secure manner. Toward that vision, the EO directed the Secretary of the Department Health and Human Services (HHS) to establish within the Office of the Secretary the position of National Coordinator for Health Information Technology (National Coordinator), with responsibilities for coordinating Federal health information technology (health IT) programs with those of relevant executive branch agencies, as well as coordinating with the private sector on their health IT efforts. On May 6, 2004, Secretary Tommy G. Thompson appointed me to serve in this position.

On July 21, 2004, during the Department's Health IT Summit, we published the " Framework for Strategic Action: The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care," (The Framework). The Framework outlined an approach toward nationwide implementation of interoperable EHRs and in it we identified four major goals. These goals are: 1) inform clinical practice by accelerating the use of EHRs, 2) interconnect clinicians so that they can exchange health information using advanced and secure electronic communication, 3) personalize care with consumer-based health records and better information for consumers, and 4) improve public health through advanced bio-surveillance methods and streamlined collection of data for quality measurement and research. The Framework has allowed many industry segments, sectors, interest groups, and individuals to

review how health IT could transform their activity or experience, consider how to take advantage of this change, and to participate in ongoing dialogue about forthcoming efforts. My office has obtained significant additional input concerning how these four goals can best be met.

- We have consulted with, and actively partnered with, numerous federal agencies in the U.S. Government including the Departments of Veterans Affairs, Defense, Commerce, and Homeland Security.
- We have met with many organizations and individuals representing stakeholders of the healthcare system to obtain their individual views.
- We have reached out to states and regions through site visits and town hall meetings to understand the health IT challenges experienced at the local level as well as best practices for the use of, and collaboration regarding, health IT.
- We have regularly testified before, and been informed by, the National Committee on Vital and Health Statistics (NCVHS) on issues critical to the nation's health IT goals.
- We have monitored, and coordinated with, the efforts of the Commission for Systemic Interoperability. (The Medicare Modernization Act called for the Secretary to establish the Commission to develop a comprehensive strategy for the adoption and implementation of health care information technology standards that includes a timeline and prioritization for such adoption and implementation.) and
- We have met with delegations involved with health IT from other countries, including Canada, Netherlands, Japan, Australia, Great Britain, and France to learn from their individual country experiences.

The *Framework for Strategic Action* and the Federal Health Architecture (FHA) are irrevocably linked in the effort to address critical health care needs. The FHA is now under the leadership of the ONC and will provide the structure or "architecture' for collaboration and interoperability among federal health efforts as specified in the *Framework for Strategic Action.* Moreover, the Consolidated Health Informatics activities are now moving forward under the FHA.

Building on the EO, The Framework, and this input, we have developed the clinical, business, and technical foundations for the HHS health IT strategy. Let me turn to some of those now.

The Clinical Foundation: Evidence of the Benefits of Health IT

We believe that health IT can save lives, improve care, and increase efficiency and potentially reduce costs in our health system. Five years ago, the Institute of Medicine (IOM) estimated that as many as 44,000 to 98,000 deaths occur each year as the result of medical errors. Health IT, through applications such as computerized physician order entry can help reduce medical errors and improve quality. For example, studies have shown that adverse drug events have been reduced by as much as 70 to 80% by targeted programs, with a significant portion of the improvement stemming from the use of health IT.

Every primary care physician knows what a recent study in the Journal of the American Medical Association (JAMA) showed: that clinical information is frequently missing at the point of care, and that this missing information can be harmful to patients. That study also showed that clinical information was less likely to be missing in practices that had full electronic records systems. Patients know this too and are taking matters into their own hands. A recent survey by the Agency for Health Care Research and Quality (AHRQ) with the Kaiser Family Foundation and the Harvard School of Public Health found that nearly 1 in 3 people say that they or a family member have created their own set of medical records to ensure that their health care providers have all of their medical information.

Some researchers estimate that savings from the implementation of health IT and corresponding changes in care processes could range anywhere from 7.5 percent of health care costs (Johnston et al., 2003; Pan et al, 2004) to 30 percent (Wennberg et al., 2002; Wennberg et al., 2004; Fisher et al., 2003; Fisher et al., 2003). These estimates are based in part on the reduction of obvious errors. For example, a medical error is estimated to cost, in 2003 dollars, about $3,700 (Bates et al, 1997). However, these savings are not guaranteed through the simple acquisition of health IT. If poorly designed or implemented, health IT will not bring these benefits, and in some cases may even result in new medical errors and potential costs. Further, these are estimates which we have not yet seen realized in the health care system generally.

Therefore, achieving efficiency and potential cost savings requires a much more substantial transformation of care delivery that goes beyond simple error reduction. Health IT must be

combined with real process change in order to see meaningful improvements in our delivery system and systems must be standards compliant and interoperable so that patient information can be communicated to all possible points of care. It requires the industry to follow the best diagnostic and treatment practices everywhere in the nation. For example, cholesterol screenings can lead to early treatment, which in turn can reduce the risk for heart disease. Where that has been done, there have been substantial savings on cardiac expenditures.

So, this is the clinical foundation for our work, which demonstrates that health IT can save lives, improve care, and improve efficiency in our health system; now let me turn to the business foundation.

The Business Foundation: The Health IT Leadership Panel Report

Recognizing that the healthcare sector lags behind most other industries in its use of IT, an HHS contractor convened a Health IT Leadership Panel for the purposes of understanding how IT has transformed other industries and how, based upon experiences of members of the panel, it can transform the health care industry.

The Leadership Panel was comprised of nine CEOs from leading companies that purchase large quantities of healthcare services for their employees and dependents and that do not operate in the healthcare business. The Leadership Panel included CEOs from FedEx Corporation, General Motors, International Paper, Johnson Controls, Target Corporation, Pepsico, Procter & Gamble, Wells Fargo, and Wal-Mart Stores. The business leaders were called upon to evaluate the need for investment in health information technology and the major roles for both the government and the private sector in achieving widespread adoption and implementation. Based upon their own experiences using IT to reengineer their individual business – and by extension, their industries – the Leadership Panel concluded that investment in interoperable health IT is urgent and vital to the broader U.S. economy due to rising health care demands and business interests.

As identified by the Lewin Group, the Leadership Panel concluded:

- Potential benefits of health IT far outweigh manageable costs.
- Health IT needs a clear, broadly motivating vision and practical adoption strategy.

- The federal government should provide leadership, and industry will engage and follow.
- Lessons of adoption and success of IT in other industries should inform and enhance adoption of health IT.
- Among its multiple stakeholders, the consumer—including individual beneficiaries, patients, family members, and the public at large—is key to adoption of health IT and realizing its benefits.
- Stakeholder incentives must be aligned to foster health IT adoption.

The Leadership Panel identified as a key imperative that the Federal government should act as leader, catalyst, and convener of the nation's health information technology effort. The Leadership Panel also emphasized that federal leverage as purchaser and provider would be needed—and welcomed by the private sector. Private sector purchasers and health care organizations can and should collaborate alongside the federal government to drive adoption of health IT. In addition, the Leadership Panel members recognized that widespread health IT adoption may not succeed without buy-in from the public as health care consumer. Panelists suggested that the national health IT vision must be communicated clearly and directly to enlist consumer support for the widespread adoption of health IT.

These findings and recommendations from the Leadership Panel were published in a report released in May 2005 and laid the business foundation for the HHS health IT strategy. Now, let me turn to the technical foundation.

The Technical Foundation: Public Input Solicited on Nationwide Network

HHS published a Request for Information (RFI) in November 2004 that solicited public input about whether and how a Nationwide Health Information Network (NHIN) could be developed. This RFI asked key questions to guide our understanding around the organization and business framework, legal and regulatory issues, management and operational considerations, standards and policies for interoperability, and other considerations.

We received over 500 responses to the RFI, which were reviewed by a government-wide RFI Review Task Force. This Task Force was comprised of over 100 Federal employees from 17

agencies, including the Departments of Homeland Security, Defense, Veterans Affairs, Treasury, Commerce, Health and Human Services, as well as multiple agencies within the departments. The resulting public summary document has begun to inform policy discussions inside and outside the government.

We know that the RFI stimulated substantial and unprecedented discussions within and across organizations about how interoperability can really work, and we have continued to build on this. These responses have yielded one of the richest and most descriptive collections of thoughts on interoperability and health information exchange that has likely ever been assembled in the U.S. As such, it has set the foundation for actionable steps designed to meet the President's goal.

While the RFI report is an illustrative summary of the RFI responses and does not attempt to evaluate or discuss the relative merits of any one individual response over another, it does provide some key findings. Among the many opinions expressed by those supporting the development of a NHIN, the following concepts emerged:

- A NHIN should be a decentralized architecture built using the Internet, linked by uniform communications and a software framework of open standards and policies.
- A NHIN should reflect the interests of all stakeholders and be a joint public/private effort.
- A governance entity composed of public and private stakeholders should oversee the determination of standards and policies.
- A NHIN should provide sufficient safeguards to protect the privacy of personal health information.
- Incentives may be needed to accelerate the deployment and adoption of a NHIN.
- Existing technologies, federal leadership, prototype localized or regional exchange efforts, and certification of EHRs will be the critical enablers of a NHIN.
- Key challenges to developing and adopting a NHIN were listed as: the need for additional and better refined standards; addressing privacy concerns; paying for the development and operation of, and access to the NHIN; accurately verifying patients' identity; and addressing discordant inter- and intra-state laws regarding health information exchange.

Key Actions

Building on these steps, two critical challenges to realizing the President's vision for health IT are being addressed: a) interoperability and the secure portability of health information, and b) electronic health record (EHR) adoption. Interoperability and portability of health information using information technology are essential to achieve the industry transformation goals sought by the President.

To address these challenges, HHS is focusing on several key actions: harmonizing health information standards; certifying health IT products to assure consistency with standards; addressing variations in privacy and security policies that might pose challenges to interoperability; and, developing an architecture for nationwide sharing of electronic health information. HHS has allocated $85 million to achieve these and other goals in FY 2005 and has requested $125 million in FY 2006. These efforts are inter-related, and they will be coordinated through the formation of a new collaborative known as the American Health Information Community.

American Health Information Community (the Community)

On July 14, 2005, Secretary Michael Leavitt formally announced the formation of a national collaboration, the American Health Information Community (the Community), a public-private body formed pursuant to the Federal Advisory Committee Act. The Community is being formed for the purposes of helping transition the nation to electronic health records in a smooth, market-led way. The Community will provide input and recommendations to the Secretary on use of common standards and how interoperability among EHRs can be achieved while assuring that the privacy and security of those records are protected. And, it will be designed as an open, transparent and inclusive collaboration.

HHS is currently soliciting nominations for people to serve on the Community and Secretary Leavitt will appoint up to 17 commission members, including himself as chairperson. It will consist of nine members from the public sector and eight members from the private sector. Public Sector members will be drawn from Department of Health and Human Services

(including the Office of the Secretary, the Centers for Medicare and Medicaid Services, and the Public Health Service), Department of Veterans Affairs, Department of Defense, Department of Commerce, Department of the Treasury, Office of Personnel Management, and a State government representative. The private sector membership will be drawn from purchasers, third-party payers, hospitals, physicians, nurses, ancillary services (e.g., lab or pharmacy), consumer and privacy interests, and health information technology. Nominations for membership are being accepted through August 5, 2005. The Community is expected to be convened early this fall.

The Community will start by building on the vast amount of standardization already achieved inside and outside the healthcare industry. Specifically, the Community will:

- Make recommendations on how to maintain appropriate and effective privacy and security protections.
- Identify and make recommendations for prioritizing health information technology achievements that will provide immediate benefits to consumers of health care (e.g., drug safety, lab results, bio-terrorism surveillance, etc.).
- Make recommendations regarding the ongoing harmonization of industry-wide health IT standards and a separate product certification and inspection process.
- Make recommendations for a nationwide architecture that uses the Internet to share health information in a secure and timely manner.
- Make recommendations on how the Community can be succeeded by a private-sector health information community initiative within five years. (The sunset of the Community, after no more than five years, will be written into the charter.)

The Community will be chartered for two years, with the option to renew and duration of no more than five years. The Department intends for the Community to be succeeded within five years by a private-sector health information community initiative that, among other things, would set additional needed standards, certify new health information technology, and provide long-term governance for health care transformation.

