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COMMITTEE HEARING ON COST AND CONFIDENTIALITY: UNFORSEEN CHALLENGES OF ELECTRONIC HEALTH RECORDS IN SMALL SPECIALITY PRACTICES

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COST AND CONFIDENTIALITY: UNFORESEEN CHALLENGES OF ELECTRONIC HEALTH RECORDS IN SMALL SPECIALTY PRACTICES

Thursday, July 31, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 10:00 a.m., in Room 1539 Longworth House Office Building, Hon. Nydia Velázquez [chairwoman of the Committee] presiding.

Present: Representatives Velázquez, Shuler, Gonzalez, Altmire, Clarke, Johnson, Chabot, and Buchanan.

Chairwoman VELÁZQUEZ. Good morning. I call this hearing of the House Small Business Committee to order. In the last few decades, information technology has revolutionized virtually every American industry. Today previously complex and time-consuming tasks can be easily accomplished with a click of the mouse. But, as with any large-scale shift or system overhaul, the adoption of new technology comes with certain growing pains. Nowhere is this more true than in our nation's health care sector.

By the year 2014, the national information technology coordinator expects the United States to have a nationwide network of electronic health records. Today several bipartisan proposals supporting this network are working their way through Congress. Both Democrats and Republicans recognize the value in HIT. After all, it promises to not only control costs but also to improve quality. That is an especially appealing prospect given the skyrocketing price and declining value of modern health care.

In today's hearing, we will discuss the value of HIT and also explore the various concerns surrounding its use. If properly implemented, HIT can streamline the flow of complex health care data. In doing so, the technology will improve communication between doctors and hospitals. And given the inherent complexities of medicine, a well-structured communication network is of the utmost importance.

Despite growing support for health care technology, particularly in the form of electronic health records, small practices have been reluctant to take it up. Whereas, 57 percent of large care centers use EHR, only a handful of solo practitioners do. This is partially due to the high cost of implementation.

When all is said and done, the price tag of EHR installation comes to over $32,000 for physician. Meanwhile, monthly maintenance fees run close to $1,200.

By the time heating costs have been factored in, final estimates can be $44,000 per doctor with upkeep fees of $8,500 a month for small health care providers with limited resources. These up-front costs are enough to break the bank.

In addition to the weighty financial obligation, a series of legal and privacy concerns has deterred small health practices from adopting HIT. As a practical matter, electronic information can be transmitted and reviewed more easily than paper files. In light of this fact, some health professionals worry that HIT holds potential for health care fraud.

At the same time, others are concerned that the technology might conflict with confidentiality issues outlined in the Health Insurance Portability and Accountability Act, or HIPAA.

Finally, some specialty doctors, like neurosurgeons and pediatricians, are unable to find appropriate HIT systems. Oftentimes this technology caters only to mainstream medical practices, leaving the smaller, more specialized businesses behind.

Health information technology has the potential to revolutionize American medicine. But, unfortunately, a series of concerns is blocking large-scale implementation.

There is no silver bullet solution to America's broken health care system. There are, however, a number of ways to address the issue. For one, financial incentives to HIT users will help spur uptake. So will strengthening privacy regulations for health records.

As we move forward in the quest to improve health care coverage and cut costs, we can look to current technology and future innovation. And, yet, in doing so, we must be sure to act with caution. Otherwise we risk de-operatizing both small providers and the health and security of their patient.

With that, I would like to take this opportunity to thank all the witnesses for coming here today to provide your insights regarding this issue. I look forward to their insight on the matter and yield to Ranking Member Chabot for his opening remarks.

Mr. CHABOT. Thank you very much, Madam Chair. And thank you for holding this very important hearing on this very important topic here this morning.

I would like to thank each one of our witnesses who have taken the time out of their busy schedules to provide this Committee the testimony that they will be giving us here this morning.

And I would like to extend a special welcome to a fellow Cincinnatian, Dr. Thaddeus, or Ted, Bort, who also happens to be my personal physician. So I am particularly pleased to see him here today, and I will introduce him more formally later.

Over the past 30 years, nearly every sector of the American economy has undertaken a sweeping transformation in the way information is collected, managed, and transmitted. As a result, productivity and efficiency have consistently increased.

Yet, today health care, one of the most significant, one of the most important sectors of the American economy has not yet made this transformation, at least completely, although we are certainly beginning that at this time. This hearing is an important part of letting Congress know what is happening in that area at the present time.

Some of the most serious challenges facing health care today, medical errors, inconsistent quality, and rising costs can, at least partly, be addressed through the effective application of health information technology. Linking all elements of the health care system improves information available to physicians and boosts quality and enhances preventive care and reduces errors.

