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CAN SMALL HEALTHCARE GROUPS FEASIBLY ADOPT ELECTRONIC MEDICAL RECORDS TECHNOLOGY?

HEARING

BEFORE THE

SUBCOMMITTEE ON REGULATORY REFORM AND OVERSIGHT

OF THE

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THURSDAY, APRIL 6, 2006

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON REGULATORY REFORM AND OVERSIGHT
COMMITTEE ON SMALL BUSINESS
Washington, DC

The Subcommittee met, pursuant to call, at 2:00 p.m., in Room 2360 of the Rayburn House Office Building, Hon. W. Todd Akin [Chairman of the Subcommittee] presiding.

Present: Representatives Akin, Sodrel.

Chairman AKIN. The Subcommittee will come to order. The Ranking Member is trapped in another committee hearing, which is not surprising. We usually schedule about two or three in the same time period for anybody in any committee. So she gave us permission to go ahead and proceed with the hearing. She may join us a little bit later.

I have a prepared opening statement here.

First of all, I have already said this, but to everybody good afternoon. Welcome to today's hearing. It's entitled "Can Small Healthcare Groups Feasibly Adopt Electronic Medical Records Technology."

I especially want to thank those of you who have traveled here from some distance. Two of our witnesses are from the congressional district that I am proud to represent. And so we are delighted particularly to have those of you who have made the trek up from the St. Louis area, we appreciate that.

In my role as Congressman and Chairman of this Subcommittee I have had the opportunity to interact with many businesses in just about every industry. I talk to business owners and CEOs about the many challenges they face, both domestically and abroad and time and time again they state that the rising cost of health care is crippling their firms.

Because many small businesses operate in slim margins, any increase in costs can turn a profitable business into an unprofitable one. The rising cost of health care is an important issue and there are many different voices in the public square advocating different approaches to offset these rising costs. Today this Subcommittee will focus on the electronic benefits derived through the adoption of technological processes. Is the adoption of electronic medical

records technology feasible for small businesses, specifically small doctors' practices? We also hope to determine the challenges these small groups face in adopting such technology.

There is little doubt that the adoption of electronic medical records can play an important role in increasing efficiency, reducing paperwork and redundancy and more importantly, reducing medical errors.

According to the Department of Health and Human Services it is estimated that the introduction of health information technology can reduce healthcare costs by up to 20 percent per year. The Bush Administration has stated the importance has stated the importance of implementing electronic healthcare systems, and made it a priority.

That said, doctors have increasingly faced higher liability costs, potential cuts in Medicare physician payments, and additional regulatory burdens resulting in a question as to whether smaller practices can afford to adopt this innovative technology.

I look forward to hearing the testimony of the witnesses to learn more about whether small practices can adopt this technology.

And because our Ranking Member is not here, I am not going to yield to her, but we will proceed immediately to our witness list. I have a very bad reputation in this Committee to keeping people on time in terms in making their statements. That way we get out on time, too. So the way we are going to do things will be I am going to take a five minute statement from each of you. Usually when there is other Committee members we save our questions until you get done with making your statements. Now my recommendation is that you can submit a more extensive written response which we will accept as part of the record. And so my recommendation because you have just five minutes, it is maybe almost better just to put your notes aside and just say the two or three things that you really want the Congress to be hearing about what you have to say on this subject. But if you feel a little bit more psyched out than that and you want to just read some of your notes, you can do that. But my advice is maybe just say hey this is what I think about the subject.

So with that we'll start with our opening witness. Oh, they are trying to trick me here. They have got Jack first. I go by the order coming across. So we are going to start with Joan, is it Magruder?

[Chairman Akin's opening statement may be found in the appendix.]

Ms. MAGRUDER. Magruder, yes.

Chairman AKIN.

Joan, five minutes please.

STATEMENT OF JOAN MAGRUDER, BJC HEALTHCARE

Ms. MAGRUDER. Thank you. Thank you, Mr. Chairman and Members of the Committee.

My name is Joan Magruder, and I am pleased to be here today really to talk about a very innovative way we at BJC Healthcare are approaching the introduction of the electronic medical record.

We recognize, as you said in your opening remarks, that technology has an incredible ability to transform and improve healthcare delivery and have a significant impact on the cost effectiveness of what we do. We also recognize that the timing of this is incredibility pivotal on, as the opening remarks confirmed, our physicians today are in a circumstance where as a small business, in and of themselves, the margins are slim and eroding. And in light of the malpractice issues and clearly the rising cost of healthcare, they really have two very pivotal role with the electronic medical record. One is as a self-employed business themselves is that the cost of labor and benefits of their own employees who is integral to them and, second of all is obviously providers. They ultimately are the enablers of this electronic medical record capability.

First just a couple of comments about a context for our circumstance. BJC Healthcare, as you may know, is headquartered in St. Louis. We have about 13 hospitals, about $2.5 billion of revenue. For purposes of the electronic medical record the important aspect is that we have a very diverse geography, a very diverse patient population and we have an opportunity to serve a few rural markets as well as suburban and urban.

Our goal ultimately clearly is to be a national leader on both patient advocacy, medical research and financial efficiency.

Today, really, I come to you representing one of my responsibilities which is our BJC Medical Group. We have a couple hundred physicians that we employ through our organization in about a 225 mile radius. All of these physicians are in small office settings, generally three to four person situations. And we are working as we speak to roll out the electronic medical record to these physician offices. It will represent about 300,000 patients that we will be able to cover during this time. Almost 20 percent of those are in the rural markets. These patients really represent a cross section of subspecialties. Most or about two-thirds of our providers are primary care, but we really cross the entire specialty aspect.

BJC has committed to a $8 million investment in the electronic medical record across these 200 providers. And our thinking is a couple of things.

One is that we will be able to set up this project to provide connections to external as well as internal labs. So a lot of the electronic medical records you hear about today are actually in self-contained private offices. And one of the things that we feel responsible to do is to take that precedent and extrapolate it to interface it with the hospital connectivity. And so we have actually moved ahead choosing a product that is very centric to the physician office setting and we are going to support, underwrite if you will, the interfaces back to our emergency departments, our hospitals, etcetera.

The benefit of that, obviously, from the perspective of the universal patient record is clearly to get the continuity of care not just outside the hospital, but all the way through to home care, post discharge, etcetera.

In addition, we recognize there is a lot of unnecessary are being provided. There is a lot of avoidable emergency department visits, readmissions for circumstances where patients are put on contra-

indicated medications, and obviously that's a function of the fragmented healthcare system that we have today.

So the ability to really roll this out across our 13 hospitals enables us to advance what many of you have heard about, with is the shared records capability. You have heard of a portal, you have heard of sort of a regional health network at times. And this shared records capability allows us across these 13 hospitals to in fact for about 30 percent of the patients in our market, understand the entirety of care that has been provided and understand what really would have been the ideal patient care system.

In addition, we feel strongly as was indicated as well about this interoperability issue. The concept of requiring the vendors to really have a product that really can transcend from one to another.

Our vision ultimately is to take this prototype and create a community health portal that will allow multiple provides to access medical records and allow patients to view their medical records. We think that having records through the internet will, obviously, be very advantageous and promote from the perspective of education, advice, etcetera.

In closing, we would say that BJC Healthcare is committed to the successful introduction of the electronic medical record. Our hope is that this will catalyze a regional health wide practice. As we move forward today in our conversations, we are anxious to talk about some of the obstacles from a cost and an implementation perspective which will enable the proliferation to occur.

Thank you.

[Ms. Magruder's testimony may be found in the appendix.]

Chairman AKIN. Thank you very much, Joan. And right on the five minutes. Appreciate that and your perspective and looking forward to asking some questions.

Next we are going to go to Dr. Christopher Normile. And you are the doctor of medicine from St. Charles, Missouri, which is also part of my district. Good.

Would you please proceed?

STATEMENT OF DR. CHRISTOPHER NORMILE, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. NORMILE. Mr. Chairman, fellow AAFP member Representative Christensen, and Members of the Subcommittee, thank you for the opportunity to provide testimony today.

Chairman AKIN. Could you get that mike and just sort of slide up a little closer there.

Do you go by Christopher or Chris or—

Dr. NORMILE. Chris will be fine.

Chairman AKIN. Chris. Okay. Thank you.

Dr. NORMILE. I am a partner in a two physician practice in St. Charles, there are only two of us. We are independent, we are a small business. I am also a member of the American Academy of Family Physicians, one of the largest national medical organizations with more than 94,000 members.

Chairman AKIN. You are still dropping off. Could you pull that mike even a little closer there.

Dr. NORMILE. Your Subcommittee's concern for physicians practices is well placed. We are small businesses with a significant im-

pact economically on our communities. Family physicians and AAFP have been in the vanguard in promoting electronic health records and they have provided information that has supported 30 percent of family physicians adopting EHR so far.

My job I think today was to give you my experience. And some time ago, say, in '95 I had a palm pilot and it became very apparent to me the power of these tools in improving medical care for patients. I convinced my partner to purchase an electronic health record, and we have been using it for two years now.

Today on a typical day I will come in and electronically synchronize my laptop and take information from home and work that I have done at home and file it into our computer. I log onto an internet connection with the local hospital, put up that information on my hospitalized patients. I review labs, phone messages, all sitting at my desk in just a few minutes. My efficiency has improved in that regard.

After office hours I dictate notes through a voice recognition software . I do not need to use transcriptionists. They cost us thousands of dollars anymore.

In the near future we will communicating more and more with patients through the internet. And this will be another expense that we will have absorb.

Currently the time I set aside for electronic communications with patients is not paid for by insurance company or Medicare, even though it does improve care and reduce the medical costs for the whole system.

The benefits for our office have been, you know, longer stacks of papers. We have information our fingertips. Any doctor who calls me I have information immediately at hand. The same when patients call me, I have patient's immediately at hand to discuss with them about their care.

It is much more easy to manage a diabetic or a chronic care patient's care and to keep track of those results to improve quality of their care.

The technology does not come cheap, though. We are fairly typical among users of the electronic health record. Our initial cost was about $50,000 and annually we spend about $10,000 for software upgrades, hardware, etcetera.

Far more significant to the actual financial cost, this tool has cost me a lot of time and effort. It is a very complicated system. As those of you who hate setting the clock on your VCR can only imagine the time and expense and time it takes to organize and coordinate the medical records. We are a complex office to start with and the computer makes it even more complex. So we have learn this and develop it so that it works for us.

Because of dwindling and third party reimbursements, which in our market is dominated by a few powerful insurers, we have found ourselves with progressively shrinking incomes. Therefore, the system upkeep has landed in my hands. Computer consultants charge about $150 an hour for their services. Currently that is more than three times more my hourly income. Five times more if you calculate the time and effort to put into the electronic work records and with paperwork, phone calls, etcetera. So I have to do all of the care of our computers.

As these systems become more widely adopted, costs will eventually decrease. But in order to accelerate adoption, the AAFP recommends that Congress work to provide financial incentives for small to medium size practices, and; (2) establish federal standards of interoperability, and; (3) support technical assistant programs to help small practices through the cycle of selecting, implementing and redesigning their work flow. We can use all the support we can.

Thank you.

[Dr. Normile's testimony may be found in the appendix.]

Chairman AKIN. Thank you, Chris. You actually redeemed some of your time there. You should get extra points for that. And we appreciate your interesting testimony.

Now we have been joined by my very good from Indiana, Congressman Mike Sodrel. We are just going to finish the hearing from the witnesses and then we will have things open for questions, Mike, in just a minute or so.

Our third witness, Mr. Jack Price is Vice President of Service for HIMSS. Is that His Majesty's Secret Service or something? Analytics from Melford, Delaware. Maybe that is not exactly what it means, but we are glad to have you just the same, Jack.

STATEMENT OF JACK PRICE, HEALTHCARE INFORMATION AND MANAGEMENT SYSTEMS SOCIETY, HIMSS ANALYTICS.

Mr. PRICE. Well, thank you very much, Mr. Chairman and the Ranking Minority Member Bordallo and distinguished members. Thank you for allowing me to appear before this Subcommittee.

As Mr. Chairman stated, HIMSS is the Healthcare Information and Management Systems Society and HIMSS Analytics is a research arm associated with HIMSS.

My role is that I lead a lot of research projects, produce surveys in order to routinely obtain data that is critical to efforts to improve the quality and cost efficiency of patient care.

One of these surveys that I'm currently working on right now is we are interviewing 2500 physician offices across the country. And of these 2500 offices we have found out that when we ask them if they had practice management system, the answer was always 100 percent yes. We asked them if they had an electronic medical records system, we found out that only 26 percent of those offices answered yes.

And when we further drilled down and asked the other 70 some percent if they plan on purchasing one in the next two years, the answer was no. So we are very interested in why they did not want to purchase that EMR when all the evidence suggests that on the contrary there are tremendous benefits and return on invest from purchasing an electronic medical records system.

And in healthcare we look at ROI two different ways; the soft side which is more associated with looking at patient safety factors, improved communication and the ability to improve clinical processes. We also look at hard ROI, which is really associated with things like reduction in material and resource expense, improving patient flow, therefore increasing revenue. And also improving billing improvements so you can capture more revenue that way.

So, you know, when you look at hard ROI, when you look at charts they can be seen on a clinic's computer and patient encounters can be documented in a few mouse clicks. The flow of patients through a clinical environment changes dramatically and as a result, volumes of patients can be increased and then also as a result of that, more revenue can be achieved.

EMRs also reduce the need for paper, and that is one of the big pushes for EMR. So you eliminate that paper trail. And when you do that you can also eliminate the number of transcribers that are responsible for having to do the transcription. It can be automated by the physician.