In addition to the formation of the Community, the Office of the National Coordinator issued four requests for proposals (RFPs). The outputs of the contracts stemming from these RFPs will, in part, serve as inputs for the Community's consideration. We expect to award contracts based on these RFPs in September and October 2005. Specifically, the RFPs will focus on four major areas:

Standards harmonization

We have issued a Request For Proposal (RFP) to develop, prototype and evaluate a process to harmonize industry-wide standards development, and also unify and streamline maintenance of and refinements to existing standards over time. Today, the standards-setting process is fragmented and lacks coordination, resulting in overlapping standards and gaps in standards that need to be filled. We envision a process where standards are identified and developed around real scenarios – i.e., around use cases or breakthroughs. A "use case" is a technology term to describe how actors interact in specific value-added scenarios – for example, rapidly assembling complete patient information in an emergency room; we also call them "breakthroughs".

Compliance certification

We have issued an RFP to develop, prototype and evaluate a process to specify criteria for the functional requirements for health IT products – beginning with ambulatory EHRs, then inpatient EHRs, and then the infrastructure components through which EHRs interoperate (e.g., NHIN architecture). This RFP will also evaluate a process for inspection based on conformance with these criteria.

NHIN Architecture

We have issued an RFP to develop models and prototypes for a NHIN for widespread health information exchange that can be used to test specialized network functions, security protections and monitoring, and demonstrate feasibility of scalable models across market settings. The NHIN architecture will be coordinated with the work of the Federal Health Architecture and other interrelated RFPs. The goal is to develop real solutions for nationwide health information exchange and ultimately develop a market – particularly the supply side – for health information exchange, which does not exist today. This RFP will fund 6 architectures and operational

prototypes that will maximize the use of existing resources such as the Internet, and will be tested simultaneously in three markets with a diversity of providers in each market. HHS intends to make these prototype architectures available in the public domain to prevent control of ideas and design. Through the RFP process, we encourage the development of a complete open source solution.

Security and privacy

We issued an RFP to assess variations in state laws and organization-level business policies around privacy and security practices, including variations in implementations of HIPAA privacy and security requirements that may pose challenges to automated health information exchange and interoperability. This RFP, administered by AHRQ, will seek to define workable mechanisms and policies to address these variations, while maintaining the levels of security and privacy that consumers expect.

Fraud and Abuse Study

In addition, HHS has a 6-month project underway to determine how automated coding software and a nationwide interoperable health information technology infrastructure can address healthcare fraud issues. The project is being conducted through a contract with the Foundation of Research and Education (FORE) of the American Health Information Management Association (AHIMA).

While only a small percentage of the estimated 4 billion healthcare claims submitted each year are fraudulent, the total dollars in fraudulent or improper claims is substantial. The National Health Care Anti-Fraud Association (NHCAA) estimates that healthcare fraud accounts for 3 percent of U.S. health expenditures each year, or an estimated $56.7 billion. They cite other estimates, which may include improper but not fraudulent claims, as high as 10 percent of U.S. health expenditures or $170 billion annually.

At present, the contractor is working to perform two main tasks. One task is a descriptive study of the issues and the steps in the development and use of automated coding software that enhance healthcare anti-fraud activities. The second task is identifying best practices to enhance the

capabilities of a nationwide interoperable health information technology infrastructure to assist in prevention, detection and prosecution, as appropriate, in cases of healthcare fraud or improper claims and billing. An expert cross-industry committee composed of senior level executives from both the private and public sectors is guiding this second task.

The project's final report is scheduled for completion in September 2005.

Conclusion

Thank you for the opportunity to present this summary of the activities of the Office of the National Coordinator for Health Information Technology. A year ago, the President created this position by Executive Order. In that time, we have established the clinical, business and technical foundations for the HHS health IT strategy. Now, we have begun to execute key actions that will give us real, tangible progress toward that goal.

HHS, under Secretary Leavitt's leadership, is giving the highest priority to fulfilling the President's commitment to promote widespread adoption of interoperable electronic health records – and, it is a privilege to be a part of this transformation.

This concludes my prepared statement. I would be delighted to answer any questions that you or the Members of the Subcommittee may have.

Mr. PORTER. Dr. Clancy, please.

STATEMENT OF CAROLYN M. CLANCY

Dr. CLANCY. Good afternoon, Mr. Chairman. I am delighted to outline the ways in which the Agency for Health Care Research and Quality [AHRQ], is advancing the adoption, implementation, and effective use of health information technology.

I have asked that my written testimony be submitted for the record.

AHRQ's research portfolio will help the Nation meet three vital objectives: reducing medical errors, improving the quality of patient care, and reducing the cost of health care. For nearly three decades AHRQ has funded the basic science of health IT by supporting the pioneers and innovators so that many of the Nation's leading health IT systems have actually been established from AHRQ-supported research. Our task now is to spread the knowledge and experience that we have gained more broadly throughout the health care system, and we also need to support research targeted to address some critical gaps.

In fiscal year 2004, AHRQ announced an investment of $139 million over 5 years to achieve these goals. This national initiative is now supporting 108 grants and contracts in 43 States with over half of the projects based in rural and small hospitals and clinics. All told, this investment will affect more than 40 million Americans. My written statement details extensively these projects, but I would like to provide some highlights now.

First, I would like to note briefly the important role that consumers can play in improving health care. Informed and engaged consumers who work in partnership with clinicians I think are an untapped resource. We need to make sure that they have the tools they need to make choices using evidence-based information. We have made it a priority to develop evidence-based information for consumers and are very pleased that our partner, OPM, is the leading edge of making this information available for its customers.

Mr. Chairman, as a Federal employee you can go to the FEHB Web site and use an AHRQ-developed tool called CAPS, which stands for the consumer assessment of health plan survey, to help you choose your plan.

So we are now looking to the power of health IT to customize evidence and information about treatment choices, diagnostic options, and to put that into the hands of consumers and providers.

Under the Medicare Modernization Act, section 1013, AHRQ is working with other Federal agencies to create a program to evaluate the comparative effectiveness of products and procedures. The results of those evaluations will be made available to the Medicare and Medicaid progress, as well as to other Federal programs, such as the FEHB and the general public. Our goal here is to organize the information so consumers can get it in a timely manner and use it to make informed decisions about their health care.

We are also exploring new technologies that allow consumers to gain access to their personal health information securely over the Internet, such as their medicine lists. Access to trusted information like this on the Web, particularly if it is delivered in a timely fashion, will revolutionize health care.

For providers, as you have pointed out, health IT offers great intermediate potential to improve patient safety by reducing medicine errors. The value, as you have noted, seems obvious: reducing handwriting errors, cross-checking prescribing errors, and identifying dangerous interactions before they occur.

Health IT can also greatly improve the overall quality of care by making the right thing to do the easy thing to do.

As a doctor, when I see a patient who is coughing and has a fever I can now use an AHRQ-funded electronic tool to help decide whether to hospitalize that patient. I used to have to leave the exam room, go look up the information to make treatment decisions. So it is an amazing innovation to have that information available at your fingertips when it is needed.

We have also taken health IT into settings where traditionally it has not been available, including nursing homes, pharmacies, waiting rooms, schools, and patients' homes.

The potential for cost savings from systematic use of health IT results from removing inefficiencies, improving physician decision-making, enhancing communication, and reducing followup care due to medical errors, use of inappropriate services.

A survey we fielded last fall found that approximately one-third of patients reported that they have to go back for a second visit because the relevant information was not available with their clinician at the time of their first visit.

Our research has also demonstrated that computerized reminders can reduce hospital charges per admission by approximately 13 percent, and with your support we will continue our efforts to provide sound evidence on the financial benefits of health IT.

Mr. Chairman, I cannot overemphasize how important practical technical assistance is to the successful adoption and implementation of health IT, and to that end we have created the AHRQ National Resource Center, the largest single commitment to technical assistance that we have made in our history.

This resource center leverages our investments in health IT by offering help where it is needed in real-world clinical settings that may be ill-equipped to meet the health IT challenge. We do this by facilitating expert and peer-to-peer collaborative learning and fostering the growth of online communities that are planning, implementing, and researching technology. As one of our grantees has told us, transition to health IT is one part technical and two parts culture and work process change.

This was designed initially to meet the needs of our grantees, and we have recently opened this up to the Nation's community health centers, and we will also be making it available to providers working with the quality improvement organizations.

So I would like to conclude by making a couple of brief observations.

First is that health IT alone cannot provide the improvements needed in our health care system. It has to be integrated into individual clinical practices in an interoperable system, as Dr. Brailer noted.

Second, for most health care settings, health IT is not yet an out-of-the-box or, as Dr. Brailer said, a plug and play solution. It is very important to remember that health IT applications need to

meet the needs of clinicians and patients rather than the other way around.

A third important point is that the financial exposure for providers, when added to concerns about doing it right, increases the overall risk of making these investments. In order to accelerate the pace of adoption and implementation, we are committed to making sure that best practices and new knowledge and experience are disseminated widely in order to maximize the potential for quality improvement and reduce economic risk.

We look forward to working with Secretary Leavitt, Dr. Brailer, and our other partners to making health care for all Americans better through health IT.

Thank you. I would be happy to take any questions.

Mr. PORTER. Thank you, Doctor. We appreciate it.

[The prepared statement of Dr. Clancy follows:]

Testimony
Before the Subcommittee on the Federal Workforce and Agency Organization
Committee on Government Reform
United States House of Representatives

Health Information Technology Activities at the Agency for Healthcare Research and Quality

Statement of
Carolyn M. Clancy, M.D.
Director
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 2:00 p.m.
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Introduction

Chairman Porter, I am delighted to join Dr. Brailer in outlining the ways in which the Department of Health and Human Services (HHS) is advancing the adoption, implementation, and effective use of health information technology (IT).

Achieving the President's goal of widespread use of interoperable electronic health records requires us to address a number of complex and technical issues, many of which are not specific to the health system. My testimony will focus on how the activities of the Agency for Healthcare Research and Quality (AHRQ) complement the Department's other efforts by harnessing the power of IT to improve the effectiveness, efficiency, quality, and safety of health care.

While we work with the Secretary and Dr. Brailer to ensure that the fundamental IT infrastructure is in place, we are critically examining how these IT tools can be used in real-world health care settings to make care better. This is because patients and payers are not interested in health information technology in and of itself. They are interested in what it can do to improve quality, effectiveness, safety and cost. In other words, how do we do health IT right? How do we assure that the investment gets us – patients, caregivers, providers, payers and others – what we want? What measures, methods, and best practices can be identified and used? In addition, how do we take lessons learned about what works – and what does not—and disseminate that knowledge so that the right medical practice, technology and information practices get adopted more quickly? In many ways, this aspect of the healthcare industry is in its infancy.

AHRQ exists to serve the American health care system and Federal health care programs by assuring that cutting edge knowledge is available when and where it is needed. We are happy to share with you what we are doing in this area how our work can be of assistance to the Office of Personnel Management (OPM) and Federal Employee Health Benefits Program (FEHBP) and other Federal health care programs.

For many health care providers the need to address specific local threats to the safety and quality of patient care is immediate; an increasing number of practitioners and organizations have made or will soon make investments in health IT. AHRQ's investments support evaluation of the impact of selected health IT applications on quality and safety, with a strong emphasis on the needs of caregivers in rural and underserved populations. That is why we have made awards to local and regional organizations that affect the care received by more than 40 million Americans. Leaders in health care recognize that improvement requires both incentives and the capacity to respond to those incentives. Our focus is on building the capacity within healthcare settings—large and small, urban and frontier—for the effective use of health IT, and disseminating findings rapidly. The benefits of health IT need to begin now for as many Americans as possible. The results of these investments represent tangible benefits that will be

accelerated as the private-public collaboration to facilitate a nationwide information infrastructure develops.

We are also addressing a critical stumbling block to the widespread adoption of health IT, the human dimension of the use of IT, which focuses on the intersection between IT and the health care providers who need to use it. Unlike the baseball field in the movie *Field of Dreams*, we have dramatic examples of the building of health IT systems, whose designers found physicians neither came nor played. Unless we address these issues as well as technical ones, we risk falling far short of a safer, higher quality health care system.

The Importance of Health IT

When we look at the challenges facing our healthcare system in the years and decades ahead, there is no job more important than getting health IT into place, and getting it right. As the Institute of Medicine noted in their second report on patient safety, Americans should be able to count on receiving health care that is safe. This requires, first, a commitment by all stakeholders to a culture of safety, and second, improved information systems. While transformation of our heath care system—with higher quality, patient-centric and cost-effective care —will not happen simply as a result of health IT, it is difficult to think how transformation could possibly take place without the capacities it brings. We have a fundamental problem of fractured healthcare delivery that results in needless waste of resources. Health IT can bind this system together, even as it preserves its diversity.