On April 22nd, 2004, the President signed an executive order which established the position of the national health information technology coordinator within the Office of the Secretary of the Department of Health and Human Services and announced his commitment to the promotion of health information technology to lower costs, reduce medical errors, improve the quality of care, and provide better information for physicians, as well as for patients.

In particular, the President called for widespread adoption of electronic health records and for health information to follow patients throughout their care in a seamless and secure manner.

A September 2005 report by the RAND Corporation estimated that $77 billion annually could be saved if 90 percent of physicians adopted health information technology. The report also estimated another $4 billion in savings from reductions in prescription errors.

A new report indicates that more than 35 million prescription transactions were sent electronically in 2007, which was a 170 percent increase over the year before. Despite documented advantages and federal support, physician adoption of health information technology has been slow.

Research indicates that concerns about high cost, uncertainty of return on the investment, and worry over the usability and obsolescence of new technologies rank highest among reasons surveyed of physicians have not yet adopted health information technology.

Doubts about the privacy and security of patient data, practice compliance with the Health Information Portability and Accountability Act of 1996, and the potential for inappropriate disclosure of patient information to third parties ranked just behind the financial concerns that I mentioned previously.

Health information technology is a complex issue. The decision to implement health information technology in a small medical practice is considered an act of courage by many physicians. It will impact their work flow, staff, patients, and practice finances.

Successful adoption of health information technology, including electronic medical records, will require evaluation, selection, planning, implementation, and effective use of the technology.

Early adopters agree that there are multiple benefits but recognize a cultural change is required. Madam Chair, I look forward to working with you on this important issue. This would be another bipartisan issue that we could work on together, as we have done many times in the past. The rest of Congress may not do it, but you and I do.

And, again, I want to thank you for your cooperation in this hearing today. And I want to thank the witnesses. We are looking forward to hearing their testimony. And I yield back the balance of my time.

Chairwoman VELÁZQUEZ. Thank you Mr. Chabot. And I recognize Mr. Shuler for an adoption statement.

Mr. SHULER. Thank you, Madam Chair.

It is great to see that this meeting is being held. Before my days here in Washington, I actually ran a company called My Health Card, which was electronic medical records that people carry around in their pocket, a company that we found very difficult to get off the ground, very difficult to get the hospitals, their programs, whether it be GE Medical or whether it be Op Path or whether it be any of the major electronic medical record groups to get you to do an interface with their systems. But we did find a company that allowed us to do that.

And in relationship with the University of Tennessee's medical system, we actually worked with a geriatric population. We gave them all their cards for free. The hospital used it more as a marketing tool, but we realized in a very short time that it actually saved lives. So it wasn't a chain pharmacy, but it was actually a pharmacy that allowed us to be able to put the database into their system.

So a person would go to the primary care physician. That information was then downloaded onto the card, had a 119-digit encryption code, HIPAA-compliant.

And then the person would go to the pharmacy. The pharmacy then would be able to only look at the information that the doctor put on the meds size.

And we found out we saw drug interactions. They went from their primary care physician to a specialist. The specialist had no idea what the primary care physician had prescribed. And we saw numerous times of drug interaction that was caught by the physician. He then had the phone number because it was time-stamped and dated on the card. And they recognized very quickly that they had a problem.

In the geriatric population, we saw a decrease in days in the hospital. Times in the emergency room significantly dropped. The hard part that we had was because of the interfaces with the big companies, if you will. They wanted to capture that data.

We had other problems with pharmacies being able to allow the other pharmacies—they wanted to capture that data. They wanted their data for their own personal use. We didn't look at it. We didn't care about the data from the standpoint of what meds were being taken. We just wanted to make sure that the health and the care of the patient were taken care of first and foremost.

And then we realized that the hospitals actually had no idea what was happening internally within their hospital. Now, when a person would come to the emergency room because they outsource their emergency room, that information technology system was different than the one that they have inside the hospital. Then they would go to an operating room. Well, the OR software is different than the outpatient surgery software. And so you had no way to communicate within the hospital.

So we found ourselves having to implement interfaces with all of these systems. By the time we got one interface completed, we had to then start all over because it was time to complete the interface again.

So we went through this, a complete circle of finishing the interface. And by the time we got it done in order to make the card

work completely throughout the hospital, we were forever doing an interface.

And that cost money. So I commend you for being here today and talking on this very important subject. Actually, one of the most important things that we were able to do with the country—it seems like we do our philanthropy work more than anything—is kids with foster care. The child would go from place to place to place. The medical records were never with them. And so this card they can take with them.

So, Madam Chair, I thank you for holding this very important hearing. It is a way to cut down costs of our overall medical crisis that we are in. And I think this is going to be a very important part of making a difference in health care.

Thank you, Madam Chair. And I yield back.

Chairwoman VELÁZQUEZ. Thank you.