And so you can also reduce the amount of space that it takes to actually store these tons of medical records that are out there.

So there are many benefits along a hard ROI perspective. And it also provides a very easy way to capture data that normally could not be captured for billing and submitting it electronically to the payors.

So from the standpoint of a small business practice, we see many advantages from using EMRs. And so clinics have reported doubling or even tripling their case loads with corresponding jumps in revenue and with only marginal increases in staffing. And at the same time many report that they more easily pass regulatory audits than before.

And after EMR implementation practices see decreased medical liabilities, they see more accurate and thorough documentation, enhanced patient care and improved quality of review.

Patients also no longer must wait to see a physician. And so the patient satisfaction increases dramatically as well.

However, as the results of our recent survey pointed out, many providers are still reluctant to invest in EMR technology. And one reason may be the fear factor associated with these enormous startup costs and the cost of the software, hardware, implementation, training and support. And you also have to realize that many physician practices do not have that support staff that hospitals have when they implement EMR. So a lot of it falls on the physicians, as we have heard in previous testimony.

So the amount associated with implementation is a daunting and can be a very disruptive task for a practice. And perhaps one of the biggest barriers to overcome is really more of a resistance to change itself.

But we see ambulatory care clinicians who have implemented EMRs really have no shortage of advice for their colleagues. And one of the things that we suggest is that these physicians continue to be champions and offer a valuable experience, hands-on experience to those physicians that really need to grasp EMRs and move forwards. So for small healthcare groups considering EMR, this is a very valuable resource and must be tapped.

So with that I will say on behalf of HIMSS and HIMSS Analytics thank you again, Mr. Chairman and Ranking Minority Member Bordallo for the opportunity appear before this Subcommittee.

Thank you.

[Mr. Price's testimony may be found in the appendix.]

Chairman AKIN. Thank you very much. And also doing a great job on time there for us.

The staff that put the hearing together because of the nature of this Committee, focused a lot of it on small business, which is appropriate, particularly the small business of the smaller practices and things. I guess the two questions that sort of jump out at me, and they are partly small business related but partly just in general on these medical records, I would like to toss them out to any of the three of you that want to take a shot at either of these questions.

The first one it seems like, you know I used to work for IBM. It seems like there is a technical question as to what software you use and what sort of format that you use in transmitting medical information. And I have heard there are some different theories. One of them is stand back and wait patiently for a couple of years until somebody in the government comes up with an absolutely perfect way of doing it.

The other approach seems to be well you are waiting for the government, you will wait forever. Maybe it is a better thing just to let free enterprise take over and while there will be a little bit of some fitful starts and maybe some competing software, competing approaches, it may be a little harder to get to some perfectly standardized approach, yet probably the market will sort that out faster and more efficiently than letting the government do it.

So if you have a thought on that, or any other thing that relates to the problem of how do you format the information and make it so that you can talk from a doctor's office to a hospital to a hospital somewhere else where somebody is vacationing, to get that record. And then the second question I have we have got every since the days of AIDS became a politically correct disease to protect and everything, we have got some very, very strong laws regarding patient privacy. And I am just wondering if that gets in the way also of transmitting records. You know, Todd lives in St. Louis, works in D.C., he is vacationing in Massachusetts and has some sort of bad symptoms, goes into an emergency room or something. Can Massachusetts pull up the records from St. Louis and Washington, D.C., all at once the doctor is making a decision with all of the data? And what are the questions in terms of the legality of transmitting that information.

I just wanted to toss out, those are the two main things I had. If you could just give me, anybody who wants to take a shot at either of those it would be helpful.

Ms. MAGRUDER. I guess I would comment on the question about how much to allow to free enterprise versus government interaction. You know, I think for us we have thought that the ideal is sort of a hybrid of the two, a combination of sort of a public and private partnership.

The idea behind BJC putting $8 million behind the electronic medical record is all the earlier testimony about the risk aversion of the physicians and the fact that it is not time neutral. And, in fact, in the short term it is costly to them in many ways. And so our piece of the investment was let us get them over that hump and hold them accountable for none of the one time costs, but only the in-office costs.

Now the reason that we thought that was important was your other point, which is that our experience has been that the elec-

tronic medical records that have been adopted are only in free-standing independent office situations and feel to really get at the cost effectiveness of care, needed the benefit of an interface to the hospitals, the emergency departments, etcetera. And so the public/private aspect is that we would like to see a situation where people like ourselves seed large sums of money and ideally can have a partial match from the public sector to inscient that that proliferation really be accelerated but with a clear understanding that it is not a proprietary product, that it really can continue to move in an interoperable fashion and proliferate in the community. And that we can serve somewhat as a financing vehicle for the physicians that maybe they have to pay back some of it over time, but make that less onerous in the long run. So sort of a public/private partnership.

Chairman AKIN. The public aspect being that there would be some maybe tax incentive or something like that to try to help reimburse the hospital some for your investment in that technology.

Ms. MAGRUDER. Exactly. Because honestly one of the things that I was up against, I happen to run our physicians practices. And most institutions are going to want a product that is centric to an institutional approach to things, which is often synonymous with not what is in the best interest of the physicians. What I really wanted was a product that was physician centric that really spoke to the ambulatory environment so that physicians would ultimately adopt it and find it to be useful.

So the incentive idea was that hospitals or otherwise are not going to readily approach it in the way that really inscients a win/win there.

Chairman AKIN. Thank you.

Chris or Jack, either?

Mr. PRICE. I see it as a very complex problem and it does require a lot of balancing between what is good for the hospital, what is good for the physician offices sometimes. And, for example, if you have a system within a healthcare integrated delivery s stem that you can push out to your physicians, your independent physicians, as we just heard, may not really like that type of an approach. And they may want to have additional systems which would then put an extra burden on the hospital in being able to support a myriad of different types of technologies. So that sort of a cost shifting type of thing.

But to get back to your question—

Chairman AKIN. Do you not think that the individual physicians would tend to kind of go with the main hospital they work with, though, from a data processing point of view?

Mr. PRICE. They could or they could be in a scenario where they are admitting patients to a number of different competing facilities, and that could create some problems, too.

Chairman AKIN. So now maybe you got putting patients into three different hospitals, each one is on a different system, and now you really got a headache?

Mr. PRICE. And some of that drives some of the work that is being done with the regional health information organizations in order to ensure that we have this level this communication between different organizations. So there is great work that is being

done with creating standards, but a lot of it ends up not being the physical standards as you were speaking to earlier, but a lot of it is related to sort of like translating. If I am speaking Spanish and they are speaking English, how do I translate between one organization and another? Because what I call a CBC may not be called a CBC in a system that we are trying to communicate with.

So there are a level of problems that complex that we are trying to work through. But I think over time we will reach a point where we can do those types of transmissions very easily.

Chairman AKIN. In answer to my other question, do you think it is a good thing just to let the hospitals and doctors work on this just in the free side of things instead of saying "Hey, hold everything. The government in D.C. is going to come up with a—"

Mr. PRICE. No, I do not. And I say that simply because I do not think that that is always going to be a priority for those organizations. Because you are going to see a competition for capital and there is going to be much more money being shifted to buying new MRIs and things of things of that nature, and there is only a limited amount to spend.

Chairman AKIN. So you are saying that you do think that government should be coming up with sort of a standard format for the transmission of data?

Mr. PRICE. The government is working on and through certification groups is working on standard formats.

And also I believe that the payors are going to have to play a significant role in this just so that we can find some other opportunities to help fund the physicians as they start up these practices. There may also be some relaxation of START that has to happen in order to eliminate the issues and things of that nature.

Chairman AKIN. Go ahead.

Dr. NORMILE. You know I think that certainly there should be a national situation. This is something where we all need to work together, LabCorps and different labs we use are national organizations. To be able to communicate with one hospital group and not another just is not going to work. We need to have something that will work for everyone. And I can communicate to a doctor in New York and California just as well as next door.

Chairman AKIN. I think we are okay time wise.

I assume that right now are there vendors that have software packages? Is that what you went shopping for, Joan?

Ms. MAGRUDER. Yes, we did. We went with a vendor called NextGen. There are lots of vendors, I think several of whom are very credible.

I think you asked a question earlier about inferentially whether the software was where it needed to be. I think the software, in and of itself, is reasonable as a starting point. But I think that the real key is that, again, it remains mostly a silo technology in free-standing physician offices. It is difficult enough to get individual offices to go up. I think what we really need to get to is the integration of all healthcare providers. And I think that that's really going to cause some alignment of incentives.

I think the payors have to pay a key part of this. I think that if we are going to advocate transparency, which is part of what this will do for us, we need to make sure that the payors treat that as

a positive and appropriately. And so I would love to see a situation where physicians who have been willing to step up are in fact rewarded for doing so and not at risk for things going on a website about their information because they were—

Chairman AKIN. The first to stick their head up?

Ms. MAGRUDER. Exactly. Exactly.

Chairman AKIN. Okay. Sounds good.

Dr. NORMILE. Personally my experience has been, you know this technology really is almost there to the point where it is a break even situation for me. I think it still has a ways to go.

Chairman AKIN. Okay. Anybody want to comment on the second part of the question about the privacy of information transmitted? Is that a problem or is that no sweat?

Mr. PRICE. No. It is a problem. It is a problem in the sense that organizations are very aware of what they need to do to protect that information. And, in fact, some of that has driven the way some RHIOs have designed their architecture so that information is not resident in anyone, let us say, database and that you have processes that can go out through secure networks and be able to pull information from these different locations where a patient may have been at some point in time.

So it is at the forefront of every organization in terms of addressing security, internally and externally.

Chairman AKIN. Are you saying that that is being built into a lot of the programs in the system's design?

Mr. PRICE. It is being built into software programs. It is being built into physical safeguards for facility's procedures, policies. Auditing is taking on a whole new front. I mean, a lot of this really started with HIPAA. But it is just the right thing to do, as we all agree, to protect the privacy of individuals.

Chairman AKIN. Thank you all very much.

And now I will turn to my good friend, Mike, did you want to ask some questions?

Mr. SODREL. Yes. Thank you, Mr. Chairman.

I am certainly not a computer wiz, did not grow up in the era, but I ran a business before I came to the Congress. And, in fact, this is the first time I have ever served in elective office. Ad some of the questions that I have been asking of the American Medical Association, some other doctors I have talked to about interoperability. You know, I mean how do you get a system that talks nationwide and talks to the providers and the payors and everybody else might be appropriate. And the answer I get is, no offense, Doc, but they said doctors are kind of like to herd cats. Unless the government provides some carrots and sticks to the process, everybody will go out and buy independent systems and they are not necessarily going to talk to each other or reach the desired end.

And it is kind of a follow up on the Chairman's question, how do we provide the carrot and stick for the industry to come up with a standard software practice and standard language and standard system so that they can talk to each other, both the hospital to the insurance company to other appropriate entities? I mean, how do you think we should be approaching the problem?

Dr. NORMILE. The primary think I think would be to approach the software company that produce these and if they start seeing

that there is a common way to communicate, doctor's practices will want to get on and involved with that. And doctors, we all want to be able to communicate and that is vital to our practice. So, you know, I do not think the issue is really hurting as far as the patient. It is a matter of getting the software companies to provide it.

Mr. PRICE. Dr. Brailer is currently heading up a lot of different approaches that are requiring certification processes. And what we are hoping is that over time software vendors will have to adhere to certain certifications. And part of that certification will require this interoperability issue to be addressed.

So these types of things are happening right now. But in the meantime, you still have to conduct business. So there is still organizations that have to make these types of purchases and hope for the best in terms of being able to communicate outside the confines of their office.

We have addressed a lot of that with HIPAA for the financial side of the equation, and it may be beneficial to have things that are similar on the clinical side to be able to share that type of information back and forth. But a lot of that is like the train is already moving on that.

Mr. SODREL. The other thing that occurs to me is you lose a paper trail when you go to electronic records that a hot site is going to be really important. I mean if you look at Katrina, Rita, tornados go through the midwest. You are a doctor and the system is gone in an F3 tornado, those records need to be someplace else on a clone or some system that is running parallel where you can get them back up in a short period of time. So it seems to me that is a risk as well of losing the data.

Dr. NORMILE. Those are becoming more available where you can copy information to another site. And certainly in our practice we copy all the data to a tape and I take it home at night with me. It is one of our biggest fears that our system would go down. It would be devastating. But we do have backups for patient information. And all that information is on a tape and I have it at home.

Ms. MAGRUDER. I think the other form of redundancy goes back to this issue of whether these EMRs are going to be self-contained in an ambulatory setting or connected to the in-patient settings. Because you then, obviously, have another set of redundancy.

In our circumstance we are trying to create the backbone and allow physicians to choose to attach to it or not. And so whether they have the option to back it up in their office and we then have the backup, if you will, at the organizational level. So that becomes sort of a double protection.

I do think, though, that whatever we do in this regard if we really think we want to get at sort of the cost effectiveness and the universal care aspect, I think we are going to have to figure out a way to get the in-patient centers to get moving, not just the physician setting. Because right now there are so many things that are being vested upon in the in-patient setting, this is really not a top priority. And so I think that that is something we just do not want to lose track of as we try to think that we are targeting a very universal comprehensive record. I think that will be important.

Mr. SODREL. Thank you, Mr. Chairman.

Chairman AKIN. If I could just do a follow up question about Mike was saying. At least it seemed like to me, maybe one thing that might be helpful, maybe this has already been done, but the information that you are going to be collecting if you could define what the fields are? In other words a treatment date and have some common definition for what that is or whatever the other basic things that would go with it regardless of what software, how to design the database. If your definitions of what this, that and the other term meant, it would seem like it would make it much, much easier to make things interoperable if you are using a common set of definitions. Has that been thought of is that already being taken of or is that something that maybe some sort of national group could help with?