Think for a moment about what is happening in health care settings around the country. Millions of decisions are being made about people's lives without the right information in hand:

- Is chemotherapy alone the best treatment for a patient with breast cancer, or should she be treated with radiation and chemotherapy?
- Which of our young athletes should be screened and with what type of diagnostic test for heart abnormalities, as a front-page story in the *Wall Street Journal* asked last month?
- How does a person with diabetes, high blood pressure, and obesity manage all the different demands of their conditions?

Patients and consumers struggle with even more basic decisions: Which provider to see? When to seek care? Which treatment option is best for their needs?

Many of these decisions are difficult even in the most ideal circumstances, when there is sufficient time to assess good, reliable information. But as we all know, these decisions frequently must be made at times and places where information is not available, and time is of the essence. The power of IT can help us to

regularly assess quality and outcomes while bringing us reliable data that can be accessed at the point-of-care.

For nearly three decades, AHRQ has funded the basic science of health IT, development and testing of tools to facilitate its use, and supported the work of innovators. Many of the leading systems of our Nation were created on the backbone of AHRQ and National Library of Medicine (NLM) grants over the last three decades. The most prominent examples are Intermountain Healthcare in Utah and the Regenstrief system in Indiana, which are now models for the effective use of health IT. The task we have now embarked upon is to move that knowledge and experience into the health care system more broadly and to support targeted research to fill the gaps in our knowledge base that are critical to widespread diffusion of health IT. Successful implementation of health IT in turn provides the best possible platform for delivering scientific evidence to clinicians and patients when decisions are made.

AHRQ's Current Health IT Activities

In FY 2004 AHRQ awarded 108 grants and contracts to address a number of those gaps in our knowledge and to advance the use of health IT. Reflecting a commitment of $139 million over five years, these awards were truly nationwide in scope. They spanned 43 states, with over half of the projects based in rural and small hospitals and clinics. In combination, the communities where AHRQ health IT grants or contracts were awarded include more than 40 million Americans.

AHRQ's research portfolio is making significant advances in meeting three objectives:

1. Reducing medical errors.
2. Improving the quality of patient care.
3. Reducing the cost of health care.

Reducing Medical Errors

Medication errors are a grave threat to patient safety and one of the greatest opportunities for reducing medical errors. The potential value of health IT here seems intuitively obvious: reducing handwriting and other communication errors, electronic cross-checks for errors in medication strength, identification of interactions with other medications or other adverse events reflecting the patient's overall medical condition. Our projects span the spectrum from prevention to detection and prompt treatment of medication errors, and identify the most effective ways to use health IT to achieve each of these goals.

Patients, especially patients with chronic illnesses, can play an important role in preventing medication errors. Some of our projects are developing Internet-

based portals to enable patients to manage their own care, including medications. In the course of deploying this technology, we are learning valuable lessons about how patients want to participate. Patients are very enthusiastic about documenting their medications, giving their clinicians new insights about medication compliance as well as other supplements the patients may be taking on their own initiative. An unexpected side benefit from the move to an Internet-based system was that the children of elderly patients who are living in a different state were able to assist in their parents' care in a new and engaged manner, when parents authorized access by their children.

Recognizing that medication errors can still occur even when health care providers are vigilant, a team at Duke University is attempting to minimize the potential for serious patient harm. They are testing a monitoring system for hospital patients that will detect the onset of an adverse drug effect, immediately alert the hospital staff, and suggest the most appropriate intervention. AHRQ is also funding systems for the voluntary reporting of errors.

Improving the Quality of Care

The linkage between health IT and improving the quality of care occurs on multiple levels. We know that we cannot improve the quality of care unless we can measure performance. But monitoring and reporting the quality of care is time-consuming, inaccurate, and incomplete without IT systems. A challenge shared by AHRQ and the Centers for Medicare & Medicaid Services (CMS) is how to best translate measures of quality into computable, automated quality reporting systems in settings such as hospitals and physician offices.

The maturation of IT for use in daily practice comes at a time when the burden of good healthcare delivery is rising. Many patients obtain care from multiple providers and experience the effects of poor coordination of information and care. Indeed, 69 percent of Americans report that poor coordination among their providers is a serious problem for them, and 32 percent report that they or a family member have created their own medical record to assure that all health care professionals they see have accurate, current information about their health issues. Health IT can reduce this burden by facilitating the transfer of information among providers customizing knowledge for the patient, and facilitating communication between providers.

AHRQ has funded cutting-edge research into how to translate medical knowledge into specific information, tailored to the patient at hand and immediately available to the clinician when decisions are being made. These include alerts about inappropriate therapies, reminders about preventive care, and assistance in automatically doing the right thing. Health IT has the potential to rapidly disseminate knowledge previously available only to in large urban academic health centers.

For example, an AHRQ project in Boston brings cutting edge diagnostics to emergency medical services helping caregivers identify heart attack victims even before they reach the emergency room. At least two manufacturers have now incorporated this decision support system into EKG machines. By helping emergency medical service teams and emergency room physicians better determine when a patient with chest pains actually has suffered from, and may still be vulnerable to, a heart attack, quality of care will be greatly enhanced. Those who truly need care will receive it and those who may be suffering from less serious problems, like indigestion, will be spared the risks, worries, and costs that accompany unnecessary hospitalizations.

Our research has made clear the importance of system issues such as organizational culture and workflow. Our investments evaluate specific strategies to close the gap between the potential of health IT to improve care quality and the less promising reality experienced by many providers due to suboptimal product design or challenges in integrating health IT with the work of clinicians.

For example, we are funding studies of technology integration, using time-motion studies, culture surveys, and observational techniques to understand why technologies are accepted or sabotaged by the clinical users. But we don't stop there. AHRQ funds research projects to explore how the technology can adapt in intelligent ways to clinician needs. We have a suite of projects with Partners Healthcare System in Boston to develop "SmartForms" for various settings—smart because they anticipate the physicians' needs for information based on the patient, and automatically assist the physician in pulling together the various action plans necessary to execute the right care plan. An additional benefit of this project is the ability to report back to the physician -- immediately and individually -- their performance on clinical quality relative to their peers. By giving immediate feedback to caregivers, we raise their awareness of how their decisions impact the quality of care patients receive.

Finally, the breadth of our current portfolio has been instrumental in enabling AHRQ to take health IT into settings where traditionally there has been underinvestment. These include nursing homes and pharmacies, waiting rooms and schools and homes, to parents and caregivers, to rural and small settings, to the blind and chronically ill, and to those recovering from serious acute events. Each of these new frontiers requires the discovery of the unique needs of the targeted population, growing new partnerships, and creatively transferring knowledge about lessons learned.

Reducing the Cost of Care

The potential for increased efficiency, including cost savings from systematic use of health IT, includes avoidable expenditures in the administrative and financial aspects of health care institutions, the improved efficiencies in workflow, improved physician decision making (especially when decision support systems

provide immediate access to information on comparative effectiveness and cost effectiveness), and in the reduced need for additional patient care that medical errors often entail.

There are also significant financial and non-financial costs to patients that can be reduced through the introduction of health IT: the potential for bringing health care to the patient's location (which can be a serious issue for those isolated geographically, or receiving care at home or in nursing homes), removing the inconvenience, expense, and increased risk of harm associated with inpatient admission, reducing or eliminating the need to return to a tertiary care hospital for follow-up consultations, and the potential for patients to substitute e-mail or other Web-based consultations in place of office visits with their physicians. One-third of Americans surveyed reported that they needed to return for a repeat visit because their clinical information was not available.

Further, consumers are a critical resource in improving the value of health care services. To that end, we are also taking steps to provide healthcare consumers with the tools they need to shop for the best quality care. Under the Medicare Modernization Act's (MMA) Section 1013, AHRQ is working with other Federal agencies to establish a program to evaluate the comparative effectiveness of products and procedures. The results of those evaluations will be made available to the Medicare and Medicaid programs, as well as to other Federal programs and the general public. When individual providers, health plans, and others help make the results available to consumers through personal links to consumers' health information and medical records, it can be a powerful tool for achieving both quality and value in health care.

AHRQ's prior investments provide evidence of the potential for savings in selected care settings, and work in progress will demonstrate the value obtained from investments in health IT in a broad array of settings. Over the last decade work by one of our grantees demonstrated that computerized reminders can reduce the cost of tests ordered for hospitalized patients by approximately 10 percent.

Another example is the Utah Health Information Network (UHIN), developed a decade ago by then-Governor Leavitt, which demonstrated the potential for savings in administrative and billing costs through the use of health IT. By creating a single way to submit bills, UHIN both reduced costs and reduced the administrative burden of re-entering the same data for different payers. AHRQ now is working with UHIN to add clinical data to their statewide system to enhance its potential to improve the quality and safety of patient care as well.

AHRQ is funding other statewide regional health information exchange projects in Indiana, Rhode Island, Colorado, and Tennessee. The Indiana project, led by the Regenstrief Institute, a national health IT leader, is another example of the power for IT to directly impact care. The impetus for this statewide initiative was

the rationale that health care information should be reliably available for patients seen in Emergency Departments regardless of where they usually get care. When current data are available, redundant testing can be avoided, and the right care can be delivered more rapidly. In an effort to more definitively identify the cost savings of health IT, we are concurrently funding an evaluation of the value of that exchange, not only in the hospital system but also throughout the State's primary care and specialty clinics. This well-designed evaluation will provide the Nation with clear evidence of whether the actual savings are as significant as many hope. This will provide crucial evidence for those seeking to make a business case for health IT.

In addition, the results will be incorporated into a simulation model developed by the Center for IT Leadership, letting real-world numbers improve the best estimates of IT thought leaders. AHRQ-sponsored research will also help to demonstrate the costs and benefits of the statewide electronic prescribing roll-out in Massachusetts, undertaken by a consortium that includes Blue Cross Blue Shield. AHRQ researchers will have access to claims and utilization data for over 1000 prescribers, translating to approximately 480,000 prescriptions over the course of the year.

The results of AHRQ's current research will also inform America about the wide-ranging effects of the large investments in health IT by integrated delivery systems. One evaluation project studies the effects of Kaiser's $3 billion investment in electronic medical records for ambulatory physician practices on patient outcomes and resource utilization. As a result of our funding, the evaluation findings regarding these major investments will be available to the public. This will accelerate adoption by enabling health care institutions to learn from the early adopters.

National Resource Center for Health IT

Mr. Chairman, I cannot over-emphasize how essential technical assistance is to the successful adoption and implementation of health IT. To assure that as many Americans as possible benefit from our research, we are committed to exporting lessons learned from current demonstrations rapidly and widely. We have been inundated with requests for help from payers, providers and health care systems attempting to adopt health IT. In response, we have created a National Resource Center for Health IT, the largest single commitment to technical assistance in AHRQ's history.

The Resource Center leverages our investments in health IT by offering help where it is needed—real world clinical settings that may feel ill equipped to meet the implementation challenge—facilitating expert and peer-to-peer collaborative learning and fostering the growth of online communities who are planning, implementing, and researching health IT. Our initial needs assessment led to the

development of a series of educational teleconferences on critical topics for health IT implementers:

- How to comply with rules and regulations.
- How to design workflow, how to evaluate effectiveness.
- How to tackle clinical decision support systems.

In June, we convened a highly successful, weeklong meeting attended by over 700 doctors, nurses, pharmacists, and IT professionals to share practical knowledge about health IT, and linked it closely with the goals for patient safety. As one of our grantees from Kentucky said, "this meeting brought real life case study experience to so many of the issues facing us today."

AHRQ has also used the Resource Center to assist States that are initiating statewide clinical data sharing. We have convened small, round-table working meetings of experts to share detailed expertise with States that are starting the process of determining the governance and technical architecture of their data-sharing organizations. The first of these was in Tampa, at the invitation of the Florida Governor's Health Information Infrastructure Advisory Board; we have planned expert roundtables in New York, Wyoming, and Montana, with further assistance to Delaware, Maryland, and Georgia. In these roundtables, AHRQ has been fortunate to draw upon the expertise of our State contractors who are intimately involved with this work in their own States, as well as consultants from our Resource Center.

The Resource Center provides a Web portal with critical infrastructure for convening practitioners, encouraging collaboration, and disseminating best practices. The portal gathers communities of practice with similar interests and concerns to share and learn. While it was initially only open to AHRQ grantees, we are opening this rich resource to other Federal grantees. We recently announced AHRQ will support a special portal for the Nation's community health centers as they adopt health IT, with plans to expand to providers involved in the Medicare initiative to assist with the changes to clinical practice resulting from health IT in physician offices, known as DOQ-IT, and to providers in the Indian Health Service (IHS). In recognition of the widespread interest in rapid turnaround of health IT knowledge, the Resource Center will be expanding its practical, educational teleconferences to any organization, and providing in-depth "learning collaborative" curricula for a smaller subset of interested organizations.