And now it is my pleasure to welcome Dr. Philip W. Tally. Dr. Tally is a neurological surgeon in privacy practice and the Chief of Staff for Manatee Memorial Hospital in Bradenton, Florida. He currently serves as the Chairman of the Florida Medical Association's Health Information Technology Committee and is a member of the American Medical Association's HIT Advisory Panel. The American Association of Neurological Surgeons and The Congress of Neurological Surgeons represent more than 4,000 United States physicians trained and certified in the specialty of neurological surgery.

Welcome. You have the timer. We will have five minutes when it is going to have the green light. And then red means that your time is expired. Welcome.

Dr. TALLY. Thank you.

STATEMENT OF PHILIP W. TALLY, M.D., NEUROSURGEON, NEURO-SPINAL ASSOCIATES, ON BEHALF OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS

Dr. TALLY. Good morning, Chairwoman Velázquez, Ranking Member Chabot, and members of the Committee. Thank you for inviting me to appear today to discuss the challenges small physician specialty practices face in adopting electronic medical records.

My name is Philip Tally. And I am one of three neurosurgeons in a small but full-service neurosurgical practice in Bradenton, Florida. I am here, as you stated, representing the neurosurgeons. I have been the Chairman, as you have stated, of the two committees.

I would like to spend my time with you this morning telling you my story about how we integrated electronic medical records into our practice, some of the challenges we faced, the costs we incurred, and ultimately the benefits that we have reaped, both for our practice and our patients.

In 1992, our practice was the fifth medical practice in the country and the first neurosurgical practice to go fully paperless. Implementing this new system was no easy feat. We could not simply plug in the machine and flip the switch.

Because these systems are set up in a one-size-fits-all manner, it took over 1,000 hours to configure our system and create

neurosurgical templates since there were no existing specialty-specific programs. All told, implementing the first system required about a year of prep time to purchase, configure, and implement. In addition, it took about another year to refine it and for our practice to become proficient with it.

The costs of setting up and maintaining this system were significant. We spent about $50,000 on the initial setup. The system also required regular maintenance and upgrades, which cost us at that time about $5,000 a month.

During the early years, our vendor continued to create new systems and upgrades. Every improvement resulted in some unintended consequence, which required a software engineer's time to repair. Implementing the system was particularly difficult on the staff. And not everyone was pleased to move to this new paradigm shift in our practice.

These changes, coupled with the daily stress of working in a neurosurgical practice, simply proved too much. We suffered a 30 percent staff turnover as they had difficulty in adapting to and learning entirely new procedures and methods. This produced problems with continuity of patient care and loss of productivity as we went the through process of hiring and training new staff.

As our practice transitioned to EMR, we also had to keep the paper records for legal reasons. Interoperability was not even a concept at that point, and there was no talking between systems. Every paper document had to be scanned and transferred into the EMR.

Notwithstanding these challenges, the physicians and our staff recognized the benefits of going paperless. The efficiency of the practice increased significantly. Staff no longer had to search for paper charts to answer patient phone calls, and they could quickly get information to the neurosurgeons.

Our ability to quickly review and create new charts allowed us to spend more time with our patients. We improved our communications with other physicians since the completed patient record was never misplaced, always legible, and test results resided in a distinct folder within the EMR.

In 1997, we converted to a Windows-based system. And we went through the same process again, incurring similar costs, down time, and lost productivity. This new system was an improvement and significantly expedited patient care.

Maintaining this system for the last ten years has been a challenge. Hardware has failed. Servers have been hacked. Security requirements, particularly HIPAA, are onerous. And keeping a full-time IT employee in a competitive job market has been difficult.

This year we are once again in the process of converting to yet another new program and platform and incurring all the same costs as before. Even with our practice's lengthy history and experience with EMR, this upgrade has been a costly and difficult process, with considerable loss of productivity. Furthermore and notwithstanding our experienced eyes, after we purchased this system, we have found flaws in the vendor's product.

Madam Chairman, as you can see, our practice has been ahead of the curve in using EMR. Unfortunately, most physicians have not shared this experience. Despite the fact that EMR has the po-

tential to improve the delivery of health care, most physicians have been slow or reluctant to adopt these systems.

A recent study found only four percent of physicians have a fully functional EMR system. So we have a very long way to go. And a three to four-year timetable for nationwide implementation is optimistic at best.

Perhaps the new prescribing provisions included in the recently passed Medicare bill will help encourage physicians to implement this entry-level mode of EMR. However, over 70 percent of the 3 billion prescriptions written every year are by primary care and emergency room physicians, currently the 2 groups with the lowest rates of EMR adoption.

In addition, there are significant implementation issues, such as the pharmacy familiarity; proposed and fatally flawed new rigid DEA rules for Schedule II drugs, which will make compliance by most neurosurgical practices very difficult.