Mr. PRICE. I believe SNOMED, which I can't remember exactly what that stands for, but it is a common vocabulary that is being looked at as one of the key sort of integration languages to use for this interoperability. This sort of translation between the Spanish and the English. But get everybody to speak the same using SNOMED vocabulary in the way they define diseases, the way they—

Chairman AKIN. Is that a commercial—

Mr. PRICE. Yes. It has been used in pathology for a number of years. Yes.

Chairman AKIN. So it is one that is already somewhat established and it is almost one that is starting to take on a sort of standard in and of its own, to some degree?

Mr. PRICE. Right. And there is discussion about other formatting types of capabilities whether it be a continuity of care record or some other mechanism for being able to ensure that these data elements were defined properly and they are the same, whether you are talking in an ambulatory and acute care setting.

Chairman AKIN. Okay. That covers it pretty well.

Okay. I did not have anything else particularly. I just wanted to thank you all for coming in.

We have broken our witnesses into two panels and if you would like to stick around, you will see that we have saved an interesting witness for our second panel here, a colleague of ours, a medical doctor who is a friend of ours and somebody from the city of Atlanta who we like to harass, but in a friendly sort of way.

Thank you all so much for your testimony. And we will just proceed right into the second panel.

Mr. PRICE. Thank you.

Ms. MAGRUDER. Thank you.

Chairman AKIN. Welcome to the Subcommittee, Congressman.

Mr. GINGREY. Thank you, Mr. Chairman.

Chairman AKIN. Congressman Phil Gingrey is also a doctor and a honorable, and from according to my notes, Georgia 11. I have been there, but I did not know it was 11. But we are delighted to have you, Phil. If you would like to proceed. I understand that you have some legislation that you are working on, and we are all ears. We would like to hear what you have got.

STATEMENT OF THE HONORABLE PHIL GINGREY (GA-11), U.S. HOUSE OF REPRESENTATIVES

Mr. GINGREY. Mr. Chairman, thank you very much. I didn't realize that a panel could be a panel of one, but I am proud to be here not as a VIP or a DV, as a doctor member of the House. And it is an honor to be here before this Subcommittee, Chairman Akin, Representative Sodrel. I know Ranking Member Bordallo, a very good friend, and other members of the Regulatory Reform and Oversight Subcommittee.

I have got some written remarks, Mr. Chairman. I would like to go through those and submit them in their totality for the record.

Chairman AKIN. Without objection.

Mr. GINGREY. But let me just say that on behalf of the citizens of Georgia's 11th Congressional District, and I thank the Chairman for visiting in my District and holding a field hearing, thank you all for allowing me the opportunity to testify before you today.

Every day we read in the headlines about the rising cost of healthcare and what it means to every American in this country. There are many ways to tackle the problem of skyrocketing healthcare costs, but today I am here to focus on healthcare information technology, just as the previous panel. Why does Congress need to be invested in the adoption of healthcare information technology? Well, in September of 2005 the RAND organization released a study that showed how a health information technology system that is implemented correctly and as the previous panelists said, widely adopted could save the American healthcare system more than $162 billion annually.

Since we all know the tremendous stress our healthcare system is currently operating under, these savings alone are very compelling justification for congressional involvement. Even more important than saving money. Integrating technology into our healthcare system will reduce medical errors and save lives. However, it was not until I went out into my District, I met with physicians like the physician from Missouri and representatives from the health IT industry, I realized the answer to the question of congressional action.

The key to the RAND report and my personal research centers around the concept of, as I said, widely adopted. And this is why we are here today. What role can and should the government play in ensuring healthcare information technology is widely adopted?

There are a variety of thoughts, opinions and pieces of legislation centered around this particular question. The RAND study simply states that in order to take full advantage of this potential savings, we needed incentives for physicians to buy quality systems and integrating system. So the question becomes not only what would be the most effective way to incentivize physicians, but what is the most fiscal responsible way to incentivize the physicians.

I was anxious as a physician member to go out and visit doctor's offices that were already utilizing health information technology to see what differences it makes out in the real world. And make no mistake about it, the physicians in the trenches have already lead the charge. You know, I know the government is very important, that we get it right. But there are a lot of systems out there, Mr. Chairman, that are already operating and operating well. It was

just three short years ago that I stopped practicing medicine. I remember vividly the overwhelming burden of administrative paperwork. It robbed physicians of time with their patients, literally taking away from them the real joy of the profession. And what I saw in a paperless medical practice when I went out recently was just amazing to me.

I visited a three doctor OB/GYN group, that is my specialty, in my District, Carrolton, Georgia. And they had purchased their electronic health records system in 2002. We are talking four years ago.

I was able to watch Dr. Rick Martin of West Georgia OB/GYN as he demonstrated the established routine he follows during a patient visit utilizing his computer tablet. Not a paper chart. He stated that the vendor company that they had worked with, they had worked very hard to ensure the process flowed to his liking and the words and the phrases that he used most frequently were utilized in the chart template.

It was amazing to me how efficient the system was in documenting a patient's chart and any necessary tests and imagines, all at the point of care when it was needed. I saw how revolutionary health IT was to the health care world. It transfers how physicians do business on a daily basis by streamlining the process, giving them the tools and the information they need when they need it.

It even left me thinking if this political career work out, I might want to go back, jump into medicine and enthusiastically embrace this new paradigm.

What I heard from my discussions were how satisfied the customers were. The physicians I spoke with are enjoying a higher quality of life, more efficiency in follow up with their patients, the flexibility to complete charts and, indeed, even take calls from the comfort of their homes.

The office managers spoke emphatically about the almost immediate increased revenue from automating their coding and billing process. Not only did they receive payment from insurance companies, third party payers we call them, quicker but they received more accurate payments. An increase in revenue to a physician's bottom line is one of the biggest wins in purchasing electronic health record system. The system not only automatically codes the patient's visits, but correctly codes the visits to ensure the physician is reimbursed accurately for the services rendered.

Early in their career physicians learn quickly that it is easier to actually down code a visit than to submit a claim that ends up being rejected by the insurance company which requires your office to then resubmit the claim, wasting valuable staff time and taking money away from the practice. But different sections in the healthcare system and the Federal Government that there are numerous, maybe too many hurdles preventing physicians from practically incorporating health IT into their offices. These concerns range from the time and energy required of physicians to learn a new system, teach an old dog new tricks, a potentially unsustainable decrease in productivity over the short haul and a natural apprehension that comes with any large financial investment. However, I want to present an example of what one practice

saw as a return on investment in their first year of purchasing a complete health IT system.

I would like to submit for the record an example administered by Microsoft Windows Service System, Mr. Chairman. They performed a customer solution case study on a five doctor OB/GYN practice in New York. For this practice implementing an integrated electronic health record system has cut down on the administrative work required by each doctor by one hour a day. And it has allowed them to see an additional 25 patients each week and given them a first return on investment of $400,000.

It is for this particular reason that I believe the best thing Congress can do is to create incentives for physicians to incorporate health IT and then get out of the way.

And, Mr. Chairman, you alluded to it at the beginning of my testimony. This is why I introduced HR 4641 the Adopt Health IT Act. This is what it does. It creates these incentives by increasing the deductions offered under Section 179 of the tax code for health care providers that purchase an EHR system.

I have heard from physicians and industry alike that Section 179 is a strong incentive for their decision to invest in health IT. But under the current law the maximum deduction is not adequate to increase adoption among all physician groups. Under current tax code small businesses can deduction around $100,000 of the cost of a qualified business expense that are placed into service in that tax year.

Basically what my legislation does is it increased this maximum deduction in the first year from $100,000 to $250,000, therefore creating a more realistic incentive to spur adoption among physician practices of all sizes. Current small businesses have a maximum threshold of $400,000 for qualified equipment purchases in any given year. My legislation would further increase that amount to $600,000, again, narrowly defined to include only those healthcare professions that purchase an EHR system.

The logic behind the idea, Mr. Chairman, is that physicians like all small business owners look at what the tax code can offer them as they consider purchasing equipment for their business. And HR 4641 allows section 179 of the tax code to better represent the actual cost of EHR systems.

For example, the cost of a system for an average practice including four to six physicians, like a single specialty OB/GYN practice, can be as much $200,000. This then restricts what other medical equipment that office can purchase that year. So that is why we increased the overall amount from 400,000 to 600,000.

By appealing to a physician's business instinct and allowing the tax code to provide incentives we can create a much more effective way of getting healthcare information technology into every physician's office around the country. These incentives will work far better than simply dumping federal grants into the healthcare system.

So, Mr. Chairman, in closing I want to again express my gratitude for this opportunity, respectfully ask for your consideration of the initiative that I am laying out to you this afternoon.

Mr. Chairman, I am prepared to respond to any questions or comments you or Representative Sodrel or other Members may have about the legislative proposal that I am recommending.

[Congressman Gingrey's testimony may be found in the appendix.]

Chairman AKIN. Thank you for your testimony.

I gave you a little extra time because you are a Republican.

Mr. GINGREY. Thank you, Mr. Chairman. I appreciate that.

Chairman AKIN. But I thought your comments were very helpful and in good order. You came to the end what I was going to ask, just some sort of basic numbers. One of these systems can cost you 200,000 bucks if you are a physician. Is that hardware and software or is that—

Mr. GINGREY. Mr. Chairman, that is right. That is hardware and software. And that would not be an individual physician cost, but a group of about five members; that is about what that cost would be. And, of course, it is a first year cost but it does include an update and a training part in addition to, as you point out, the hardware and software.

Chairman AKIN. So that is basically the package to get you up and going in a way?

Mr. GINGREY. That is indeed the package to get you up and going and actually probably covers a couple of three years of upgrades to the software system and hand-holding, if you will, training of the office personnel, not just physicians. But the front and back office people.

Chairman AKIN. You say that is a five doctor group, maybe?

Mr. GINGREY. That would be for about a five doctor group.

Chairman AKIN. What would happen if you were just one or two or something? Would it start to get pretty iffy in terms of cost justifying it?

Mr. GINGREY. A great question, Mr. Chairman. The way these systems work. of course, is you would not be able to divide that six member group by six and come up with a cost of $30,000. It is going to be significantly more than that for just one person. And there are those one and two person practices out there, believe it or not, that just like to work independently. Maybe it is an OB/GYN, maybe it is a family doctor that is making house calls. But they need, and I think the previous panel would agree, that we need to make sure that everybody is into this system and can afford to do that because the chain is only as strong as your weakest link. And if we do not have those small group practices that really cannot afford to come up $75,000 to $100,000, let us say for a smaller group, they are not going to do it. And patients lives are going to be in jeopardy because of that. So this is an opportunity to incentivize them. It is not the government necessarily giving out grants and deciding who needs some money, is it a big hospital system that needs a big government grant or is it the small doctor situation. And I am afraid if we look at it from that perspective, most of the time the big doctor organizations will win out in any grant proposal. And they probably can afford to invest on their own a lot better than a small medical doctor group can.

Chairman AKIN. Okay. Thank you very much for that. I think that made a couple of things clear.

Let me just ask if you have different physicians motivated to use this technology, now they are getting a tax break in a sense to try to get this thing up and going, are you going to have any trouble

with just the format of the medical records so that you are going to have all kinds of different systems that do not really work together. And have you thought about that, or is that something where there is enough standardization going on now that increasingly they are going to be able to talk back and forth?

Mr. GINGREY. Mr. Chairman, that is a hugely important issue. And, of course, the previous panel as I caught the end of their testimony talk about it. And Dr. Brailer, who is the National Coordinator for Healthcare IT under Department of HHS is working as far as credentialing and making sure that we get it right, that the RHIOs are established and that there is connectivity. I am kind of like Representative Sodrel. I am not a computer wiz kid and I have got to learn a lot about this and the acronyms and that sort of thing. But it is very, very important that the software companies that have been involved in this business for six years now, like the company in Carrolton, Georgia that have developed a very good software program, kind of unique maybe to the general surgery specialty or the OB/GYN specialty, we cannot all of a sudden have the government create a program that carves them out when many of these physicians, they are out there, they have marketing people, they have salesmen that are selling these programs and doctors that have bought in at about an average price of $200,000. We have to make sure that they're not left on the sideline holding a bill of goods that now becomes worthless. It is very important that we work together with them.

Chairman AKIN. Is it your understanding then that there is an ongoing cooperation between the software developers and people defining what the fields mean? So that we are talking the same language, more or less?

Mr. GINGREY. Well, it is my understanding, Mr. Chairman. I think that is true. But I think there is an angst and heartburn among some of these vendors who are sort of on the outside looking in and they are concerned. And obviously they want their member of Congress, you, Mike Sodrel, myself to make sure that we represent them at the table. And that is a part of why I am here, and that is part of why I have introduced this bill.

Chairman AKIN. Thank you.

And, Mike, would you like to ask questions?

Mr. SODREL. I think you stole all my good questions, Mr. Chairman.

Thank you.

Chairman AKIN. Well, I really appreciate your leadership on this and particularly the fact that you are coming at it from being a doctor and understanding what those practices are like. It is really important.

It sounds like you have got a pretty good balance, too, between some sort of structure that we are trying to provide and at the same time letting the market develop products.

I just have one last question. How far away are we on not just your OB/GYN office talking to the local hospital, but my wife being off on vacation somewhere and their being able to tap in so that the doctor making a decision away from home has the same data that her doctor would have at home?