Working in Partnership

To advance health IT, AHRQ is working closely with public and private organizations, such as the National Governors Association (NGA), eHealth Initiative, Markle Foundation, Connecting for Health, and America's Health Insurance Plans to promote the development of solutions for many of the challenges I have described. With the NGA, we will be participating in developing

and providing leadership resources for State officials on investing in health IT and healthcare quality improvement.

Health IT can accelerate improvements in safety and quality if there are clear objectives. Working closely with leading medical professional organizations (American Medical Association, American Academy of Family Physicians, and American College of Physicians), America's Health Insurance Plans, payers, consumers and other stakeholders, AHRQ's leadership has been essential for prioritizing goals for improving physician performance in ambulatory care. The results of this collaboration, known as the Ambulatory care Quality Alliance (AQA) will be adopted broadly in early 2006 in the private sector as well as by CMS. The AQA is now developing strategies to collect and report the requisite data, including the use of health IT when feasible. Improvements in care will start now and can be accelerated by efforts to establish a nationwide information infrastructure led by Secretary Leavitt.

AHRQ is working with the Leapfrog Group, an organization of leading employers, to develop an evaluation tool that allows hospitals and physicians to ensure that their computerized physician order entry (CPOE) systems and electronic prescribing are effectively reducing medical errors. These tools will be available by the end of the year. AHRQ is also providing support to the Medical Group Management Association (MGMA) Center for Research to understand the level of adoption of electronic health records and other new technologies in medical groups and the issues associated with their successful implementation. By documenting barriers encountered in adopting these technologies and mechanisms, we will know better how to target our research to overcome these barriers.

AHRQ is collaborating with other Federal agencies to align our health IT efforts. With CMS, we are active participants in the design and evaluation of health IT projects that support research and evaluation of pay-for-performance, electronic prescribing, and the implementation of the MMA. With the IHS, we have supported enhancements to their electronic health record, and, incidentally, that system has been chosen by the National Aeronautics and Space Administration to be its electronic health record. In all of our efforts, AHRQ maintains close relationships with other agencies, in order to maximize the Federal investment of health IT dollars. We maintain these relationships, in part, through working with the Federal Health Architecture (FHA)/Consolidated Health Informatics (CHI) Initiative in the Office of the National Coordinator for Health Information Technology. The FHA has been tasked to provide an architecture, or framework, to guide Federal health IT investments, and to foster interoperability through the selection and adoption of health data standards, including privacy and security standards.

Concluding Observations

Mr. Chairman, I would like to conclude by offering a few brief observations based upon our work in health IT.

First, health IT alone cannot provide the improvements needed in our healthcare system. These improvements will depend upon the integration of high quality health IT into the very fabric of care by incorporating systems into our individual clinical practices, hospitals, and other settings.

Second, for most health care settings, health IT is not likely to afford an "out-of-the-box" solution. Effective use of health IT begins with a careful examination of the health care setting and then uses the power of IT to enhance its effectiveness and efficiency.

Third, the development of a health IT infrastructure will be a critical element in our Nation's effort to accelerate the pace of innovation and the speed with which patients will benefit from new medical breakthroughs. The inherent delays in our current system for assessing the effectiveness of new drugs, devices, and procedures will decrease dramatically with widespread use of health IT and advance our common goal of evidence-based medicine.

Fourth, to accelerate the pace of health IT adoption and implementation, we need to facilitate the sharing of both knowledge and experience through additional opportunities for voluntary peer-to-peer learning. Given the level of economic investment that is required, providers are understandably worried that a mistake in judgment could prove financially catastrophic.

Finally, health IT can be an effective tool to assure safety, improve quality, and increase the efficiency of our health care system. This vision can only be realized if we have the means to develop to implement the programs that purchaser, providers and healthcare consumers want and need. One essential attribute will be the development of key capacities by public and private partners. AHRQ and its National Resource Center for Health IT are looking forward to working with OPM to develop these capacities.

Mr. PORTER. I am concerned to a point where I felt today was a critical hearing to start the process as my chairmanship in this area. I think it is truly the future of health care in America. But I am also concerned. Government does not always do things very well. There are some things we do extremely well and some things we do not do very well. But I believe, from a health care perspective, we can do a lot of things right because of some of the sizes of our employees, the quantity of our employees, and the size of the market that we could use as a term now to work with.

But I am concerned outside with the private sector because, as you have mentioned, there are the small providers and there are the mid-size and the large. But I have seen so many of the small providers that are accustomed to doing things the way they have always done things.

Let me talk about doctors for a second. I know there are a lot of doctors in this room and some of my best friends are doctors. They do not always make good business people. They certainly are practicing medicine and their specialty and they are independent and they certainly—the bulk are very, very good and some of the best in the world. But I am concerned that many of them are not going to be receptive to this change in the way of doing business.

Again, from the Federal perspective I think there are a lot of things that we can do. But in the private sector what can we do to help especially the small—I would think that the smaller providers might have a bigger challenge even than the larger ones because of the cost and the change. What can we do from a market-based approach to help give incentives to these providers, the doctors, the health care professionals to get them to step up to the plate? I truly believe this is the future of health care. I guess I ask that of both of you.

Dr. BRAILER. I think your concerns are accurately placed. There are certainly many large providers today that have the capital, the know-how, and the capacity to go through this very long-term process of changing their businesses to be more oriented around their customers, less error-prone, and more efficient. One of the good things about health IT is we have all those success stories, which began making, I think, this a very real phenomenon. And we are leaving behind a large share of providers, and it is not just capital, it is know-how or human capital.

I think the question comes down to: how do we make sure that they have the capacity to finance this and they have the human capital to make it succeed, because it is ultimately not about software, it is about changing the way their practices operate.

Unfortunately, this is probably one case where physicians are being good business people. It is not in their financial interest to put these tools in place. They do not get paid for better quality. They do not get paid for more efficiency. In fact, when they are more efficient they have less revenue. So for the standard physician the implementation of the electronic health record is a losing proposition.

So we view this as a three-part equation. How do we increase the benefits of the electronic health record by allowing them to monetize better quality? I think the efforts that CMS has underway in pay for performance that are being followed and matched by var-

ious parts of the private sector are very encouraging. And, by the way, most of those efforts have up to 20 percent of their program aimed at health IT subsidies through those efforts.

Second, how do we lower the cost of the technology? One of the implications of interoperability is that prices become more modular, products become more modular, and prices I think go down. But beyond that, one of our initiatives is around certification so you can compare two electronic health records on their features and know if they are the same and then ask, if they are the same, why does one cost more than the other.

Third is lowering the risk, and I think this is where the human capital equation comes in. How do we make sure that these practices are not just buying software but they are changing the way decisions are made and communications occur and they engage with their patients. The QIOs have done a lot with this, the Health IT Resource Center from AHRQ has done a lot with this. There is a burgeoning movement of regional projects, local projects, where providers come together to be able to help provide those resources through medical societies or hospitals.

One thing that we can certainly do is to remove regulations that prevent those kinds of collaborations between hospitals and physicians around developing an integrated model of care for their patients with health IT.

So there is a lot we can do, but I think the fundamentals are moving in the right way and the question is how do we now accelerate it and be able to make sure that it delivers the kind of result not just for doctors but for consumers.

Dr. CLANCY. Just to add to those points, with which I agree completely, it is incredibly important because something like 60 percent of the Nation's physicians practice in groups of five or less, so this is not a problem that can be ignored or that we can envision will somehow mysteriously transition away.

Many of these small practices provide very high-quality care. I would agree with David completely that I think consistent demands for quality are likely to set the stage for greater interest among physicians in small practices.

Recently there has been a collaboration that involves both the public and private sectors to select and prioritize metrics for reporting on quality and ambulatory care. Private sector organizations are going to be writing these into their contracts in 2006, and these are also the same metrics that CMS will use, so that reduces the burden of reporting at the same time that IT is ultimately going to make it easier for them to do that, so I think that is going to be a powerful incentive, in addition to the growing interest in pay for performance.

And I would echo what Dr. Brailer had to say about practice strategies. It has been observed by some people that one of the reasons that physicians have been slower to adopt, in addition to the economic ones, is that there has not been a so-called "killer application" for them in private practice. Yesterday I heard about one from a small practice. If you are a doctor and you have a patient for whom you have to get authorization for selective prescriptions this often involves a 10 to 12-minute wait on the phone. It is a lit-

tle bit hard to be seeing another patient while you are waiting online here.

So a physician whose four-person practice has gone through this transformation and is very excited about it told me that their nurse quit last week and this nurse used to actually sit on the phone, and he figured out a way to automate this using their electronic health record system, and suddenly, all of his partners were newly re-excited about this. I think that is likely to happen, but I think all of the efforts that we are talking about here to make it easier to shorten this transition phase from moving from paper to electronic records is going to make it easy for small practices.

Mr. PORTER. I know the doctors, and I am fortunate my doctor I have been seeing for 20 some years is small practice and he has stayed ahead of the technology curve, but I just see so many that are overloaded with paperwork, and the file cabinet gestapo comes in if it is not locked properly, and doctors were getting frustrated, and many of those that want to change even are having a hard time paying their medical liability costs and staffing and they are not encouraging young folks or even those that are changing careers to get into the profession. I see this domino thing happening in health care.

But two points. One, I look forward to continued discussion. I hope we can sit down and have a round table discussion some time that involves some give and take in the future. But it seems to me in the medical liability end that is the one thing that has brought doctors together across the country, and especially in Nevada, or the cost of medical liability insurance has brought doctors together. We have had a serious crisis in Nevada where you will see a for rent sign on OB/GYN offices throughout the State because they cannot afford medical liability insurance. I know Nevada is not isolated. It is happening all over the country. So we are looking at liability caps and different ways to help the doctors.

But maybe something we could consider is finding some incentives for the medical liability carriers to provide some assistance to the medical doctors and providers that fall into using this new technology. There is no question the numbers show that there is life savings and far fewer risk involved with technology, so maybe that is something we can talk about at some point, incentive for insurance carriers, because I know they are having trouble even staying in business.

But the other thing I touched upon earlier, as a group of Federal employees we have an opportunity to change culture across this country because of the massive size of the group, and I would think some of the things that you are working on and that we are working on to put in place for Federal employees will help create a new culture because of just the pure size of our group. And we touch most every major insurance carrier across the country and we touch families and doctors in most communities. So I look forward to working with you both as we look at both of those avenues.

I know we now have another Member with us. Any questions or comments at this point?

Ms. NORTON. Mr. Chairman, I want to apologize because this is a hearing that I very much wanted to attend. In this last week of Congress we seem to be chasing our tails, as I think committees

justifiably try to get in under the August wire but are not leaving us all of the time to get where we must.

I just want to say one of the things we have to ask ourselves is why what would appear to help save lives, correct errors in a huge industry like this has been as slow as it has been to do the IT conversion that others have been quicker to move to. I am led time and again back to cost. Maybe this is overly simplistic, but if it was all that much to it you would have thought that the cost/benefit would have been done and the results would have been in health care what you see in other places.

The chairman mentioned one reason why, I think, and you add on to that others. He talked about the cost, for example, physicians, particularly in a city like this or any big city, have with liability insurance. You talk about the out-of-control cost of health care, period, outstripping inflation year after year no matter what is done. There are huge structural problems built into the way we deliver health care, paying more for health care than anybody else and providing less health care than any G8 or any advanced nation.

I think one of the concerns in the system that should be the model, the FEHBP, will be for the average Federal worker or Federal organization will be it is going to cost some money and who is going to pay for it. The cost of doing what it seems to me inevitably must be done anyway and could have been done far more cost efficiently had it been done a little at a time beginning some years ago, but the cost of doing it—and you have to do it now just to keep up with everything that practitioners and health care organizations, just to keep up with—I mean, just to keep in touch with those people you are going to have to do it, so the inevitability of it is clear.

But when it really gets down to it, you are going to find thoughtful people in the Federal work force are asking who will pay for this, who will they pass the cost on to. Insurance companies? Well, anybody who has seen the rise even in what we have flattered ourselves to believe is the most efficient of the health care systems in the country will have to simply snarl at that one.

So I think your major problem or the major problem of the Federal Government is going to be how to accomplish this in a way that does not result in what almost everybody thinks it will—that the cost of premiums are going to go up, that when the buck gets passed it finally gets down to the family who is middle income, cannot afford the health care they have, happen to be in the Federal work force, and now, on top of rising premiums, have the cost of the transition, the transaction cost, if you will, into the IT that is inevitable and now is beginning to occur and beginning to pay for it.

Have you thought through the—and perhaps I missed everything important because I am just getting here. Have you thought through whether that is the basic problem in this entire sector, and, if it is, how we might begin to get around that obstacle?

Dr. BRAILER. I appreciate your question, and certainly right here in the District are some leaders in health information technology who are showing how to do this, but all report the same challenge you raise. It is quite expensive, and every business person outside of health care that we explain this to says essentially the same

thing: it does not make sense. IT makes the bottom line better for most organizations, so why not do it? And then we explain how DRGs work and fee for service payments and various discounts and all the other pieces, and if they are still following at that point they begin to realize that it is not a very clean slate.

A large health care system can work through that and largely will make an investment in health IT for strategic reasons, to be out where they can be in the future. But the standard doctor's office, small doctor office, small hospital faces significant challenges. And the challenges I think come down to being able to have what the doctor does and how they get paid be aligned with how they produce better care.

This is why I think some of the efforts in pay for performance, to be able to pay for better health status that is seen by patients, is something that also incents health IT because it is hard to do those over the long term without having the information tools in place, and it is hard to report them and to demonstrate what you have done without having the tools to document.

There are also a lot of ideas about how to lower the cost of these technologies, and there are a variety of proposals in this area, but the simplest and most accessible ones are letting the physicians have better access to market forces, to use their negotiating power and the tools that they can use to get better tools for their demand.

There is one area where I think we are concerned about, and that is for very small physician practices, between one and five physicians, that they do not have the kinds of tools available to them at a good price. This is the area where we have targeted the Medicare's Vista Office DHR product, which is a much lower-cost solution for those practices.

So I think there is a lot that can be done, but I think your comments are directly in the spirit of thism it is a very long-term change, and no matter how fast we go it is going to be a series of hopefully radically incremental steps, but certainly incremental steps in their own right.

Ms. NORTON. Finally, let me say if your view is as mine is, if anybody can afford to be the model it is the FEHBP, it is the Federal Government, then the first thing you want to erase from your vocabulary is the word "radical." Government does not operate in that way. And what it seems to me can be most useful to us is for those of you—is this Mr. Clancy?

Dr. BRAILER. It is Dr. Brailer.

Ms. NORTON. Dr. Brailer, I am sorry. It is Dr. Clancy. Those of you who have been thinking this through can, for a moment, posit the real world in which we live. We do not live in a world in which market forces determine health care. See? You are all waiting for that. You are going to have to wait perhaps longer than any transformation to IT occurs. There are too many competing interests and views about health care.

The Federal Government has, in fact, led the way in doing a lot of things, but it has never taken huge steps. We have been willing to take steps using agencies, parts of agencies. We have been willing to do pilots. So if you want to frame this issue the way you did in answering my question about how we have to let physicians have more access to market forces and we have to understand that

people, in order for people's insurance to be based on the state of their health care, which lots of younger people want, that you are going to have to have information to the data.

If that is the way, if that is the futuristic way in which you want to frame it, then I can guarantee you that the incremental steps—and the words "radical" and "incremental" is very good for the private sector, does not work over here.

The kinds of tough thinking we need is how to hook us up. It might be through those parts of the health care system that we have some control over. That is why I mentioned FEHBP. But you could also mention parts of the Medicaid system, you could mention parts of the Medicare system. You could take parts of that system where you do not put democrats against republicans by having coming out of your mouth "market forces."

If you are going to talk that way, you are going to get people like me to say, what are you going to do about 43 percent of the people that do not have any health care? You are going to get people like me to say, and I can give you another 40 percent who have it, cannot afford it, and are giving it up every day.

You need to help us think through a way to move the health care sector gradually here by having Uncle Sam, who is in the best position to take a giant step, prove that it can work by carving out so that we can see how to make it work, what works, and what does not work, carving out some part of what we have some control over and then going ahead to doing it.

So I am just asking you not to put all of your ideas on the table in one point, because all you do is divide us then. You have terrible, terrible divisions here on health care. If what we are talking about is what brings us all together is what Newt and Hillary are talking about, that IT'ing all of this can help save lives and even ultimately reduce cost, then you have a huge laboratory over here.

Find parts of it, recommend to the chairman an agency, part of the health care systems that we operate for Medicare to Medicaid to FEHBP. I would be most open to working with the chairman and to any others who are interested in bringing the Federal Government as a pathbreaker into IT, saving lives and saving money.

Dr. BRAILER. Thank you. Congresswoman Holmes Norton is my Congresswoman and the point is well taken. Thank you. I look forward to working with you.

Ms. NORTON. Obviously he lives in D.C. and he knows he had better not cross me. [Laughter.]

Mr. PORTER. Again, we thank you and we will conclude this portion.

Dr. Clancy, Dr. Brailer, we appreciate it. I have another hundred questions, but I will save those for some other time. I look forward to working with you in the future.

Thank you.

Our fourth panel, we will hear from Dr. Harvey Fineburg, president of the Institute of Medicine; David St. Clair, founder and CEO of MEDecision, Inc., and Jan Walker, the executive director for the Center for Information Technology Leadership.

Welcome. We appreciate your being here today. If you would, keep your comments to about 5 minutes.

We will start with Dr. Fineburg. Thank you for being here.

STATEMENTS OF HARVEY FINEBURG, M.D., PH.D., PRESIDENT, INSTITUTE OF MEDICINE; DAVID ST. CLAIR, FOUNDER AND CEO, MEDECISION, INC.; AND JAN WALKER, RN, MBA, EXECUTIVE DIRECTOR, CENTER FOR INFORMATION TECHNOLOGY LEADERSHIP [CITL]

STATEMENT OF HARVEY FINEBURG

Dr. FINEBURG. Good afternoon. It is a pleasure for me to be here. I am delighted to be here this afternoon, Mr. Chairman. I thank you for the privilege of testifying before the committee today.

You have a very important subject that you are tackling, and I would like to just offer a few observations orally. I have submitted my written testimony to the committee.

The first point I would like to make, Mr. Chairman, is to reiterate a point that came up earlier, that when we are talking here about the quality of health care and the safety of individuals, information technology is a tool, but it is a tool that has to be embedded in a complete system dedicated to higher quality and greater safety of care.

Rather than thinking about devising a training program that can prepare physicians and other health professionals who are capable of delivering high quality care that is safe, doing the right thing, we ought to be designing systems of care that are incapable of doing the wrong thing. If you want a fail safe health care system, information at the time you need it that is accurate and relevant to the decisions that are being taken is an essential part of that puzzle.

So information technology in its own right has a great deal to contribute to making the system a safer and a high quality system.

The second point that I would like to suggest is that, as you look at the opportunities for the Federal Employees Health Benefits Program, both for the welfare of those employees who are entrusted to this committee and also as a model for the Nation, there are many opportunities, I believe, that you can extend on the important initiatives that were described earlier today by Director Springer and others.

For example, the FEHBP can make a commitment to recognize only certified IT products at the time national certification comes online. It can hasten, in other words, the adoption and reliance upon products that meet common standards.

Second, the FEHBP can do more to insist upon the collection and reporting of quality measures using data that is electronically available and demonstrate improved performance for the members of FEHBP. It can do this in a way that also utilizes pay for performance that depend upon the success of interventions to meet standards of quality.

The health informatics available through the FEHBP can be applied to deliver the best quality care for the patients in the program, regardless of whether they are in acute care hospitals, in chronic care facilities, in ambulatory settings. It can encourage those data systems that can also be used to reduce the likelihood and to increase the detection of fraud and abuse in the system. And the particular advantage that is has, Mr. Chairman, is that the FEHBP, while a Federal program for Federal employees, is embed-

ded nationwide in the private sector and the private insurance system, and therefore it is a perfect case in point where initiatives of this type can encourage and can hasten the adoption of appropriate information technology.

I would like to conclude by saying that it will take more than information technology to accomplish what information technology, itself, is aimed to accomplish: the high quality care. It will take change on the part of those physician practices and the payers of care, as well as those who are involved in the service and support functions. But there is a great deal of ingenuity and willingness in the community all over this country, and putting the incentives in the right way through FEHBP I believe will encourage the right decisions at the right time for all of our patients.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Fineburg follows:]

Opportunities for the Federal Employees Health Benefits Program: Using Information Technology to Improve Health Care

Statement of

Harvey V. Fineberg, M.D., Ph.D.
President of the Institute of Medicine
The National Academies

Before the

Subcommittee on the Federal Workforce and Agency Organization
Committee on Government Reform
United States House of Representatives

July 27, 2005

Statement of Harvey V. Fineberg, M.D., Ph.D.

Good afternoon, Mr. Chairman and members of the Subcommittee. I am Harvey Fineberg, president of the Institute of Medicine of the National Academies. As an independent, scientific adviser to the nation for improving health, the Institute of Medicine seeks to provide advice that is unbiased, based on evidence, and grounded in science. We produce about 50 reports each year on health care and biomedical research policy, the majority of which are commissioned by federal agencies, sometimes under a mandate from the United States Congress. Our work ranges across the spectrum of our nation's health concerns, embracing, for example, the public health infrastructure, the conduct of biomedical research, the emergence of microbial threats, and disparities in health care and health outcomes among different races and between the rich and the poor.

One major series of studies examines how to improve the safety and quality of health care received by Americans. Those studies include many recommendations related to healthcare information technology. Technology alone cannot solve the problems of quality in health care. Properly designed and implemented, however, information technologies can provide an essential infrastructure for transforming health care. Studies related to the use of information technologies to improve health care quality and safety can, I believe, prove useful to those making decisions about the future of the Federal Employees Health Benefits (FEHB) Program and about issues of healthcare policy in general.

Although the FEHB program exists to meet its own clients' needs, it also has a role to play as a model and a test bed for improving the performance of the U.S. health system as a whole. This notion of *Leadership by Example* was the subject of an IOM report, requested by the United States Congress, which examined the role of other federal health programs (Medicare, Medicaid, Department of Defense TriCare, State Children's' Health Insurance Program, the Veterans Health Administration, and the Indian Health Service) in demonstrating possible improvements in U.S. health care.[1]

At this time, the Federal Employees Health Benefits Program has unprecedented opportunities to encourage and to benefit from uses of health information technology to improve the quality and safety of health care.

I would like to provide an overview of relevant studies and initiatives. Then I will offer a few ideas about how the FEHB might test and demonstrate some

approaches to using information technology to improve the quality and safety of health care.

Institute of Medicine Studies

As early as 1991 the Institute of Medicine recognized that computer-based patient record systems incorporating decision support could play an essential role in supporting the quality of care.[2] Not mere repositories of patient information, such systems were seen as interactive assistants, providing critical information and advice as clinicians were making diagnostic and therapeutic decisions. Nearly a decade later, a study of medical errors[3] lent urgency to efforts to make computer-based patient record systems, now called electronic health records (EHR) widely available. The finding that tens of thousands of Americans were dying in hospitals each year as a result of medical mistakes spurred investigations into ways to improve the safety and quality of care. A consistent recommendation of these studies was to develop and implement EHR systems designed to minimize the opportunity for errors of omission and commission. The goal was to help clinicians to do the right thing—and only the right thing. Rather than merely train clinicians who are capable of getting it right, we should aim to create systems—including professional education, evidence-based and consistent practices, equipment re-design, process improvement, and information technology—that cannot get it wrong.

The Institute of Medicine's 2001 report, *Crossing the Quality Chasm,* recommended that "All healthcare organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable."[4] Other recommendations called for the use of information technology in support of those aims. Examples include:

- Use of the Internet, among other means, to provide continuous access to communication with one's own care providers, to one's own health records, and to reliable health information for personal decision making and self-management of health concerns;

- Use of clinical decision support at the point of care to remind clinicians of needed services, to alert them to possible dangers, and to advise them about evidence-based practices;

- Creation of a national health information infrastructure to support health care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education.

Crossing the Quality Chasm also recommended that, "Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement."[5] Implications for informatics include incentives for acquiring and implementing health information technology and using the technology in a variety of quality improvement initiatives. Electronic health records are essential, for example, to obtain quality measures as the basis of pay for performance.

The Institute of Medicine's 2004 report, *Patient Safety: Achieving a New Standard for Care,* enlarged upon these recommendations, specifying that "all healthcare organizations should establish comprehensive patient safety systems that:

- Provide immediate access to complete patient information and decision support tools (e.g., alerts, reminders) for clinicians and their patients;

- Capture information on patient safety—including both adverse events and near misses—as a by-product of care, and use this information to design even safer care delivery systems."[6]

Other recommendations called for the establishment and adoption of standards to permit communication across information systems for clinical care, administration, reimbursement, research, quality improvement, safety, and public health reporting. Such standards are critical to the development of regional and national information infrastructures.