Mr. GINGREY. Mr. Chairman, a great last question. I am so glad you asked that. You know, the President has said that he wants to see a fully integrated operational system by I think the year 2014. I really believe we can and desperately need to do it before then. At $162 billion cost savings per year, that is a lot of money. That could pay for a lot of Head Start programs and other things that we want to do that we maybe cannot afford to fund as fully as we would like to.

It is hugely important that we get this done sooner rather than later, as you point out. I think we can do it. I think we are on the track to do it. I hope that we can get this done maybe within five years.

And you mentioned an example of your wife. I was just recently in Antarctica on a trip and I was able with my American Express card to get U.S. dollars so I could buy some souvenirs at the New Zealand Station. And that was a wonderful thing. And yet I could not help but think if I had slipped down and fallen and hit my head on the ice, there was plenty of that there not much grass, and gone to an emergency facility and was unable to speak, you know they would not know that I had open heart surgery three years ago and I am on four medications and that I am a little goofy to boot that they would know how to treat me. And I think it is just so important that we are able to do that. And even more so in, let us say, a country where they do not speak your language. And that is why we really need to get this done.

Chairman AKIN. Well, I really appreciate the wisdom of your answers, Congressman, and also the courage of a southern boy to go all the way to Antarctica. It would not have thought it could have happened.

Thank you.

Mr. GINGREY. Thank you, Mr. Chairman. Thank you, Representative Sodrel and the Committee. I appreciate the opportunity to present to you.

Chairman AKIN. Committee's hearing stands adjourned.

[Whereupon, at 3:07 p.m. the Subcommittee was adjourned.]

W. TODD AKIN, MISSOURI
CHAIRMAN

MADELEINE Z. BORDALLO, GUAM
RANKING MINORITY MEMBER

Congress of the United States
House of Representatives
109th Congress
Committee on Small Business
Subcommittee on Regulatory Reform and Oversight
2361 Rayburn House Office Building
Washington, DC 20515-6319

Opening Statement
April 6, 2006
Regulatory Reform and Oversight Subcommittee
House Committee on Small Business
W. Todd Akin, Chairman

Good afternoon and welcome to today's hearing entitled, "Can Small Healthcare Groups Feasibly Adopt Electronic Medical Records Technology?" I especially want to thank those of you who have traveled to be with us here today. Two of our witnesses are from the Congressional district I am proud to represent, Joan Magruder and Dr. Christopher Normile, a warm welcome to both of you.

In my role as a Congressman and Chairman of this Subcommittee I have had the opportunity to interact with many businesses in just about every industry. I have talked to business owners and CEOs about the many challenges they face both domestically and abroad, and time and time again they state that the rising cost of healthcare is crippling for their firms. Because many small businesses operate on slim margins, any increase in cost can turn a profitable business into an unprofitable one. The rising cost of healthcare is an important issue and there are many different voices in the public square advocating different approaches to offset these rising costs.

Today this Subcommittee will focus on the economic benefits derived through the adoption of technological processes. Is the adoption of electronic medical records feasible for small businesses, specifically small doctors' practices? We also hope to determine the challenges these small groups face in adopting such technology. There is little doubt that the adoption of electronic medical records can play an important role in increasing efficiency, reducing paperwork and redundancy and more importantly, reducing medical errors.

According to the Department of Health and Human Services (HHS), it is estimated that the introduction of Health Information Technology can reduce

healthcare costs up to 20 percent per year. The Bush Administration has stated the importance of implementing electronic healthcare systems, and HHS has made it a priority.

That said, doctors have increasingly, faced higher liability costs, potential cuts in Medicare physician payments, and additional regulatory burdens resulting in a question as to whether smaller practices can adopt this innovative technology.

I look forward to hearing the testimony of the witnesses to learn more about whether small practices can adopt electronic medical records technology. I now yield to the gentlelady from Guam, Madame Bordallo.

Subcommittee on Regulatory Reform and Oversight of the House Committee on Small Business
April 6, 2006

Statement of Joan Magruder
Vice President, Business Development, Physician Services and Alternative Care Sites
BJC HealthCare
St. Louis, Missouri

Thank you, Mr. Chairman, Ranking Member Bordallo and members of the Committee. My name is Joan Magruder and I am pleased to be here today to talk about an innovative way we at BJC HealthCare are approaching the introduction of electronic medical records.

We recognize the power that technology has to transform and improve health-care delivery. However, the cost of implementing new technology is often a very real barrier to the adoption of new and better ways of handling information and care processes. That's why we are working to introduce electronic health records into community-based physician offices – for the benefit of the patients we serve.

First, let me tell you a little about BJC HealthCare for context. Headquartered in St. Louis, Missouri, BJC HealthCare is one of the largest nonprofit health-care organizations in the United States. Our 13 hospitals include nationally recognized Barnes-Jewish Hospital and St. Louis Children's Hospital, which are affiliated with Washington University School of Medicine. Our hospitals and multiple community health locations serve urban, suburban and rural communities in the greater St. Louis, southern Illinois and mid-Missouri regions. We have annual net revenues of $2.6 billion, and employ nearly 26,000 people. Our goal is to be the national model among health-care delivery organizations in patient advocacy, medical research, employee satisfaction and financial stability.

Today, I speak with you as the BJC leader responsible for managing the BJC Medical Group, our network of employed physicians. We are working to implement an electronic health record system among more than 200 participating physicians serving more than 300,000 patients. It is important to note that approximately 53,000 of these patients live in rural areas in the state of Missouri.

To do this, BJC HealthCare has made a commitment to invest more than $8 million dollars to achieve this goal within the next 24 months. We are starting by deploying an electronic health record system to approximately 65 geographically diverse physician practices covering a 225-mile range. The project also will provide connections to multiple laboratory and pharmacy systems, and BJC hospitals.

With these connections, lab orders will be sent electronically and lab results will be automatically integrated into patient charts. If patients are admitted to the hospital, registration data will be sent to the hospital electronically to eliminate the need for patients to register in person.

Still, you may ask why BJC would choose to introduce electronic health records through physician practices. Our research shows few physicians have implemented electronic health record technology because it requires resources not typically found in small physician practices. The practices that have implemented electronic records are typically specialty practices and often the records are not interoperable with other existing technology platforms.

Not only is the implementation of electronic health records costly, but it may be disruptive to the physician practice as records are scanned and recorded. Billing systems need to be revised, new equipment needs to be purchased and new processes must be put in place.

The one-time costs to transform a doctor's office from paper records to electronic records range from $30,000 to $45,000 per provider, excluding in-office equipment. So, to accelerate the adoption of electronic medical records, BJC is underwriting the one-time implementation costs, if physicians buy the needed equipment. This equipment, including scanners and printers, averages $10,000 per provider. However, the return on investment can be achieved over 2 to 3 years with the elimination of paper records, transcription costs and through efficient use of staff time.

Both the individual consumer and the payor community also will realize the benefits of this technology, including lower costs and improved patient care. Individuals will save time providing personal information and medical history and should benefit from more comprehensive records among multiple providers. For example, multiple prescriptions with possible negative interactions could be easier to identify. Lower costs and greater safety should result from improved records accuracy, less duplicate testing and better sharing of patient care data. Other community benefits will result as electronic health record capabilities and data sharing become common practice.

Our vision is to create a "community health portal" that would allow multiple providers to access patient health records, as allowed by law, and allow patients to view their own medical records. We would like records to be available through the Internet so that test results, progress notes, education, advice, appointment scheduling and related information could be available in real time.

In closing, BJC HealthCare and the BJC Medical Group are committed to the successful introduction of electronic medical records. Our hope is that our project will catalyze efforts to create a Regional Health Information Organization (RHIO) consistent with the national vision. As we move forward, we plan to engage others in the community, such as local government leaders, community health groups, other health-care providers and insurance companies to help to shape this effort for the benefit of patients.

Thank you for allowing me to speak today. I will be happy to answer any questions.

STATEMENT of the American Academy of Family Physicians

Before the

House Small Business Subcommittee on
Regulatory Reform and Oversight

"Can Small Healthcare Groups Feasibly Adopt Electronic Medical Records Technology?"

April 6, 2006

Presented by

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Mr. Chairman, fellow AAFP member Rep. Christensen, and members of the subcommittee, thank you for the opportunity to provide testimony today on implementing an electronic health record system (EHR) in a small family practice. I am Dr. Christopher Normile and I am a partner in a two-physician practice in St. Charles, Missouri.

I am also a member of the American Academy of Family Physicians (AAFP), one of the largest national medical organizations, with more than 94,000 members. AAFP has over 57,000 members in active practice, the vast majority of whom serve in small and medium size practices - effectively small businesses. Your subcommittee's concern for physician practices is well placed. As small businesses, family physicians have a significant economic impact on their communities. The average economic impact of one family physician office in a rural area is $1.2 million; for urban areas direct and indirect impact for a family physician office, approaches a million dollars a year. But our impact is greater than economic since family physician offices are where most people first encounter the health care system. Nearly a quarter of all physician office visits each year are made to general internists and family physicians. That translates to 215 million office visits each year.

As a physician, my mission is to serve my patient. But in order to continue that mission, I also need to function as a businessman. The business of caring for patients is unique, in both the services we provide and how we are paid for those services. From federal reimbursement rates, which are not keeping up with the cost of providing care, to a variety of different insurance plans with a variety of different rates, a family physician's office is deluged with information. As payment complexity grows and patient visits increase, technology will play a greater role in office efficiency and quality of care. AAFP views EHRs as part of a larger practice redesign that will allow family physicians to integrate patient care and provide for ongoing quality improvement at the practice level.

Family physicians are leading the transition to EHR systems in large part due to the efforts of AAFP's Center for Health Information Technology. The Center was established to increase the availability and use of low-cost, standards-based information technology among family physicians. To complement its educational mission, the Center provides interactive tools including a readiness assessment, physician product review, and an e-mail discussion list. As a result, over 30 percent of AAFP's members have adopted EHR in their practice.

I have been using an EHR in my own practice for over 2 years now. My partner and I had, until January 2003, been employed by a hospital group. We decided that we wanted to regain control of our own destinies and left to form our own business. We were impressed by the powerful tools coming available at the time and we believed a computerized medical record system would increase the efficiency and quality of patient care and the management of our business.

Let me give you a glimpse of how the EHR affects my practice. My day begins by electronically synchronizing my laptop with the server to transfer to the office system work I have done at home, phone calls returned, and notes I've taken. I then log on to my internet connection to our local hospital to check the condition of patients I have there. I review labs and phone messages my staff has received, sending my response with a tap of my pen. I then carry my laptop with me as I see patients, making notes as I take histories, printing or faxing prescriptions and orders. After office hours, I dictate more complicated information, which is immediately transcribed by my voice recognition software.

In the near future we will be communicating with patients electronically, although this will be another expense we will have to absorb. Currently, time I set aside for an electronic communication with a patient, whether it is to answer a question, check on compliance, or send information is gratis. We cannot be reimbursed by insurance or by Medicare, even if this electronic consultation is done in lieu of an office visit. Recognizing the value of ongoing communication and compensating the physician for *all* the time involved in caring for a patient will be an integral part of accelerating this technology.

EHR Adoption

Of AAFP members that use EHR systems, 78 percent would recommend such a system to a colleague and nearly 80 percent believe these systems improve the health of their patients.

Indeed we have seen many improvements in my office. We no longer see stacks of charts and papers everywhere. Nor must we employ a person to keep them in order and to fetch them for us when we need them. Now, if a doctor calls to discuss a patient I have all the information immediately at my fingertips. Drug interactions are analyzed with the click of a button. Prescriptions are faxed directly to the pharmacy from the patient's room, and *they are legible.* I can easily consult information sources on the Internet while the patient is in front of me, providing her or him with an opportunity to ask questions without needing to schedule another office visit. It is easy to manage a diabetic patient's course of treatment and manage care of chronically ill patients *and* to keep track of our results for quality improvement. We have saved thousands of dollars monthly by limiting our use of a transcriptionist and now have powerful tools to analyze our business. Billing accuracy and speed of reimbursement have also significantly improved.

Cost of Implementation

Technology does not come cheap, however. Among AAFP members not utilizing an EHR, over half cite affordability as the primary barrier to adoption. The cost of implementing an EHR system can range from $5000 to more than $50,000, per physician with the largest percentage – 25 percent – falling between $10,000 and

$20,000 per physician. The system I use in my practice in Missouri cost $50,000 and annual maintenance costs, including software upgrades, total an additional $10,000.

In addition to the upfront investment, I have learned this tool is something of a double-edged sword. One of my goals was to get my paperwork and dictations done more efficiently, to allow me to get home to my family at a reasonable hour. This just hasn't occurred. In fact, I now spend more time at the office than ever. Data still must be entered into the chart, and currently it still takes longer than dictating. The costs of my time have been immense.

Those of you who hate setting the clock on your VCR can't even imagine the complexity of installing and using the hardware and software required to run an already complex business. Because of dwindling third party reimbursement, especially in our local market which is dominated by a few powerful insurers, as well as continued increases in the cost of doing business, we have found ourselves with progressively shrinking incomes. Because I pushed for the purchase of this system, its upkeep has fallen upon me. We simply cannot afford to pay consultants or new staff to manage any but the most complicated of problems. Computer consultants charge about $150 an hour for their services. Currently, that is more than 3 times my hourly income - 5 times more when you calculate the time involved with paperwork and phone calls.

If a laptop breaks down, we try to scavenge parts from another laptop that previously crashed. It takes an incredible amount of time to research the available hardware and software options on the market. When we first started using our system we had to reduce the number of patients we could see while we learned to use it. It took months before we were up to normal speed.