In January 2004 the Institute of Medicine convened a Summit Conference of community and national leaders to identify strategies for achieving high-quality care. The report of that conference[7] included strategies for federal leadership to accelerate the adoption of electronic health records, citing an IOM Letter Report[8] that identified eight core functions for an electronic health record:

1. Health information and data
2. Results management

3. Order entry/ management
4. Decision support
5. Electronic communication and connectivity
6. Patient support
7. Administrative support reporting
8. Population health management

Such health records, as part of a local, regional, or national information infrastructure, would facilitate coordination of care among the many providers serving a single patient and assist patients in the self-management of their chronic illnesses. However, financial incentives would need to be realigned to support the acquisition and implementation of health information technology, the provision of coordinated care, and the integration of patient self-management into care processes. A new report, issued jointly on July 20, 2005 by the National Academy of Engineering and the Institute of Medicine, calls for the application of systems engineering methods to health care enterprises to bring about these and other needed changes.[9]

Current Federal, State, and Private Initiatives

Currently there are many efforts underway to implement these and other recommendations of the IOM reports on the quality and safety of health care.

The federal government is partnering with states and with private entities to develop and demonstrate regional health information networks. Federal and private agencies are collaborating on the development and adoption of standards.

The Office of the National Coordinator for Health Information Technology[10] has issued RFPs for a number of initiatives that will support the functionality and interoperability of healthcare information technology in the interests of improving quality, including:

- A process to harmonize national standards for data and technology;

- A process to specify criteria for the functional requirements for health IT products and to certify compliance;

- The development and evaluation of models and prototypes for a National Health Information Network for widespread health information exchange;

- A process for addressing variations in privacy and security practices.

In the past two weeks, the Secretary of Health and Human Services has announced new initiatives to further these efforts.[11] In addition, DHHS has a 6-month project underway to determine how automated coding software and a nationwide interoperable health information technology infrastructure can detect and reduce healthcare fraud. The final report is due in September.

To facilitate the adoption of electronic health records in physicians' offices, the Center for Medicare and Medicaid Services has announced that it will make available free of charge a version of the Vista system in use throughout the Veterans Administration health care system.[12] While there will still be some costs for training and implementation, the total outlays should be substantially lower than for commercial alternatives. The lower cost will make it feasible for many practices to implement electronic records, and the widespread use of a common system will facilitate exchange of information.

Bills are before Congress to increase support for standards development and harmonization, for regional and local health information infrastructures, for the acquisition and implementation of health information technologies, for the voluntary reporting of errors, and for rewarding providers who demonstrate quality consistent with the six aims.

Ideas for FEHB Actions

The current climate is rife with opportunities for the Federal Employees Health Benefit Program to provide models and test beds for the use of information technology to improve quality and efficiency in health care. In contracting with health plans, those responsible for the FEHB program might consider a number of strategies, including:

1. **Favor health plans and providers that use electronic health records consistent with national standards to perform the functions outlined above. As the certification process for compliance of electronic records with functional requirements and harmonized**

national standards becomes available, recognize only certified products.

2. **Encourage the use of federal and other resources for adoption of certified health information technology, participation in health information networks, and training of clinicians, patients, and others in the optimal use of the information and the technology.**

3. **Provide incentives for collecting and reporting quality measures via data from the electronic health record and for demonstrating improved performance consistent with the six aims for high-quality health care (safe, effective, patient-centered, timely, efficient, and equitable). The providers and health plans contracting with the FEHB offer an excellent test bed for alternative models of payment for performance on criteria of quality.**

4. **Create and test economic models of uses of health informatics to achieve the six aims of health care, taking into account:**

    - Coordinated clinical care of individuals, including measures of quality and cost, especially for those with chronic illnesses
    - Health of populations and public health reporting
    - Post-market surveillance of medications and health devices
    - Detection of fraud and abuse
    - Biosurveillance
    - Homeland security

Thank you for the opportunity to provide this overview and set of suggestions to the committee. If there are ways that the Institute of Medicine may be helpful as you proceed with your deliberations, we would be pleased to respond.

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Mr. PORTER. Thank you.
Mr. St. Clair.

STATEMENT OF DAVID ST. CLAIR

Mr. ST. CLAIR. Thank you, Mr. Chairman. Thank you for having me here.

I guess I would like to start by echoing something that Dr. Brailer said. As the CEO of a technology company, I would like to simply state that I agree with his assessment that this is not about technology. This really is ultimately about improving the quality of care and managing the cost of care so that it can be available to more and more of our citizens in the coming years.

Having said that, a lot of the advances that we can make are, in fact, based in technology, but those are a means to an end, not the end, itself.

One of the things that I think is important—my testimony has been submitted in writing and I am going to just sort of make a half dozen points—conversations about the electronic health record, the EHR, are not synonymous with talk about electronic medical records systems. The EMR, the information that is available in hospitals and doctors' offices is not the totality of the EHR.

Frankly, discussions as to how and when we should start getting value from clinical data in terms of clinical decisionmaking at the point of care should be separated as quickly as possible from discussions about how to explicitly expand the use of EMRs, per se, because I believe in the near term—in fact, in production today—are systems that can take clinical data and deliver them to the point of care to improve patient care, to improve the quality of care, and reduce cost without the presence of EMRs, without the presence of high-cost technology in the doctor's office.

We are, for instance, today in production with systems that take paid claims data and care management data and pharmacy data and lab data that are available to the large regional payers, highly processing that information into what we call a patient clinical summary, which looks remarkably like an electronic health record and, in fact, I would argue is the most complete picture of a patient's health available today.

We are able to deliver that over the Internet in printable form to a physician's office, and we are today delivering it to emergency rooms in the State of Delaware to allow physicians to get a more complete picture of their patient's history than would otherwise be available to them.

This particular approach we believe is particularly important for the FEHBP because of the fact that it is a step that you can take essentially immediately to start getting the health care system accustomed to using new sources of information, new sources of data in the treatment of their patients, and it does not require anything more than an Internet connection and a printer in any particular physician's office.

Furthermore, I think that it is important for us to recognize that the infrastructure for any national health information system is going to be paid for ultimately by us being able to take better care of the 10 percent of the population that is the sickest, that is consuming 80 percent of the resources.

It is by achieving some substantial return on investment with that particular population by improving their quality of care, by reducing the amount of duplicative care in their lives, that we are going to afford to pay for the infrastructure that will support transactions for those of us who are fortunately far less sick.

So there are strategies that are at work today in this country that allow those folks who essentially are responsible for the payment of care to get healthy returns on their investment in systems that start to disseminate information to the point of care with very, very little expense on the provider side. Those tend to work through emergency departments, through the sickest of the case and disease management patients, but there are strategies that are being employed today in the State of Delaware and in other States that essentially follow that model.

The good news is that those strategies are not in any way inconsistent with Dr. Brailer's strategy for the national health information network. In fact, the availability of those data sets early on in the process will help drive adoption of the peer-to-peer networks and the regional health information networks he wants to see by giving early users of those networks access to data from the first day.

Ultimately, we think that we can help share the benefits of HIT across the breadth of the population without waiting for universal adoption of EMRs and other technologies in the provider setting. I believe that technology needs to be available for an extended period of time, because there is going to be some period of delay between the adoption of EMRs by, in effect, the richest provider groups, and it will slowly then be adopted in the others. We need to have multiple ways of delivering and gathering information from the provider setting.

Thank you very much.

[The prepared statement of Mr. St. Clair follows:]

TESTIMONY FOR THE
SUBCOMMITTEE ON THE FEDERAL WORKFORCE AND AGENCY ORGANIZATION

Mr. Chairman, Ranking Member Davis and distinguished members of the Subcommittee. Thank you for allowing MEDecision, Inc., to submit a formal statement for the record on the extremely important topic of using information technology to improve healthcare. I am David St.Clair, Founder and CEO of MEDecision, Inc. the recognized market leader in collaborative care management solutions for the health insurance industry. Our clinical systems are used by more than 60 payer organizations around the country to help coordinate care for about one in every six insured people, including sizeable numbers of federal employees and their families.

We commend this Subcommittee's commitment to drive reform in the healthcare industry through the development, standardization and interoperability of health information technology. For seventeen years, MEDecision has been leading the effort to create clinical information technology both to improve the quality of healthcare and to lower its cost, thus expanding its affordability. In that regard, we believe it necessary to focus on providing data-rich health care records for each individual that can be used by them and by their providers and managers of care to improve outcomes while reducing costs to the overall system.

The core of today's efforts is the electronic health record. In general, the EHR is most valuable today for the sickest members of our society – the 10% of the population that consumes 80% of the cost. With multiple conditions requiring multiple specialists, many powerful medications, numerous ancillary care providers and careful care coordination from case and disease managers, these individuals are also likely to be the least able personally to communicate the complexity of their histories and health status to their next treating physician. Yet it's exactly that complexity that confounds the medical community's attempts to reduce errors of omission and commission and to minimize the cost of duplicative and otherwise unnecessary care. Fortunately, however, the cost savings potentially available from resolving the health care information deficit by using the payer-based health record (PBHR) and the individual health record (IHR) for the sickest patients in our country will likely pay for the national health information network infrastructure used by the entire population.

Sources of Healthcare Information

Broadly speaking, there are three sources of health care information about patients: the patients themselves (or their care givers); the patients' physicians, hospitals and other providers; and the patients' health plan or other payer.

Most patients have only limited information about their own care and even less ability to obtain, retain and store such data. Worse, a patient's ability to personally maintain their own health record decreases with illness, infirmity and, often, with age. Even the most user-friendly personal health record (PHR) systems available today are seldom used and even less frequently updated on a timely basis by their owners.

Physicians, hospitals and other providers are required by law and professional ethics to maintain significant records pertaining to the care they provide. These providers do not either generally or comprehensively obtain patient data from the spectrum of other providers. Thus, hospitals might have a deep reservoir of information regarding the services and tests provided to patients within the facility and, perhaps, by the admitting physician, but little, if any, information from other facilities or physicians who have treated those same patients. A single physician knows and has records of everything the patient has told him and the treatment he has provided, but that provider knows neither what the patient has been told by other physicians nor what treatment other physicians have provided. Complicating the distributed nature of the information is that it remains overwhelmingly paper-based and hand-written, rendering it exceedingly difficult to integrate, analyze and/or transmit effectively.

Today, payers have the electronic data from which to construct the broadest picture available of an individual's history across the continuum of care. The health plans know what they have gathered through care management functions and what they have paid in the past through claims. These data cross all provider types – doctors, hospitals, laboratories, pharmacies and so on. In addition, payers increasingly have access to detailed laboratory results for their beneficiaries and remote monitoring data from patients in their disease management programs.

Payer-based Health Records and the Patient Clinical Summary

Today, health plans are beginning to offer their collected information, generically called a payer-based health record, to both physicians and patients as the basis for discussions about what actions would likely best serve the patient's clinical and behavioral needs.

MEDecision has developed a payer-based health record known as the Patient Clinical Summary (PCS) (a copy is attached to my remarks). The PCS chronicles an individual patient's comprehensive health plan record, including every medical treatment, lab test, medication and related service that has been paid for by the individual's health plan. This summary can include a patient's demographic profile, health status measure, medical conditions, inpatient and emergency room admissions, monitored services, specialist visits and treatment options.

Providers depend on a reasonably complete health care picture of a patient to make important medical decisions. Unfortunately, they are often unable to get complete and accurate information quickly enough to determine the best course of care to obtain the best outcome. There is no better example than in an emergency room in which patients often arrive unconscious and unaccompanied to be treated by physicians who have little and often no knowledge of the patient's existing medical conditions, whether they are taking medication, or their degree of susceptibility to allergic reactions. In such instances, physicians have the greatest need for patient data yet are least likely to be able to obtain it.

In every emergency room in the country, physicians attempt to obtain medical information about arriving patients by interviewing them if they are conscious, inquiring about their history from family members or from the ER's own computerized records should the prospective patient have been treated there previously. An ER's internal electronic record system is often the sole means of obtaining patient data for patients arriving unconscious and alone.

PCS Improving Healthcare Today

Being tested today between a health benefits company and a major health system, the PCS analyzes and summarizes patient health records for immediate application by attending physicians. Health plan member data and clinical best practices information is made immediately available when and where physicians need it most, at the point patients are about to be treated.

Initial tests of the program indicate electronic transmission of the PCS to emergency room physicians lowers ER patient treatment costs. Anecdotal experience indicates that approximately 7.5% of high-acuity patients seen in the ER would not be admitted if attending physicians had immediate access to the data in the PCS. At a typical ER admission cost of approximately $8,000 per patient, millions of dollars could be saved annually as a result.