In a Commonwealth Fund case study dedicated to EHRs in small and solo group practices, initial EHR costs averaged $44,000 per year for a full time health care provider; ongoing annual costs averaged $8,500 or 19 percent per year. Software, training, and installation costs averaged $22,038. The actual cost for the twelve practices studied ranged from $37,056 to $63,600. Revenue losses from reduced visits during training and implementation averaged $7,473 per physician, ranging from none, in practices already technologically savvy, to $20,000 per physician. The return on investment ranges from two and half years to more than 9 years – and counting - for one practice.

These divergent ranges demonstrate one of the difficulties in implementing these systems. There is little transparency in the marketplace, which makes assessing risk more difficult. As these systems become more widely adopted, costs will eventually decrease. But in order to accelerate adoption, AAFP recommends that Congress works to provide financial incentives for small to medium-sized practices, establish federal standards of interoperability, and support technical

assistance programs to help small practices through the cycle of selecting, implementing and redesigning their clinical workflow.

Again thank you for this opportunity, I would be happy to answer any questions you may have.

Written Testimony

of

Jack Price
Vice President of Services
HIMSS Analytics

Submitted to

U.S. House of Representatives
Committee on Small Business
Subcommittee on Regulatory Reform and Oversight

April 6, 2006

Mr. Chairman, Ranking Minority Member Bordallo and distinguished members of the Subcommittee. Thank you for allowing HIMSS Analytics to submit a formal statement for the record for the hearing entitled, "Can Small Healthcare Groups Feasibly Adopt Electronic Medical Records Technology?" I am Jack Price, Vice President of Services for HIMSS Analytics, LLC, a wholly owned and not-for-profit subsidiary of the Healthcare Information and Management Systems Society (HIMSS). Our focus is on current and future trends of information technology in the healthcare market. We collect data from over 4,000 hospitals and 28,000 care delivery organizations on an annual basis. In addition, we routinely conduct surveys of healthcare professionals to obtain data critical to efforts to improve the quality and cost-efficiency of patient care.

In one of our recent surveys, we conducted a random sampling of 2,500 physician group practices across the country. These physician practices ranged in size from solo practices to multi-specialty group practices and clinics. When asked if the practice had a Practice Management System for billing, 100% answered yes. But when asked if the practice had an Electronic Medical Record System/Electronic Health Record (EMR-EHR), only 26% answered yes. We then asked the 74% who do not have an EMR-EHR if they plan to purchase an EMR-EHR in the next 24 months. 75% said no.

That's a significant number of physician group practices who have made the decision to not invest in EMR-EHR technology within the next two years. However, there is considerable evidence to support that investing in EMR-EHR technology will return both a soft and hard return on that investment.

Healthcare institutions generally view ROI in two ways: soft ROI, which highlights important but unquantifiable improvements in patient care, workflow and other areas; and hard ROI, which measures dollars and cents.

Soft ROI

This paper defines "soft return on investment" as clinical benefits resulting from the use of EMR-EHRs in such areas as patient safety, process improvement and regulatory compliance. These results are generally supported by detailed analysis but they do not always include hard statistical data that proves the business case.

It may be that many such factors are simply immeasurable. Unlike the many industrial companies that practice Six Sigma principles—a process improvement protocol requiring reams of data—healthcare providers face many challenges in quantifying every aspect of their practices. Though every treatment made by a physician or a nurse is chargeable, as lengthy medical bills attest, they are not always definable in terms of hard ROI.

Still, soft ROI carries just as much—and possibly more—importance to healthcare institutions, since many soft-return factors are transformative. Reducing errors in medication through decision support systems saves lives. Having access to a patient's entire healthcare history improves care. Aggregated data analysis focuses providers on performance enhancements. EMR-EHR software offers a wealth of clinical data, and in that data can be found the seeds of improvement, of change, of challenge and of success. Soft ROI includes:

Improved Patient Safety

The healthcare industry sees improving patient safety as a major imperative, especially since an Institute of Medicine study in 1999 revealed as many as 98,000 Americans may be dying every year from missed diagnoses, fatal drug interaction and inappropriate treatment by physicians and nurses.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has made improving patient safety one of seven initiatives for the coming year.

In fact, simple things such as replacing the bad handwriting of harried physicians move healthcare providers toward more accurate treatment of patients while reducing the time staff and pharmacists devote to dealing with drug interactions or prescribing issues. EMR-EHR software embedded with decision support alerts physicians, nurses and other staff to the potential for prescription problems while helping them automatically calculate dosages based on patient characteristics.

Process Improvement

Summarizing all the process improvements that come with an EMR-EHR implementation is difficult. A common user interface is one process improvement that allows providers to navigate user-friendly screens to locate patient data, in stark contrast to the hodgepodge of software systems and interfaces many organizations employed in the past. By using consistent electronic data sets for every patient—again, a novelty since paper medical charts changed over time, creating difficulties when attempting to compare information—healthcare providers now can standardize both data and care.

Other improvements come with eliminating duplicate records, and from electronic charting and discharge, electronic signatures, patient check-in and access to referring physician information.

The physician inbox of many software systems can display documents to sign and review, phone messages and consult orders. In the past, this all required a large stack of folders, pink callback slips and other paper forms. Instructions to nurses, too, tend to be clearer and more precise with an EMR-EHR.

Communications

The presence of EMR-EHRs greatly enhances communication among providers and patients. Something as simple as legible documentation, rather than physician scrawl, helps pharmacists offer the right medications at the right dosages. Something as complex as decision support reminds doctors to suggest patients get Pap smears, mammograms, blood-pressure checks, vaccinations, and so forth. Communications can make a world of difference in a large provider environment.

Regulatory Compliance

Hospitals are required to document their care to several important regulatory bodies and to their own oversight committees. They must also abide by new federal guidelines providing for patient privacy.

The EMR-EHR software assists greatly in hospitals reaching for full compliance with a host of regulatory issues that will, in fact, lead to greater patient safety and better care.

The ability of physicians and nurses to document every patient encounter in the EMR-EHR, to view a patient's entire history in a consistent format, and to see best-practice treatment protocols helps enormously in complying with the myriad of healthcare regulations.

An additional point is worth making. By employing passwords and other security protocols that offer differing levels of failsafe user clearance, computerized health records can effectively restrict access to patients' confidential records. This makes complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that much easier.

But HIPAA is not the only rule providers need to work within. The protocols promulgated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Centers for Medicare and Medicaid Services (CMS), state agencies and others have oversight of hospitals and clinics.

Again, the data-crunching capabilities and alert systems inherent in EMR-EHR software help nurses and doctors comply with national and institution-based protocols. It's the tap on the shoulder to check twice, or do again.

Hard ROI

The definition of hard return on investment on EMR-EHRs involves two measurements: Quantifiable returns that can be demonstrated in financial terms, and process improvements that would suggest cost savings that may fit an identifiable—or measurable—metric.

Physicians and nurses do not always measure their work with the kind of metrics available in other industries. Providers simply have not had the tools to conduct a thorough vetting of hard RIO. But with more sophisticated electronic systems now available to healthcare, the ROI equation is changing. These systems facilitate hard ROI data capture using more comprehensive methodologies.

In general, hard ROI from EMR-EHR installations can be grouped into three major categories: patient flow, materials and staffing reductions, and billing improvements. Some increases are astonishing; others show marginal—if still important—savings, or higher reimbursements.

Evidence of hard ROI is much richer in ambulatory care settings, perhaps because the data involves a smaller number of physicians and patients, and smaller, less diffuse budgets. Therefore, running the numbers and getting a feel for cost savings, patient flow and billing yields a richer palette of statistics than is evident in larger hospitals and practices.

Patient Flow

Only a handful of acute care institutions have looked at data that suggested an EMR-EHR installation could generate greater patient volumes, thereby increasing revenues and profitability. But there is anecdotal evidence that EMR-EHRs help healthcare providers move patients more efficiently through the care continuum. In fact, inpatient stays are generally shorter and patients receive better care, on average, with an EMR-EHR in place. Hard data is, frankly, slender on this issue.

Reducing and Reallocating Resources

Since EMR-EHRs reduce the need for paper, transcribers and space for medical records, their introduction can reap immediate financial rewards. However, it's notable that a reduction in staff may not always occur, because employees who once performed data entry, for example, might be deployed in new areas. That kind of employee shifting, common in hospitals, alleviates the need to hire new employees.

Radiology is another area where resources have been dramatically reallocated. Paper and non-digital film requires labor to organize, chart, file and find, but computers do the same things in seconds, not minutes or hours. Thus, digital radiology has been a key source of savings in many institutions.

Billing Improvements

Clearly, having an EMR-EHR system clarifies the often-messy world of billing. Capturing charges is easier and real-time, so submissions to insurers can be completed digitally and within hours of treatment, rather than days. Studies show

as much as 50 percent of care in some hospitals never even gets submitted for reimbursement. The EMR-EHR function helps providers keep track of treatment and assists in coding for accurate billing.

Conclusion

Small healthcare groups see many of the same advantages from using electronic medical records as larger institutions. In many ways, ambulatory-care applications are more personalized and data-rich, and affect an astonishing, near-total transformation of the business. In some cases, clinics report doubling or even tripling caseloads—with a corresponding jump in revenue—and with only marginal increases in staffing. At the same time, many report that they more easily pass regulatory audits than ever before.

Even in the touch-and-go world of pediatrics, after EMR-EHR implementation, practices see decreased medical liabilities, more accurate and thorough documentation, enhanced patient care and improved quality-review scores. Patients no longer must wait as long to see a doctor, increasing their satisfaction. And staffers are happier, because their world no longer is awash in paper charts. Meanwhile, unlike hospitals, practices can demonstrate a bevy of soft and hard investment returns, accompanied by a wealth of statistical data that underlines the successful automation of their practices.

When charts can be seen on a clinic's computers and patient encounters can be documented in a few mouse clicks, the flow of patients through a clinical environment changes dramatically.

Clinics have found remarkable numbers when studying their return on investment for electronic medical records. Billing increased, paper costs sank, chart pulls nearly disappeared, patient volume skyrocketed and revenue showed outstanding gains.

However, as the results of our recent survey point out, many providers are still reluctant to invest in EMR-EHR technology. One reason may be the fear factors associated with the cost of software, hardware, implementation, training and support. The amount of work associated with implementations can be a daunting task and very disruptive to the practice. Perhaps one of the biggest barriers to overcome may be the resistance to change itself.

Lessons Learned

Ambulatory care clinicians who implemented electronic medical records have no shortage of advice for their colleagues. Since they work in small environments where nearly every staffer was touched by the transition to the EMR-EHR, they offer great ideas as both participants in the process and as champions of a new

operations structure. Among their suggestions:

- Investigate applications that enhance office workflow. Give yourself time to select an appropriate system and build in customizations.
- Invest in good products that have active user bases and are not likely become part of a "legacy system."
- Find a company that allows template customizations and has a good product development track record with frequent upgrades.
- Try the "little bang" theory of installation, implementing only portions of the EMR-EHR at a time for minimal disruptions.
- Do not force-feed change. Incremental improvements have a big trickle-down effect; use less enthusiastic adopters as your benchmark. If the tools work for your skeptics, they'll work for everyone.
- Buy an uninterruptible power supply such as 15-minute UPS for clinical workstations.
- Consider leasing hardware. That way, you may have greater flexibility to add, upgrade or change. Also, hardware prices decline and leasing can spare you from committing to an over-priced purchase.
- Make no assumptions during contract negotiations with vendors. Bringing in an EMR-EHR consultant and a good attorney.
- Research, then go back and do some more research. Some practices studied 20 vendors.
- Offer lots of training, allow for both Web-based and in-office training.
- Make sure the office layout features a plan for a dedicated server room and wiring for workstations, unless you're going wireless.
- Know the certification level of the system administers working with you on the install. The higher the certification, the better.
- Learn basic hardware and software maintenance.
- Employ two or three backup systems to save data.
- Consider touch-screen computers in each exam room to add to patient interest and satisfaction.
- Ask plenty of questions about the level of tech support your vendor will provide.

On behalf of HIMSS Analytics, thank you again, Mr. Chairman and Ranking Minority Member Bordallo for the opportunity to appear before this Subcommittee. I am prepared to answer any questions you may have.

Congressman Phil Gingrey
Testimony on H.R. 4641
Small Business Subcommittee on Regulatory Reform and Oversight
April 6, 2006

Chairman Akin, Ranking Member Bordallo, and Members of the Regulatory Reform and Oversight Subcommittee, on behalf of the citizens of Georgia's Eleventh Congressional District, thank you for allowing me the opportunity to testify before you today. I want to take this time to discuss with you what I have discovered as I have researched and investigated economic viability of healthcare information technology.

Every day we read in the headlines about the rising cost of health care and what it means to every American in this country. More and more businesses are no longer able to afford health care benefits for their employees, too many Americans are uninsured, health care premiums continue to rise each year and the neediest of our nation are not given the access to the quality care they deserve.

There are many ways to tackle the problem of skyrocketing health care costs, but today I am here to focus on healthcare information technology. Why does Congress need to be invested in the adoption of health care information technology? In September of 2005 RAND released a study that showed how a health information technology system that is implemented correctly and **widely adopted** could save the American health care system more than $162 billion annually. Since we all know the tremendous stress our healthcare system is currently operating under, these savings alone are a very compelling justification for congressional involvement. However, it was not until I went out into my district, met with physicians and representatives from the health IT industry that I realized the answer to the question of congressional action.

The key to the report and my personal research centers around the concept of "widely adopted" and this is why we are gathered today. What role can and should the government play in ensuring healthcare information technology is "widely adopted." There a variety of thoughts, opinions and pieces of legislation centered around this

question. The RAND study simply states that in order to take full advantage of this potential savings we need incentives for physicians to buy quality systems. So the question becomes not only what would be the most effective way to incentivize physicians, but what is the most fiscally-responsible way to incentivize physicians.