The Advent of the Individual Health Record

This fall, MEDecision and one of the innovative vendors of PHR software, will release what we believe will be the first individual health record capability in production. The IHR will be available to a test population of health plan members enrolled in a disease management program and will be pre-populated and updated by the individual's PBHR. The IHR concept, supported by America's Health Insurance Plans and many other organizations, allows us to combine the data collected continuously by the payers with the information collected directly from patients and their family. This enhanced record, when thoroughly

processed by our clinical analytics and combined with information on clinical best-practice to create the PCS, becomes an even more powerful tool for use by the patient, their physicians and their care manager. The advantage of the IHR over either the PHR or the PBHR by themselves is that it can include information not normally known by payers, like allergies and family history, but also can be used for patients who either can not or simply do not build or update their records themselves. It also can readily offer portability of information should the patient choose to change health plans.

Federal Employee Health Benefit Plan

As you know, the Office of Personnel Management (OPM) in its Carrier Letter for the coming benefit year asked for several health information technology improvements from the FEHBP carriers. While OPM did not specifically mandate the implementation of a payer-based health record, the PCS could be a major step to resolve many of OPM's concerns. We believe that the federal workforce and their families, as well as the 280 million citizens they serve, would benefit greatly from the implementation of a payer-based health record. We believe that the Patient Clinical Summary, or something like it, ought to be adopted by OPM and by every other Federal agency that purchases health coverage. There is no better or more cost effective way to get vital patient health data directly to care providers today, the result of which will be improved patient care, lower costs and the wider availability of affordable health care for all. And, of course, all citizens benefit from the better health and increased productivity of federal workers.

Low Cost of PCS Implementation

One of the hurdles most commentators raise for adoption of electronic health records is the cost of implementation for providers. While few dispute the value of providing health care professionals with comprehensive patient health information and diagnostic aids electronically and in real time, as members of the Subcommittee are well aware, many obstacles exist to improving patient outcomes and reducing health care costs via electronic record exchange. Beyond the cultural reluctance of some to adopt electronic patient health records, cost is usually the number one impediment, followed closely by an alleged need for new and possibly untested technology.

It is our experience that cost and lack of technological innovation need not be an impediment to the quick and cost effective electronic availability of patient health records. In fact, to make patient medical records available to as many care providers as possible, we have purposively committed ourselves to a low-cost, low-tech, incremental approach to electronic health record delivery. By starting with the environments whose patients are highest cost and at highest risk, we can use the early quality of care improvements and savings to build trust, momentum and the business case for subsequent levels of investment and effort.

To implement the PCS, a hospital or doctor's office need not make an investment beyond a PC and an Internet connection to receive a printable PDF file containing a patient's PBHR or IHR. Preliminary data indicate the IHR program cost at between 50 cents and $1.00 per health plan member per month. For far less than 1% of the cost of health insurance, plan members can immediately benefit from their medical records being electronically accessible to all qualified and authorized health care providers in complete and total compliance with HIPAA privacy requirements and consistent with state laws.

Interface with Other Systems

Mr. Chairman, as you know, last week The Centers for Medicare and Medicaid Services (CMS) announced that it would give to physicians, at no cost, the electronic medical record (EMR) system currently used by the Veteran's administration, the VistA program. But VistA is only one of many EMR systems on the market, so interoperability is key to the future of the use of the PCS in the provider community as it is in the PHR market. MEDecision is taking a leadership role in helping to define standardized transactions for use with the current major vendors. While these standards will likely be modified or replaced by the eventual emergence of true national standards embraced by every vendor, value can be created for all parties in the short term by linking the most widely-used EMRs with the PBHR or IHR being offered by the regionally-dominant payers.

This early demonstration of the value of clinical data exchange will help fuel the further development of the peer-to-peer networks envisioned by ONCHIT and many in the healthcare information technology industry.

Coordination with ONCHIT

Mr. Chairman, the evolution in health care information has, we believe, finally reached a tipping point. While the Office of the National Coordinator of Health Information Technology tackles the essential tasks of developing a National Health Information Network Architecture and standards for interoperability, we can provide the critical first step which will demonstrate the value of such information at the point of care, with relatively little cost to consumers, providers or the system. In fact, the early indications demonstrate that the savings from the emergency room alone may cover the entire cost of the PCS infrastructure.

Making PCS available to physicians and other care providers at the point of care can facilitate the development of the National Health Information Network and the goal of electronic integration of all medical records. Delivered through one of the first connections to a peer-to-peer Regional Health Information Network (RHIN), a standards-based PCS can guarantee early adopters of appropriate EMRs that significant data will be available from the RHIN for their use, driving adoption far more quickly than if we had to wait for patient data to accumulate in the new systems. Payer data will continue to be of special value, of course, during the extended period before all care is delivered by providers with compliant EMRs.

The PCS is the first step that will help pave the road to full interoperability. This will improve the quality of care delivery and provide consumers the knowledge they need to really control their health care decisions regardless of whatever health care plan they choose

Given the capability of existing technology to provide physicians and other care providers with such a range of meaningful and relevant information, and given the fact that such information is already routinely gathered by existing health plans throughout the nation, we at MEDecision urge both the federal and state governments to support the meaningful exchange of this clinical information from health plans to patients and care providers. The result will be improved patient care, lower healthcare costs and more affordable healthcare for all.

Mr. Chairman and Ranking Member Davis, the commitment of this subcommittee, of Representatives Murphy and Kennedy, and, of course, of the President will help yield the greatest benefit of all: better health for our citizens. We at MEDecision are proud to be part of that process. We look forward to working with you, the subcommittee, Congress, OPM and ONCHIT to develop a healthier future for all Americans.

Thank you again, Mr. Chairman and Ranking Member Davis for the opportunity to appear before this Subcommittee. I am prepared to answer any questions you may have.

Mr. PORTER. Thank you, Mr. St. Clair.

Dr. Walker, welcome.

STATEMENT OF JAN WALKER

Ms. WALKER. Thank you and good afternoon.

I am a nurse from Boston with a longstanding interest in understanding patients' experiences with our health care system. I am currently executive director of the Center for IT Leadership, which is a leadership group at Partners Health Care System, and I am a member of the Health Information and Management System Society [HIMSS]. You invited me today to provide my views on how the Federal Government can use its buying power to influence the use of technology in health care.

I brought a written statement to include in the record, and I would like to make just a few remarks.

Professionally, I believe that information technology will transform care in this country. But I am also a nurse and a private citizen with a family and I would like to tell a personal story.

A few months ago my nephew was diagnosed with thyroid cancer. He lives in a small town in Kansas and goes to a State university about 300 miles away. He needed surgery and he was referred to a surgeon in a neighboring city. His parents called me for advice. Should they send their son to this surgeon?

Of course, I wanted to know how many of these types of cases the surgeon had done and how his patients had fared. To paraphrase Dr. Clancy, I wanted to make an evidence-based decision. But I could find no information to answer any of these questions, and in the end we decided to bring my nephew to Boston where I could depend on my local contacts to find the most experienced doctors.

It sounds simple enough, but it required a barrage of phone calls, signatures, and faxes to get information from his Kansas workup. Scans were mailed to the wrong place and had to be sent again. Results from several lab tests never did arrive and had to be redone. A Boston pharmacist could not fill a prescription because he could not reach the Kansas pharmacist by phone until the next day.

Our studies at the Center for IT Leadership have analyzed how information technology would address inefficiencies like these, transforming the cost as well as the delivery of care.

As an example, we found that if all clinics and laboratories ordered and reported lab tests electronically in a standardized way, we could avoid $4 billion in unnecessary, redundant tests, and $27 billion in paper handling and phone costs every year.

If every clinic in the country adopted computerized order entry with advanced decision support, we could save $44 billion and avoid 136,000 life-threatening, adverse drug events every year.

If the main stakeholders in patient care, doctors and hospitals, labs and radiology centers, pharmacies, public health departments, and payers, all adopted systems that allowed them to exchange electronic information in a standardized way, we could save $77.8 billion every year.

I will close with three thoughts. First, as we have seen in multiple studies, the return on investment from HIT is overwhelmingly

positive. It has the potential to save billions of dollars and dramatically improve the quality of care for all Americans.

Second, HIT costs money. We must prime the pump by giving providers incentives to invest. The costs of HIT are a huge barrier to adoption, especially for small offices and small hospitals. A combination of low-interest loans, tax credits, and rewards for using HIT could help providers make this transition.

Third, none of this can happen without national standards that allow computers to talk to each other. Most of the dollars we spend on systems that do not adhere to such standards will go down the drain. If the Federal Government can use its buying power to support standards development and implementation, to facilitate availability of capital for providers, and to reward providers who use HIT, we will move closer to transforming care.

This week my nephew returned home to Kansas. I am crossing my fingers that his Kansas doctors will hear from his Boston doctors. In the end, these inconveniences did not compromise his care, and I would even say they were relatively minor glitches. Many patients are less fortunate. We feel very lucky.

On behalf of HIMSS, I thank you for this opportunity to speak with you today. Both HIMSS and the Center for IT Leadership stand prepared to help you in any way we can.

Thank you.

[The prepared statement of Ms. Walker follows:]

Written Testimony

of

Jan Walker, RN, MBA
Executive Director
Center for Information Technology Leadership (CITL)

Submitted to

U.S. House of Representatives
Committee on Government Reform
Subcommittee on the Federal Workforce and Agency Organization

July 27, 2005

Is There a Doctor in the Mouse: Using Information Technology to Improve Healthcare

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Mr. Chairman and members of the Committee, on behalf of the Healthcare Information and Management Systems Society (HIMSS), I want to thank you for this opportunity to provide my views on how the federal government can use its healthcare buying power to influence the transformation of health care delivery using technology.

For over 45 years, members of the Healthcare Information and Management Systems Society (HIMSS) have focused on providing visionary leadership for the optimal use of health information technology and management systems for the betterment of human health. Our 17,000 individual members include providers, payers, insurers, consultants, management engineers, technology and electronic health records vendors, government and public health officials, manufacturers, academics, consumers and students; and our 275 corporate members employ more than 2 million people focused on transforming healthcare. Working collaboratively, our goal will always be to frame and lead healthcare public policy and industry practices through our award-winning advocacy, educational and professional development initiatives designed to promote quality improvements in healthcare for all.

I am a member of HIMSS and I also have the pleasure to serve as the Executive Director of the Center for Information Technology Leadership (CITL). CITL was chartered in 2002 by Boston-based, nonprofit Partners HealthCare System as a research organization established to help guide the healthcare community in making more informed strategic IT investment decisions. Using a rigorous, analytic approach, CITL assesses information technologies, disseminates its research findings, and provides additional services designed to help healthcare providers realize greater value and improve quality of care. CITL's research is also used by technology vendors to develop more effective healthcare IT products. HIMSS and CITL are pleased to be collaborators and work closely together on initiatives to advance solutions in the healthcare industry.

I am honored to be here with you and I appreciate your interest in this important topic – one that has the potential of transforming US healthcare delivery, and the quality of life for every American.

You invited me here today to talk about the value of investing in technology to improve the quality of healthcare. This is a topic that is near and dear to my heart.

Today, healthcare executives are under tremendous pressure to address a host of healthcare system ills including medical errors, rising costs, inconsistent quality and unwarranted variation in care, inefficiency in care delivery, declining job satisfaction among healthcare professionals, and mounting staff shortages in critical areas such as nursing and pharmacy.

Treating these ills will lead ultimately to better healthcare, but the process for realizing these goals appears as complex and overwhelming as the challenges themselves.

Many senior leaders seek to address healthcare system complexity and inefficiency with information technology (IT). Information – or the lack of it – is a big part of these problems. I believe that the application of healthcare IT is central to transforming healthcare in this country. I have spent the majority of my professional life studying how information technology may improve healthcare delivery, and building electronic health records in a public company, and in academic delivery systems. We believe the application of healthcare IT is critical to our future at Partners Healthcare and the Harvard teaching hospitals, Massachusetts General Hospital, and the Brigham & Women's Hospital, and it our CEO's number one priority. The Institute of Medicine highlighted IT as integral to improving healthcare in its seminal report Crossing the Quality Chasm.