As a physician Member of Congress, I was anxious to go visit doctors' offices that were utilizing health information technology to see what differences it makes out in the real world. I stopped practicing medicine just three short years ago, and I remember vividly the overwhelming burden of administrative paperwork. It robbed physicians of time with their patients, taking away from them the reason they had decided to go to medical school. What I saw put into practice was amazing to me.

I visited a three doctor OB/GYN practice in Carrolton, GA, which purchased their electronic health record system in 2002. I was able to watch Dr. Martin as he demonstrated the established routine he follows during a patient visit utilizing his computer tablet. He stated that their vendor company worked hard to ensure the process flowed to his liking and the words and phrases that he used most frequently were utilized in the chart template. It was amazing to me how efficient it was to document a patient's chart, pull up any necessary tests or images; all at the point of care, when it was needed. After my time with Dr. Martin in Carrolton, I realized how revolutionary health IT was to the healthcare world. It transforms how physicians do business on a daily basis by streamlining the process, giving them the tools and the information they need when they need it. It even left me thinking if my political career doesn't work out, how I would want to jump back into medicine with both feet.

My discussions with these physicians, their office managers and representatives from vendor companies, left me astounded by the recurring theme of satisfaction. The physicians I spoke with are enjoying a higher quality of life, more efficiency in follow up with their patients and the flexibility to complete charts and take "call" from the comfort of their home. The office managers spoke emphatically about the almost immediate increased revenue from automating their coding and billing process. Not only did they

receive payment from insurance companies quicker; and they received more accurate payments.

An increase in revenue to a physician's bottom line is one of the biggest wins in purchasing an electronic health record system. The system not only automatically codes the patients' visits but correctly codes the visits to ensure the physician is reimbursed accurately for the services rendered. In medical school, physicians learn quickly that it is easier to "down" code a visit than submit a claim that is rejected by an insurance company which requires your office to resubmit the claim; wasting staff time and taking money away from the practice.

There are perceptions in the health care system and the federal government that there are numerous hurdles preventing physicians from practically incorporating health IT into their offices. These concerns range from the time and energy required of physicians to learn a new system, a potentially unsustainable decrease in productivity and the natural apprehension that comes with any large financial investment.

However, I want to present an example of what one practice saw as a return on investment in their first year of purchasing a complete health IT system. I would like to submit for the record an example administered by Microsoft Windows Server System. They performed a customer solution case study on an OB/GYN practice in New York that sees about 200 patients a day. For this practice, implementing an integrated electronic health record system has cut down on the administrative work required of each doctor by one hour every day, it has allowed them to see an additional 25 patients each week and has given them a first year return on investment of $407,000.

It is for this particular reason that I believe the best thing Congress can do is to create incentives for physicians to incorporate health information technology into their practices and then get out of the way. This is why I introduced H.R. 4641, the ADOPT Health IT Act, which creates just such incentives by increasing the deductions offered under section 179 of the tax code for health care providers that purchase an EHR system. I have heard

from physicians and industry alike that section 179 is the strongest element of their decision to move into the world of health IT; but it is not extended far enough to be as useful as possible. Under current tax code, small businesses can deduct around $100,000 of the cost of qualified business expenses that are placed into service that tax year. My legislation increases this maximum deduction to $250,000; therefore, creating a more realistic incentive to spur adoption amongst physician practices of all sizes.

Currently small businesses have a maximum threshold of $400,000 for qualified equipment purchases in any given year. My legislation would increase that to $600,000, again narrowly defined to include only those health care professionals that purchase an EHR system.

The logic behind this idea is that physicians, like all small business owners, look at what the tax code can offer them as they consider purchasing equipment for their business.

H.R. 4641 allows Section 179 of the tax code to better represent the actual cost of an EHR system. For example, the cost of a system for an average practice that includes between 4-6 physicians can be as much as $200,000. This then restricts what other medical equipment that office can purchase that year. By appealing to a physician's business instinct and allowing the tax code to provide incentives, we can create a much more effective way of getting health care information technology into every physician's office around the country. These incentives will work far better than simply dumping federal grants into the health care system.

In closing, I again want to express my gratitude for this opportunity and respectfully ask for your consideration of the initiative I laid out today. Mr. Chairman, I am prepared to respond to any questions or comments you or other members may have on this legislative proposal.

RAND HEALTH

RESEARCH HIGHLIGHTS

Health Information Technology

Can HIT Lower Costs and Improve Quality?

RAND RESEARCH AREAS
THE ARTS
CHILD POLICY
CIVIL JUSTICE
EDUCATION
ENERGY AND ENVIRONMENT
HEALTH AND HEALTH CARE
INTERNATIONAL AFFAIRS
NATIONAL SECURITY
POPULATION AND AGING
PUBLIC SAFETY
SCIENCE AND TECHNOLOGY
SUBSTANCE ABUSE
TERRORISM AND HOMELAND SECURITY
TRANSPORTATION AND INFRASTRUCTURE
WORKFORCE AND WORKPLACE

The U.S. healthcare system is in trouble. Despite investing over $1.7 trillion annually in healthcare, we are plagued with inefficiency and poor quality. Better information systems could help. Most providers lack the information systems necessary to coordinate a patient's care with other providers, share needed information, monitor compliance with prevention and disease-management guidelines, and measure and improve performance.

Other industries have lowered costs and improved quality through heavy investments in information technology. Could healthcare achieve similar results? RAND researchers have estimated the potential costs and benefits of widespread adoption of Health Information Technology (HIT). The team also has identified the actions needed to turn potential benefits into actual benefits.

Key findings:

- Properly implemented and widely adopted, Health Information Technology would save money and significantly improve healthcare quality.
- Annual savings from efficiency alone could be $77 billion or more.
- Health and safety benefits could double the savings while reducing illness and prolonging life.
- Implementation would cost around $8 billion per year, assuming adoption by 90 percent of hospitals and doctors' offices over 15 years.
- Obstacles include market disincentives: Generally, those who pay for Health Information Technology do not receive the related savings.
- The government should act now to overcome obstacles and realize benefits.

HIT's Potential Includes Significant Savings, Increased Safety, and Better Health

The RAND team drew upon data from a number of sources, including surveys, publications, interviews, and an expert-panel review. The team also analyzed the costs and benefits of information technology in other industries, paying special attention to the factors that enable such technology to succeed. The team then prepared mathematical models to estimate the costs and benefits of HIT implementation in healthcare.

HIT includes a variety of integrated data sources, including patient Electronic Medical Records, Decision Support Systems, and Computerized Physician Order Entry for medications. HIT systems provide timely access to patient information and (if standardized and networked) can communicate health information to other providers, patients, and insurers. Creating and maintaining such systems is complex. However, the benefits can include dramatic efficiency savings, greatly increased safety, and health benefits.

Efficiency savings. Efficiency savings result when the same work is performed with fewer resources. If most hospitals and doctors' offices adopted HIT, the potential efficiency savings

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for both inpatient and outpatient care could average over $77 billion per year. The largest savings come from reduced hospital stays (a result of increased safety and better scheduling and coordination), reduced nurses' administrative time, and more efficient drug utilization.

Increased safety. Increased safety results largely from the alerts and reminders generated by Computerized Physician Order Entry systems for medications. Such systems provide immediate information to physicians—for example, warning about a potential adverse reaction with the patient's other drugs.

If all hospitals had a HIT system including Computerized Physician Order Entry, around 200,000 adverse drug events could be eliminated each year, at an annual savings of about $1 billion (see Figure 1). Most of the savings would be generated by hospitals with more than 100 beds. Patients age 65 or older would account for the majority of avoided adverse drug events.

Health benefits. The team analyzed two kinds of interventions intended to enhance health: disease prevention and chronic-disease management. HIT helps with prevention by scanning patient records for risk factors and by recommending appropriate preventive services, such as vaccinations and screenings.

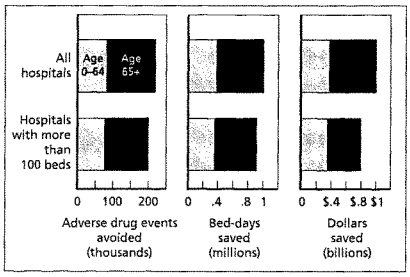
The table shows the estimated effects of increasing five preventive services: two types of vaccination and three types of screening. Together, these measures would modestly increase healthcare expenditures. But the costs are not large, and the health benefits of improved prevention are significant. For example, at a cost of only $90 million each year, between 15,000 and 27,000 deaths from pneumonia could be prevented.

HIT can also facilitate chronic-disease management. The HIT system can help identify patients in need of tests or other services, and it can ensure consistent recording of results. Patients using remote monitoring systems could transmit their vital signs directly from their homes to their providers, allowing a quick response to potential problems. Effective disease management can reduce the need for hospitalization, thereby both improving health and reducing costs.

Overall Savings Are Large Compared with Costs

Costs include one-time costs for acquiring a HIT system, as well as ongoing maintenance costs. Analysis of other industries indicates that full adoption of new technology requires about 15 years. Because process changes and related benefits take time to develop, net savings are initially low at the start of the 15-year period, but then rise steeply. Figure 2 shows the net potential savings (total savings minus total costs) for HIT implementation over a 15-year period. These savings are from increased efficiency only; health and safety benefits could double the savings.

Figure 1
Estimated Annual Benefits from Inpatient Computerized Physician Order Entry Systems, After Full Adoption

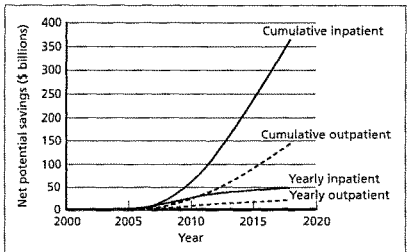


Increasing Preventive Services Could Save Lives with Only a Small Increase in Cost

Service	Annual Cost (in millions)	Deaths Avoided Each Year
Influenza vaccination	$134–$327	5,200–11,700
Pneumonia vaccination	$90	15,000–27,000
Breast cancer screening	$1,000–$3,000	2,200–6,600
Cervical cancer screening	$152–$456	533
Colorectal cancer screening	$1,700–$7,200	17,000–38,000

NOTE: Assumes 100-percent participation of all persons recommended to receive the service by the U.S. Preventive Services Task Force. This assumption is intended to set an upper bound for potential costs and benefits, not to suggest that 100-percent participation is probable.

Figure 2
Potential Net Savings from Increased Efficiency over a 15-Year Period



NOTE: Assumes full adoption (by 90 percent of hospitals and doctors' offices) at the end of the 15-year period.

Market Forces Present Obstacles to HIT Savings and Benefits

Current market conditions place serious obstacles in the way of effective HIT implementation.

- Relatively few providers have access to HIT. Only about 20 to 25 percent of hospitals and 15 to 20 percent of physicians' offices have a HIT system. Small hospitals and hospitals with half or more of their patients on Medicare are less likely to have HIT.
- *Connectivity*—the ability to share information from system to system—is poor. HIT implementation is growing, but there is little sharing of health information between existing systems. There is no market pressure to develop HIT systems that can talk to each other. The piecemeal implementation currently under way may actually create additional barriers to the development of a future standardized system because of the high costs of replacing or converting today's non-standard systems.
- Finally, one of the most serious barriers is the disconnect between who pays for HIT and who profits from HIT. Patients benefit from better health, and payors benefit from lower costs; however, providers pay in both higher costs to implement HIT and lower revenues after implementation. Figure 1 shows one part of the problem: Hospitals that use HIT to reduce adverse drug events also reduce bed-days—and reduced bed-days mean reduced hospital income.

The Government Should Act Now

Government intervention is needed to overcome market obstacles. RAND's recommended policy options fall into three groups: continue current efforts, accelerate market forces, and subsidize change. All three groups rely on the aggressive use of federal purchasing power to overcome market obstacles. Medicare (the Centers for Medicare and Medicaid Services—CMS) is the nation's payment policy leader, the party with the most to gain from HIT's cost and health benefits, and the healthcare system's largest payor. CMS's leadership would send strong market signals for adoption.

Continue current efforts. Actions include: Continue support for the development of uniform standards, common frameworks, HIT certification processes, common performance metrics, and supporting technology and structures. To help allay fears regarding confidentiality, expand liability protection for hospitals using HIT and for providers who comply with federal privacy regulations while using HIT networks. Promote hospital-doctor connectivity by allowing hospitals to subsidize portable, standardized HIT systems for doctors (which would require relaxing the current laws that prohibit such subsidies). These actions call for little or no new federal funding.

Accelerate market forces. Develop targeted investments and incentives to promote HIT. Set up a pay-for-use program for those providers using certified, interoperable HIT systems. Additional actions include: Create a national performance-reporting infrastructure to receive and report comparative performance data. Fund research on pay-for-performance incentives. Educate consumers about the value of HIT in improving their ability to manage their own health.

These actions require a moderate initial investment in policy and infrastructure development, with larger investments in later years. For example, pay-for-use programs, which are relatively easy to implement, could be followed by broad-based pay-for-performance programs, which require substantially more development.

Subsidize change. Direct subsidies would greatly speed HIT adoption. Subsidies may be particularly important in overcoming barriers to network development. Actions include: Institute grants to encourage the development of organizations, tools, and best practices to help HIT succeed. Make direct subsidies to help selected providers acquire HIT. Extend loans to support the start-up and early operation of HIT networks.

Convincing individual physicians and their patients of the value and safety of networking confidential data will be critical. Overcoming these challenges requires ongoing investment in framework, standards, and policy development.

Conclusions

Widespread adoption of HIT and related technologies, applied correctly, could greatly improve health and healthcare in America while yielding significant savings. A range of policy options could be used to speed the development of HIT benefits. Government action is needed; without such action, it may be impossible to overcome market obstacles. Our findings strongly suggest that it is time for government and other payors to aggressively promote the adoption of effective Health Information Technology. ■

This Highlight summarizes RAND Health research reported in the following publications:

Hillestad R, Bigelow J, Bower A, Girosi F, Meili R, Scoville R, and Taylor R, "Can Electronic Medical Record Systems Transform Healthcare? An Assessment of Potential Health Benefits, Savings, and Costs," *Health Affairs*, Vol. 24, No. 5, September 14, 2005.

Taylor R, Bower A, Girosi F, Bigelow J, Fonkych K, and Hillestad R, "Promoting Health Information Technology: Is There a Case for More-Aggressive Government Action?" *Health Affairs*, Vol. 24, No. 5, September 14, 2005.

Bigelow JH, Fonkych K, and Girosi F, "Technical Executive Summary in Support of 'Can Electronic Medical Record Systems Transform Healthcare?' and 'Promoting Health Information Technology'," *Health Affairs*, Web Exclusive, September 14, 2005.

Bigelow JH, Fonkych K, Fung C, and Wang J, *Analysis of Healthcare Interventions That Change Patient Trajectories*, RAND Corporation, MG-408-HLTH, 2005; available at http://www.rand.org/publications/MG/MG408/.

Fonkych K and Taylor R, *The State and Pattern of Health Information Technology Adoption*, RAND Corporation, MG-409-HLTH, 2005; available at http://www.rand.org/publications/MG/MG409/.

Girosi F, Meili R, and Scoville R, *Extrapolating Evidence of Health Information Technology Savings and Costs*, RAND Corporation, MG-410-HLTH, 2005; available at http://www.rand.org/publications/MG/MG410/.

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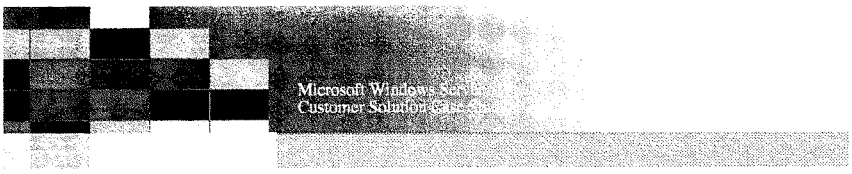


Medical Practice Achieves U.S.$400,000 Return on Investment, Increases Care Quality

Overview
Country: United States
Industry: Healthcare

Customer Profile
Oswego County (New York) OB-GYN has nine medical professionals and sees 200 patients a day at its five locations. This year, the practice will deliver some 675 babies.

Business Situation
The practice's 70,000 medical records were increasingly difficult to handle and distribute to appropriate offices in time for patient visits. Nor did the solution meet HIPAA requirements.

Solution
The PrimeSuite integrated practice management and electronic medical records solution from Greenway Medical Technologies Inc. is based on the Microsoft® Windows Server System™ and Web services.

Benefits
- Patient care enhanced
- U.S.$407,000 first-year return on investment
- Paperwork cut by one hour per doctor per day
- Practice sees 25 more patients per week
- Gross collections up by four percent

"The Greenway solution and Microsoft technology enable us to deliver better patient care even as we save money and increase productivity. It's a win-win for our patients and for us."

Daniel Maher, Practice Manager, Oswego County OB-GYN

The Oswego County (New York) OB-GYN medical practice needed a better way to manage patient records, increase insurance reimbursements, and meet requirements of the Health Insurance Portability and Accountability Act (HIPAA). Its solution: the PrimeSuite integrated practice management and electronic medical records solution from Greenway Medical Technologies Inc., based on Microsoft® Windows Server System™ integrated server software and Microsoft .NET-connected Web services. The solution helped the practice achieve the estimated U.S.$407,000 return on investment in its first year through increased savings and revenues. With paperwork reduced by up to an hour per day per physician, doctors are seeing 25 more patients per week without increasing their hours. Gross collections are up four percent. And the quality of care is enhanced, making the solution a "win-win" for patients and the practice.

"The speed of the system in generating reports is phenomenal. Previously, we had to run an aging report overnight, because it took up to eight hours. Now, our longest report takes just five minutes."

Daniel Mather, Practice Manager, Oswego County OB-GYN

Situation

Oswego County OB-GYN—the only obstetrics and gynecology practice in Oswego County, New York—has served its community for more than 40 years. The practice continues to grow. Today, it includes five physicians who are board-certified specialists; two certified nurse midwives, two certified nurse practitioners, registered and licensed practical nurses, medical assistants and support staff. The practice operates from five locations and sees about 200 patients every day. This year, the practice will deliver some 675 babies.

Managing the practice through that growth has been a challenge. Oswego County OB-GYN's practice management system was a character-based system running on terminals connected to a PC server. Connectivity among the various offices was limited to a 9600 baud dial-up modem. As the practice continued to grow, this solution was increasingly inadequate. For example, it lacked an electronic medical records (EMR) component, forcing the practice to store more than 70,000 paper-based records on-site.

Getting those records where they needed to be in time for patient visits was often difficult; a "sneaker net" (meaning, hand-delivering by walking) had medical assistants carrying 30–50 medical records per day among the various offices. And sometimes, getting records where they needed to be was just impossible—as, for example, when patients scheduled last-minute appointments. The result: doctors had to see patients without having their full medical files available.

Yet another set of issues concerned the billing of patients' insurance companies for payment. Doctors did not always check off all of the appropriate billing codes on patient records, preventing the practice from receiving all of the reimbursement to which it was entitled. And when there were discrepancies or insurance-company questions about reimbursement, the result was at least delayed payment and, in many cases, payment for less than the practice had anticipated.

Oswego County OB-GYN's interest in upgrading its practice management solution and expanding it to include an EMR component came to a head around the year 2000. Beginning in 2003, healthcare providers would have to meet provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Those provisions included a complete revamping in the way most providers—including Oswego County OB-GYN—managed patient records and billing, in order to enhance patient privacy. The practice needed a new solution in place both to meet its own, expanding needs, as well as the upcoming requirements of the new federal law.

Solution

Oswego County OB-GYN researched its new solution carefully, over an 18-month period. In July 2002, it selected the PrimeSuite integrated practice management and EMR solution from Greenway Medical Technologies, Inc., a Microsoft Certified Partner based in Carrollton, Georgia.

The Right Company: Greenway Medical Technologies

Oswego County OB-GYN chose PrimeSuite in part because it liked Greenway Medical Technologies. "We liked Greenway's company philosophy," says Daniel Mather, Practice Manager, Oswego County OB-GYN. "They offered a turnkey solution that would address all of our needs, including hardware, software, and network infrastructure. They believed in working with us closely in a team concept to implement a solution customized for our requirements. And the number of physicians and medical personnel on their staff demonstrated their seriousness in providing a solution for healthcare providers like us."

The Right Technology: Microsoft Windows Server System

"As a result of the Greenway solution and Microsoft technology, our doctors spend more time doing what they got into medicine for—seeing patients—and less time on paperwork."

Daniel Mather, Practice Manager, Oswego County OB-GYN

PrimeSuite templates make it faster and easier for doctors to complete documentation on patient visits.

The PrimeSuite solution is based on key Microsoft® technologies, including Microsoft Windows Server System™ integrated server infrastructure software. In particular, the solution relies on Microsoft BizTalk® Server 2004 and the BizTalk Accelerator for HL7 (a healthcare industry data standard), which enable PrimeSuite to communicate with insurance companies, hospitals, labs, and other external sources.

It also relies on Microsoft SQL Server™ 2000, which provides the solution's database and, through SQL Server stored procedures and triggers, much of its business logic. Finally, the solution is also based on 12 Microsoft .NET-connected Web services, which enable integration among key solution components. "We were impressed that the Greenway solution took advantage of the latest Microsoft technologies," says Mather. "Greenway's use of the .NET Framework meant that our solution would be sufficiently flexible and extensible to grow with us for years to come."

Deploying the Solution

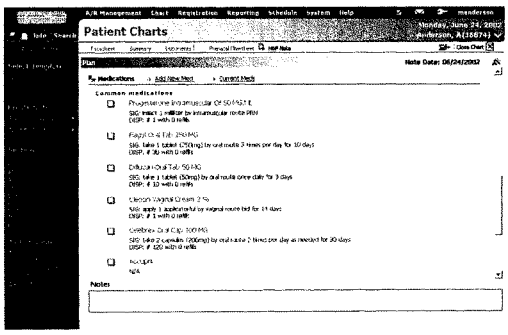
After signing with Greenway in July 2002, Oswego County OB-GYN's Mather met with Greenway in September to customize the solution. Greenway provided training—both at its facility and at Oswego County OB-GYN—in several sessions in September and December. The practice management component went live in December. Greenway trained the practice in the EMR portion of the solution in February and March 2003, and the EMR portion went live for the practice's gynecology services in March. Greenway converted the practice's obstetrics records starting in July, and the obstetrics portion of the practice was completely live with the solution in October.

"The key challenge for us was adopting the solution without missing a single patient visit throughout the process," says Mather. "We met that challenge by adopting the solution in a series of measured stages, and by ensuring that our physicians had sufficient training to see its benefits and ensure its actual use."

Using PrimeSuite

Doctors, nurses, and other authorized users access PrimeSuite data through their Web browser, Microsoft Internet Explorer 6.0, which accesses ASP.NET Web pages that interact with the SQL stored procedures and .NET Enterprise Services to deliver and accept patient information. Because the solution is Web-based, doctors can access patient records securely even when they're away from the office.

During or after patient visits, doctors use wirelessly networked, pen-based tablet computers running the Microsoft Windows® XP Professional, Tablet Edition, operating system—or laptop or desktop computers running Windows XP Professional (as they prefer)—to enter patient information into specialty-specific templates, custom-created for their use by Greenway. The templates give doctors the ability to customize their notes and



remind them of appropriate procedures and billing codes for each type of visit.

The electronic medical records that doctors create are managed by the solution as Extensible Markup Language (XML) style sheets and passed to and from key solution components via .NET-connected Web services. "Web services are a great way to handle this information, because the solution only sends and receives 'deltas' or updates, making data faster to move around and faster to display on the caregiver's screen," says Greg Schulenburg, Vice President, Software Development, Greenway Medical Technologies.

Lab reports from external labs associated with the practice also come through the solution, via Equisys's Zetafax®,routed electronically. Oswego County OB-GYN nurses do a first-pass review of results, label the results as normal or abnormal, and forward them in categorized queues that appear on the doctors' electronic desktops for their review and action, often within hours of when the patient tests were administered.

Looking ahead, Mather anticipates receiving lab results as XML data passed via BizTalk Server and Web services—as insurance information is now exchanged—when the local labs adopt this capability.

Data is stored in the SQL Server database both as XML, for easy retrieval and use, and as Adobe Acrobat Portable Document Format (or PDF) files to meet HIPAA requirements for uneditable data that will always reflect records at the moment they were stored in the system.

Benefits

Oswego County OB-GYN achieved a first-year return on investment of U.S.$407,000 with the Greenway solution. Virtually every aspect of its operations has become more productive—and the practice finds that the solution boosts the quality of medical care it can provide, as well.

Doctors Increase Patient Time, Decrease Paperwork

"As a result of the Greenway solution and Microsoft technology, our doctors spend more time doing what they got into medicine for—seeing patients—and less time on paperwork," says Mather.

Doctors now review patient lab results in as few as three hours from the time they saw the patient, down from 36 hours previously. And Time spent reviewing those results—which formerly required half an hour per day—has been cut significantly, as well. Doctors have also reduced much of the time they spent on patient charting. On these two functions, each doctor saves up to 60 minutes per day, which enables the practice to see an additional 24 patients per week without increasing the time that doctors spend in the office. In addition to providing faster care and patient service, the increased productivity enables the practice to increase revenues by more than $56,000 annually.

Gross Collections Increase by $193,764

Nearly half of the $407,000 return on investment from the solution—$193,764—comes from an increase in the gross collection rate from 52.2 percent to 56.4 percent. The increase is attributable to a variety of enhancements, according to Mather. First, billings go out much faster than they did before, and tracking mechanisms are "ten times better" than Oswego County OB-GYN had previously, making it faster and easier for administrative staff to identify aging receivables and call the insurance companies to resolve them.

"The speed of the system in generating reports is phenomenal," says Mather. "Previously, we had to run an aging report overnight, because it took up to eight hours. Now, our longest report takes just five minutes."

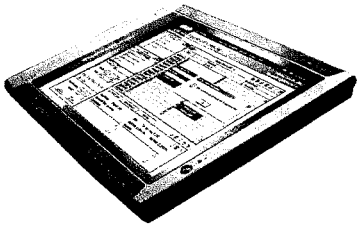
In addition, because physicians are coding office visits more appropriately—for example, coding preventative visits as such, rather than coding them as established patient visits, which have a lower reimbursement rate—the practice is realizing another $58,000 from the same office visits.

Patient Care Enhanced

Although it can't be quantified as readily as the productivity savings, Mather says the practice is also confident that the solution has increased the quality of care at Oswego County OB-GYN. With patient records available to authorized users within seconds, nurses and doctors can respond more helpfully to patients not only during office visits, but even during phone calls. With doctors spending less time on paperwork, patients can be seen more quickly. And lab results received and reviewed more quickly enable doctors to put their patients at ease more quickly when results show no problem, or to put their patients into treatment more quickly when they do reveal a problem.