Our studies at the Center for IT Leadership at Partners Healthcare in Boston have analyzed the value of healthcare IT for individual doctors, and society at large. In our study on The Value of Ambulatory Computerized Provider Order Entry, or ambulatory CPOE, we found that if every clinic in the country adopted advanced CPOE systems – the critical decision support tool within electronic health records – we could potentially save $44 billion dollars per year. These savings are achieved through reduced unnecessary and duplicative ordering of tests and procedures, improved medication utilization, and reduced medical errors. This study, however, is akin to analyzing the value of a computerized financial accounting system in one bank, without consideration of ATM banking networks. Our study of the value of ambulatory CPOE did not address the value which arises when doctors' offices, hospitals, and healthcare delivery systems can securely and reliably share healthcare information. We believe these potential savings are, in fact, conservative as they do not reflect benefits which will arise from improved preventive and wellness care nor the positive impact on chronic disease management.

Our second study at the Center for IT Leadership analyzed the value that arises when different clinic and hospital electronic health record systems can securely share information – The Value of Healthcare Information Exchange and Interoperability, or "HIEI". HIEI refers to the technologies that enable the electronic flow of patient information between healthcare settings, such as the doctor's office, the hospital, the laboratory site, the retail pharmacy, and public health departments. While individual organizations are making progress in digitizing administrative transactions (thanks largely due to the Administrative Simplification Subsection of HIPAA), and providing clinical information to clinicians within healthcare settings, the exchange of clinical information between healthcare settings is practically non-existent.

To determine the value in adopting HIEI, the Center for Information Technology Leadership examined the value of transactions among the main stakeholders in patient care and projected the value for each, at different levels of sophistication. Our primary finding was that moving to standardized HIEI would deliver $77.8 billion in annual savings in the United States. Let me say that again, by helping the healthcare system move to standardized HIEI, annual U.S. savings would be $77.8 billion. These savings are in addition to the savings which arise from digitizing individual hospitals and clinics; but they only arise if each of those settings adopts healthcare information technology

which abides by the standards which facilitate interoperability. Again, we feel these potential savings estimates are conservative and do not reflect the potential for improved disease and syndrome surveillance, bioterrorism detection and response, improved post-marketing surveillance for new drugs, and dramatic improvements in the clinical research capacity in this country – of critical importance as we enter into a new era of personalized care with our increased understanding of the human genome.

Other conclusions from our HIEI study include:

- Standardized HIEI provides quicker and more dramatic returns than non-standardized HIEI.
- Healthcare providers – physicians and hospital systems – would have an annual potential savings of $33.5 billion with full implementation of standardized HIEI.
- Other stakeholders, such as labs, payers, and pharmacies, and public health, would also benefit from standardized HIEI.

President Bush has recognized the need to improve healthcare quality and on April 24, 2004, issued Executive Order 13,355 to reduce medical errors, lower costs and provide better information for consumers and physicians. He also appointed a National Coordinator of Health Information Technology – Dr. David Brailer – who established a plan for most Americans to have an electronic health record within 10 years. In particular, the President called for the widespread adoption of electronic health records (EHRs) and for health information to follow patients throughout their care in a seamless and secure manner. I applaud and commend the President for his vision. DHHS Secretary Michael Leavitt, and Secretary Tommy Thompson before him 'get it'; the work done by the Office of the National Coordinator for Healthcare IT (ONCHIT) has mobilized both the public and private sector to respond to this challenge. The requests for proposals recently released to develop a reference architecture for a national healthcare information network, to implement a certification process for electronic health records technology, to harmonize our standards development efforts, and to coordinate state laws and business practices for healthcare information privacy, security, and exchange policies, will help the HIT market move toward this goal.

So what can you do to help promote a solution to this challenge?

1. We believe that there needs to be some form of low interest loan program for small physicians' offices and small-medium hospital environments to come up with the capital to buy HIT. Suggestions include tax credits, an HIT loan program akin to other business loans, or grants as other countries (and some U.S. payers) have done.

2. We believe that there need to be direct rewards for using HIT. This could be a small bonus payment for electronically filed claims with appropriate record attachments (in electronic form, of course), or select data elements as defined by CMS or NQF or NCQA to monitor care processes and quality of care.

3. We believe that there need to be indirect rewards for using HIT -- that is not direct payment for using HIT as in #2 above, but pay-for-performance (P4P) type rewards with strict criteria that almost force the use of electronic health records.

For many years, the US healthcare system has been plagued by a "ready, fire, aim" mentality. We have looked at adjusting reimbursement systems without first investing in the measurement tools to better understand what behaviors we should be reimbursing for. Now is the time to begin to address this problem by putting in place the infrastructure that will help us better understand what quality in healthcare really looks like and to begin to reward physicians for delivering it. There is no more important task for us today than creating a robust HIT infrastructure in the U.S.

In conclusion, HIMSS believes that if the federal government waits, our nation will postpone benefits that much further into the future. We need to act collectively now. We need to accelerate EHR adoption now. We need to be smart about how we do it so we can make adjustments as we go, but waiting kills people and costs money. **We need to prudently apply money to the challenge to support EHR adoption**. To somewhat paraphrase that great line from "Hello Dolly"..."money is like manure...you need to sprinkle it around and help things grow".

I am honored to speak on behalf of HIMSS today.. HIMSS has been working collaboratively with all interested stakeholders for over 45 years to improve healthcare for all by using information technology and management systems solutions. We look forward to continuing to help you find a solution to this healthcare challenge.

Mr. PORTER. Thank you very much, Dr. Walker.

I would like to ask all three of you a question. I think it will help jump start as this committee moves forward.

Right now there are a lot of ideas, a lot of suggestions, but we keep coming back to having to have what I believe is a plan, a strategy, and certainly an outcome, and that is to provide the best health care in the world and to make sure that single mom or that dad or that senior, no matter their income level, they have the best in the world.

What would you suggest, or how would you suggest we start this cultural change? I know that we are really limited on time and we are going to have additional meetings, but today what would your message be to this Congress as we try to move forward rapidly but also thoughtfully in this process of changing our culture in the Federal Government? What would you suggest, Dr. Fineburg?

Dr. FINEBURG. Mr. Chairman, there are many ways to begin. In fact, I think that the first one I would say is that there is not a single magic bullet to transform health care in the United States, so that we should not strive to solve the whole thing with one fell swoop. But I would say that there are significant opportunities that you have before you with the tool that you are responsible for—namely, the Federal Employees Health Benefits Program—to improve care for those beneficiaries and thereby demonstrate what can be done.

For example, if Director Springer were to be the first to adopt and insist upon the kind of certification standards that virtually every witness has testified to, that would be an enormous message of the importance of high-quality care across the whole country.

Second, looking at ways to align the reimbursement and payment systems with the kind of behavior that we are seeking on the parts of patients as well as our care system, to eliminate the advantages of doing the wrong thing by having more resources given to you, and instead reverse that so that you are reimbursed for doing the right thing and having patients better off, that is, I think, a very important opportunity which comes out of this pay for performance set of strategies.

And, by the way, no one is absolutely clear what the best way to do that is, so having in mind that you are going to try different ways and learn from the experience I think would be a wonderful frame of mind for the FEHBP, because that would suggest that you are acting and also committed to improving over time.

Those are two things I would suggest. You have turned to others.

Mr. PORTER. Mr. St. Clair.

Mr. ST. CLAIR. While I would agree that there are many, many places to start, I guess that I would also like to caution that there are many places not to start. There is the common statement these days about boiling the ocean. We cannot try to solve every problem all at the same time, which is why I think it is useful to try to break the problem down into its component parts.

I believe that a place to start is with technology that is available today broadly across the market to take data that already exists in electronic form and begin to share it now. What we want to do to start is start. There is information that is available that is tremendously valuable in different settings, like emergency rooms and

things of that nature, that we could start doing quite literally tomorrow because it is being done today, but to do it more broadly.

And the FEHBP, it is a redundant program, is a tremendous opportunity because you can influence that sort of pilot process across dozens and dozens of health plans all over the country by getting them to essentially involve your members within theirs, and that is essentially going to start drawing in their own participation in that same program. I happen to like that as one of the places to start.

But, to your point, without pay for performance you are going to start and you are going to start to slow down because you are going to start getting resistance from the provider sector once you get past the early adopters and their side. So there really are those two avenues that I would say to move down.

Mr. PORTER. Dr. Walker.

Ms. WALKER. I certainly agree with those points. I guess in a sense we have already started, and there are a lot of success stories out there. I think it will help to publicize the success stories. Providers became providers because they want to provide good care. They are humanitarians at heart. They are really busy, and sometimes I think they do not have time to see the possibilities of HIT, and I believe publicizing some of the good work that has already happened might help them get over that conceptual hump, which we need to accomplish.

Mr. PORTER. Very good. As we have mentioned throughout the hearing today, we still have the best system in the world, some of the best doctors. And yes, we really need to recognize those that are being successful.

Mr. St. Clair, I concur. There are some things we can do right away. My kids, our kids, we have a lot of folks that understand technology far better than I do, and there are young folks, senior folks that could get up to speed really quick on some of the things that you are suggesting as far as the patients and understanding. And I agree with what you are saying by separating these areas. I think that is important.

Mr. Fineburg, I concur wholly with you that the steps have to be taken as soon as possible, but what I am going to suggest is that we are going to move forward. I think we, as a Federal Government delivery system, we have some of the most advanced technologically businesses in the world that are providing health care insurance to our employees. They are the most sophisticated when it comes to investment, they are sophisticated in delivery, they are sophisticated in the product that they provide because they have been forced to by a market that is demanding better and better service.

I have no doubt that we can take some of your ideas, and I hope that you will join me as we compile some possible legislation. But I think we have the best and the brightest, of course, in the health care field, but also in the business community. If we can provide some incentives that will force some changes in a culture, I think we can help expedite in technology.

And I say this because I used to work for an insurance company for 20 years. It is not in the health care. It is property and casualty company. But I know that it is one of the largest in the country.

We had to make changes because the market demanded it, and to be competitive and to provide the best property and casualty insurance we had to do it. We were stuck with having one of the best computer systems in the 1970's in the world, and then we threw bandaids on it through the 1980's, and all of the sudden we were so far behind the curve we were forced to make some major changes.

I think that the Federal employees, as being the largest customer base in the world, probably, we can provide some incentives to make sure that the best and the brightest in our partners, the carriers, can help work with the doctors and our employees, which will set the standard and create a whole new culture for the country.

So, having said all that, we are going to have to conclude the hearing. I want to thank you all very much for being here. I am very excited to be a part of this and plan on being very active and look forward to working with all of you. Thank you all for being here today. I appreciate it.

[Whereupon, at 4:15 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Elijah E. Cummings follows:]

Opening Statement

Representative Elijah E. Cummings, D- Maryland

Hearing Entitled "Is There a Doctor in the Mouse?: Using Information Technology to Improve Health Care."

Subcommittee on Federal Workforce and Agency Organization

U.S. House of Representatives
109th Congress

July 27, 2005

Mr. Chairman,

Thank you for calling this critically important hearing to assess the utilization of information technology in healthcare.

One need not be an expert to understand how medical errors and inefficiencies in our healthcare system contribute not only to an increase in costs, but to an increase in human loss from death and injury. With that being said, I am deeply *disturbed* that medical errors result in more deaths annually than AIDS, highway accidents, or breast cancer with approximately 44,000 patients dying each year in U.S. hospitals. In clear and plain terms, this state of affairs is simply *intolerable.*

The Institute of Medicine concluded in a report entitled *To Err is Human: Building a Safer Health System*, that most medical

mistakes are the product of fundamental deficiencies in the organization of our healthcare system. For example, medical records or prescriptions that are poorly drafted or illegible can result in a patient obtaining the wrong type of treatment with potentially grave implications for their health.

Fortunately, health information technology (IT) can advance patient safety and the quality of our healthcare system by improving the collection, storage, and transfer of health information. Unfortunately, only a few healthcare providers in our nation have utilized health IT to its full extent.

The Committee on Quality Health Care in America recommended a four part plan to address medical errors that Congress needs to seriously consider. This plan seeks to improve the quality of our healthcare system through financial and regulatory incentives that range from the creation of a national reporting system to track medical treatments that result in injury or death, to the establishment of a national center for patient safety.

Congress should also work with the Administration to ensure that the development and implementation of a nationwide health IT plan that is underway is well equipped to deter medical mistakes,

improve quality, limit wasteful spending on unnecessary healthcare costs, and secure private information.

To ensure that more Americans do not have to needlessly suffer at the hands of medical errors and inefficiencies in our healthcare system, Congress must never forget that obtaining medical care should not be a game of chance where one must bear the risk of illness or death; nor should it be an act of blind faith.

Mr. Chairman, we must restore the American people's confidence in our healthcare system. We must also embrace the sacred oath woven into the fabric of medicine to do no harm. In doing so, we not only promote patient safety and quality care, but uphold the trust fundamental to the practice of medicine.

I yield back the balance of my time and look forward to the testimony of today's witnesses.