"The Greenway solution and Microsoft technology enable us to deliver better patient care even as we save money and increase productivity," says Mather. "It's a win-win for our patients and for us."

Doctors can enter data into patient charts electronically, during the patient visit, using pen-based Tablet PCs.



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Microsoft

Statement of Ms. Barbara Kasoff, President

On Behalf of
Women Impacting Public Policy

Submitted to
Senate Small Business and Entrepreneurship Committee

"The President's FY2007 Budget Request and Legislative Proposals for the SBA"

March 9, 2006

Madam Chair and Members of the Committee, I am pleased to submit the views of Women Impacting Public Policy (WIPP) on the proposed FY2007 budget for the Small Business Administration (SBA). WIPP, a bipartisan nonprofit organization, represents 550,000 women in business nationwide and 40 women business associations united in one voice.

Overall, the SBA has played a major role in encouraging the sector of the economy that has experienced growth and created jobs– small business. Women business owners have benefited greatly from the programs at the SBA and we commend the SBA on their ability to serve the needs of women who are starting and growing their businesses.

Our support for the National Women's Business Council (NWBC) remains strong and we are pleased the Administration recognizes its importance to the women's business community by continuing to fund the Council at $743,000. The NWBC plays a key advisory role to the Administration and to the Congress on women's business policy.

We also commend the Administration for continuing to fund the SCORE program at $4.95 million, but are disappointed to see that funding for this resource does not include additional funding to rebuild the Gulf Coast. Since its founding in 1964, SCORE has helped more than 7 million businesses from idea to start-up to success. SCORE represents a low cost and an excellent value for business advice from successful business men and women. By helping small businesses succeed, SCORE supports job creation in communities nationwide.

We are disappointed that the funding request for much needed counseling centers such as Women's Business Centers (WBC) and Small Business Development Centers

(SBDC) has been reduced from FY 2006 levels. The FY 07 budget request allows for $11.8 million in funding for WBCs and $87.1 million for SBDCs, a reduction for both programs from previous levels. In the budget atmosphere of cuts which currently face the agencies, WIPP acknowledges that steady funding for programs providing services targeted specifically to women business owners could be considered a victory. We would point out, however, that the SBA expects Women Business Centers (WBC) to provide greater assistance to more women who are socially and economically disadvantaged but with flat funding. According to reports by the National Women's Business Council[1] and the Center for Women's Business Research[2], women-owned businesses are increasing greatly. The estimated growth rate in the number of women-owned firms was nearly twice that of all firms (17% vs. 9%), and employment expanded at twice the rate of all firms (24% vs. 12%). This further underlines the need for resources dedicated to women-owned businesses through Women's Business Centers.

Furthermore, we echo the sentiments of WIPP's coalition partner, the Association of Women's Business Centers, in expressing our concern for the reduced funding level and request that funds be appropriated consistent with the current authorized level of $16.5 million. This is the level of funding needed in order to meet current commitments and to continue to grow the program to meet unmet demand in areas currently not served by the program. This level of funding would also help each Center meets its administrative requirements to serve women business owners.

In FY05, the Congress required that 48% of the WBC funding go toward sustainability (existing) Centers. We are disappointed that the SBA has chosen again not

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[1] National Women's Business Council, *Analyzing the Economic Impact*, September 2004
[2] Center for Women's Business Research, 2003 and 2004

to include that funding formula in its FY07 request. WIPP has stated many times and will continue to believe that existing WBCs with a proven track record should be funded by this program or transitioned into a self-sustaining mode. It just is not good business to fund new centers and stop funding the existing centers which have shown a record of success. WIPP continues to believe that devoting 52% of the funding for WBCs to the creation of new centers but spending 48% on existing centers is a much wiser use of taxpayer dollars. Women's Business Centers provide essential services to women, especially socially and economically disadvantaged women who need a comprehensive support system in order to succeed in starting a business. We urge the Congress to put in place this formula for FY07.

We regret that the Administration has chosen not to request funding for the Microloan and Microloan Technical Assistance program. The Microloan program has unique characteristics which would not likely be offered by traditional lenders. This is the loan program with the greatest reach to women business owners and is the single largest source of funding for microenterprises. According to a recent NWBC analysis of SBA loan program performance over the past five years, 45% of 7(m) program loans, and 44% of the dollars lent in the program, went to women-owned businesses in FY 2003—significantly greater shares than any other SBA loan program. We urge the Congress to reinstate funding for the Microloan and Microloan Technical Assistance programs.

With regard to federal contracting, SBA plays a pivotal role in ensuring that government agencies feel compelled to meet their small business goals. Initiatives such as business matchmaking scratch only the surface in all of the government contracting activities the SBA oversees. We urge the Congress to strengthen the SBA's hand by

giving it adequate funding and resources to carry out procurement initiatives and agency review of contracts.

We commend the SBA for recognizing the vital role that Procurement Center Representatives (PCRs) play in providing critical technical assistance for small business. The SBA has stated that it is asking its PCRs to shift some of their focus from counseling for small businesses to reviewing and influencing procurements. WIPP believes that this additional focus is critical to providing contracting opportunities to small businesses. We also believe that the Congress should consider granting additional funding to hire additional PCRs. It is our understanding that the SBA intends to hire six additional PCRs, but WIPP members believe the number should be much higher. We believe a critical need in SBA Regional Offices is procurement expertise and introductions to regional government installations. SBA Regional Offices do not currently have the personnel or the expertise to carry out this critical assistance to small business owners.

WIPP commends the SBA for its program goals for FY07 that include identifying and mitigating regulatory and statutory barriers to contracting for small businesses and identifying contracting opportunities through increased Electronic Procurement Contracting Representative (e-PCRs). We look forward to the regulations SBA states it will promulgate in FY06 to bring the Women-Owned Small Business Federal Contract Assistance Program, included in SBA's Reauthorization Act (P.L. 106-554), to fruition. Failure to implement this program has cost women businesses billions of dollars in federal contracting dollars.

Coalition Partners

American Small Business Coalition

American Women in Radio and Television

Association for Enterprise Opportunity

Association for Women in Communications

Association of Women's Business Centers

Black Women Enterprises

Boardroom Bound

Business Women's Network

Center for Women's Business Research

Consumers for Cable Choice

Enterprising Women

Euro-American Women's Council Europe – Greece

Filipina Women's Network

Financial Women International

Hispanics Impacting Public Policy

Kansas City Council of Women Business Owners

National Associations for Female Executives

National Association of Small Disadvantaged Businesses

National Association of Women Business Owners

National Business Association

National Indian Business Association

National Defense Industrial Association

National Women Business Owners Corporation

Native American Women's Business Council

New Jersey Association of Women Business Owners

Oklahoma State Chamber

San Francisco Small Business Network

Small Business & Entrepreneurship Council

Small Business Television Network

UNIFEM / USA

Women Construction Owners & Executives

Women Entrepreneurs, Inc.

Women Impacting Public Policy – Florida

Women Impacting Public Policy – Pennsylvania

Women in Technology International

Women Presidents' Organization

Women's Business Enterprise National Council

Women's Leadership Exchange

WorldWIT

Statement for the U.S. House Committee on Small Business Subcommittee on Regulatory Reform and Oversight

April 6th, 2006

Thank you very much Chairman Akin and distinguished members of the Subcommittee and staff. My name is Justin Barnes and I am the Vice President of Marketing and Government Affairs for Greenway Medical Technologies, a leading provider of integrated electronic health record (EHR) and practice management software solutions for physicians' practices. It is always a great honor and pleasure to work with members of Congress and their staff as I believe we all have a common goal to shape the new face of the healthcare industry by utilizing the vast contributions that information technology (IT) offers healthcare providers, payers, physicians and patients in achieving goals of reduced medical errors, lower costs, better quality and improved efficiency within our nation's healthcare system.

In addition to representing Greenway, I am also one of the founders of the HIMSS Electronic Health Record Vendor's Association (EHRVA) and currently reside on the EHRVA Executive Committee and serve as Chair of the Membership Committee. The EHRVA is comprised of the nation's 39 leading EHR companies currently representing roughly 98% of all EHR's implemented today. The goals of Greenway and the EHRVA are the same as those of President Bush in terms of developing an industry-wide strategy for widespread adoption of health information technology (HIT) and for converting these goals into substantial quality and efficiency improvements in less than five to eight years from now.

This Statement focuses on our dedication to assisting Congress and government agencies in achieving our health transformation goal. Greenway and the EHRVA support a truly transparent process and equal collaboration of public and private entities. Over the past year, Greenway and the entire private sector has made significant strides in EHR adoption, interoperability and proven return on investment (ROI) for long-term sustainability of this transformation progress and we will continue to make strides in this reform. We have been successful so far without government intervention or the wasting of any taxpayer dollars. Greenway's customer practices alone have realized an annual $21,600 to $81,500 post-implementation return per physician. With paperwork reduced, collections increased and coding improved, physicians provide a higher quality of care and also operate a more efficient business.

While HIT and EHR adoption currently grows at a record pace, we possess the responsibility to ensure that every policy that is enacted and every rule that is proposed must increase and incentivize HIT adoption. While we applaud the focus that the President, Congress and the U.S. Department of Health & Human Services have applied to this industry transformation, we must ensure that all decisions are created by entities that have the essential experience, dedication and factual evidence necessary to put self-sustaining plans and policy in place.

Greenway guardedly supports the efforts of the Office of the National Coordinator for Health Information Technology (ONCHIT) but believes this Office needs more private sector experience and involvement to create a real 50/50, public/ private collaboration. In ONCHIT's current state, Greenway could not support their codification until their processes become more transparent, physicians point-of-care workflow is respected and EHR certification performs the proper due diligence that is necessary for participation and private sector sustainability. We respectfully advise that all Work Groups, Committees and Boards created under ONCHIT and the American Health Information Community (AHIC) make sure that any mandates or certifications are thoroughly investigated, meticulously created and are proven to increase HIT adoption before becoming imposed on the private sector. It is essential that we continue to increase our HIT adoption rates and keep physician's daily workflow at the forefront of all decision-making in this reform and not succumb to any industry or self-serving lobby.

Greenway is one of several examples of how the private sector is committed to this transformation and has taken charge through leading the health information technology and electronic health record industry. Greenway was founded on the premise that HIT & EHRs dramatically reduce medical errors, lower costs, improve quality and efficiency and create a substantial return on investment for physicians and practices among many other constituencies. Greenway has chosen to focus on the small to mid-size practice community as our customer base consists primarily of practices with between 1-50 physicians. The vast majority of healthcare in this country is delivered in medical offices within the above mentioned market space and this environment will be the essential component in assuring widespread adoption due to the communication these practices have with hospital systems, test laboratories, and other medical practices.

Greenway has also structured its offerings to physician practices into a 10-year business plan mirroring President Bush's own Framework for Strategic Action to ensure that healthcare providers will have quality software solutions that inform clinical practices, interconnect clinicians, personalize patient care and improve the overall population health. By directing our efforts in accordance with those of the president, our customers can rest assured that their investment will consist of a fully-integrated solution streamlining their administrative, clinical and financial processes into an efficient workflow that is consistent with long-term viability.

Besides having the best EHR for their practice, it is also Greenway's belief that physicians need fiscally responsible incentives to increase adoption of HIT at a greater pace. Physicians and their practices are the backbone of the American healthcare system and since they are also small businesses, they are the backbone of our economy as well. Congress and the healthcare industry needs to stay focused on economic sustainability by providing fair, increased reimbursement incentives and by increasing the capital equipment and software purchase deductions allowed under section 179 of the Internal Revenue Code.

However, from our decades of experience, we would not support unfunded government mandates, stark-safe harbor modifications or, as mentioned previously, imposed HIT

certifications that are not proven to considerably increase EHR adoption, EHR usability and private sector sustainability. We would suggest any proposed changes in these areas get referred to a congressional or Medicare study to review and understand feasibility, longevity and factual impact on HIT adoption goals. Congress and the U.S. Department of Health & Human Services possess the ability to cripple current and future HIT and EHR adoption if they implement immature or flawed policy.

In all that we are working towards, we must also recognize physicians as consumers and realize and respect the necessity of their services. As absurd as it sounds, can you imagine a community without a physician? Their contribution to each community makes it essential that we offer solutions such as EHRs and proper public policy to help keep them in business. It is our experience that we must keep the physicians daily workflow at the fore-front of all decision-making when discussing how we may impact their offices and practice of medicine. The practical workflow involved in a physician's revenue pipeline is more paramount in EHR selection than any non-essential bells and whistles that might influence a physician's purchasing decision. Greenway and the EHRVA both have presented Use Cases and "Clinical Test Scenarios" to various Work Groups of the Certification Commission for Health Information Technology (CCHIT) and Health Information Technology Standards Panel (HITSP). These Use Cases and Scenarios were derived from real-life experiences with EHRs implemented today at the point-of-care.

This is an exciting time to help lead the healthcare information technology industry. We have the opportunity to create the most efficient healthcare system for this country and while this is a daunting challenge, it is certainly achievable. However, as we continue to move towards 2014, we want to take the prudent and fiscally responsible steps so that our healthcare vision will transform into a national reality. Speaking on behalf of the private sector, we are ready as an industry to answer the call to work in partnership with Congress and federal agencies in making these goals and the framework our future.

Chairman Akin and distinguished members of the Subcommittee and staff, I want to thank you for this opportunity and your genuine interest in this vast and important topic. I hope that my comments will help steer ideas and thoughts that can be transmitted into innovative policies shaping the future of healthcare in this country. Thank you very much.

Thank you for the opportunity to submit our comments on the FY07 proposed budget for SBA. WIPP strongly believes that SBA provides important services to women nationwide and we urge the Congress to adequately fund this important agency.

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