Congress can help pave the way to widespread adoption of EMR by passing legislation that will standardize interoperability and provide financial incentives to physicians and practices. We cannot rush this process or force physicians to adopt EMR using a stick approach as this will only create more resentment among the physicians. It took over ten years for the stethoscope to become widely accepted as a medical tool.

While it will take time, we are on the right path in promoting this. There is general agreement that HIT will improve patient safety, enhance quality of care, result in more efficient practice, and better health outcomes should follow. We should not deviate from this premise, nor should we rush launching a complex system to satisfy political or administrative goals.

Thank you for the opportunity to share my experience, and I will be happy to answer questions at your discretion.

[The prepared statement of Dr. Tally can be found in the appendix on page X.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Tally.

Our next witness is Robert Plovnick. Dr. Plovnick is the Director of the Department of Quality Improvement and Psychiatric Services at the American Psychiatric Association. He oversees preparation of APA's psychiatric treatment guidelines, development and assessment of performance measures for psychiatric services. The American Psychiatric Association has more than 38,000 members. Welcome.

Dr. PLOVNICK. Thank you.

STATEMENT OF ROBERT PLOVNICK, M.D., M.S., DIRECTOR OF THE DEPARTMENT OF QUALITY IMPROVEMENT & PSYCHIATRIC SERVICES, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. PLOVNICK. Thank you, Madam Chairwoman. Members of the Small Business Committee, I am Dr. Rob Plovnick, Director of the Department of Quality Improvement and Psychiatric Services at the American Psychiatric Association. It is an honor for the APA to present this testimony to the committee regarding unforeseen challenges of EHRs to small specialty practices.

The APA represents more than 38,000 psychiatric physicians nationwide. Our members work within a variety of systems of care, including emergency departments, inpatient settings, and small private practices.

The development of health information technology and corresponding federal and state laws and regulations are a matter of great interest and concern to the APA, our members, and their patients. The APA has one committee of members solely focused on various aspects of EHRs and a second committee solely focused on privacy and confidentiality concerns.

Carefully structured, a national HIT infrastructure has great potential to improve the overall quality of care provided to patients, inform health professionals of the latest standards of care, and to improve communication of health care information across settings.

However, there are two significant challenges to widespread adoption and implementation of EHR systems that the APA would like to highlight in our testimony today. First, the assurance of confidentiality is at the core of any effective patient-physician relationship. Electronic health information exchange could erode patient trust and impede clinical care if it facilitates dissemination of sensitive information without sufficient precautions to protect privacy and security.

Second, a significant percentage of APA members operate in solo private practices in which the up-front costs of implementing an EHR system present a considerable barrier to adoption.

Protecting and strengthening the confidentiality of the patient-physician relationship is critical to providing the highest quality medical care. This is particularly true with respect to psychiatric care because of ongoing inequity in insurance coverage, employment discrimination, and social stigma for people with mental illness.

An unintended conscience of EHRs is that patients may be discouraged from seeking treatment or sharing information that is critical to their care due to concerns that it will be improperly disseminated.

Treatment in behavioral health and other disciplines of medicine often require patients to share sensitive information, such as sexual history, drug use, pregnancy history, and HIV status. According to HHS, 2 million Americans, or 7 percent, of those with mental illness do not seek treatment specifically due to privacy concerns.

A 2007 Harris interactive poll found that 17 percent of patients withheld information from health professionals because of worries the information might be disclosed. These rates are likely to be even greater if information exchange is electronically enabled and the confidentiality and security of health information cannot be assured.

The trust required for a productive therapeutic relationship is undermined by accounts of health care workers who view electronic records of celebrity patients as well as by the loss or theft of laptops and CDs containing large quantities of health information.

Apologizing and making improvements once data is lost is not a sufficient response. Privacy and security provisions must be keystones to the development of a nationally uniform HIT infrastructure.

There are many approaches that could help protect the patient-physician relationship and optimize the advantages of the EHR environment. Examples include ensuring the strictest security protections and auditing are employed, and giving patients and clinicians a degree of control as to who can access sensitive information.

Despite the widespread recognition of the potential HIT holds to increase efficiency and quality health care delivery, system adoption rates remain low. A recent study in the New England Journal of Medicine found that only four percent of physicians had adopted fully functional EHRs and those that had tended to be in larger practices. Consistently, cost is cited as the largest barrier to wider adoption.

Although estimates vary widely, studies report that the total costs for implementing office-based EHRs range from $25,000 to $45,000 per physician. And subsequent annual costs for maintaining the system range from $3,000 to $9,000 per physician per year. These expenditures are amplified for smaller practices, where there are fewer physicians to share the costs.

Psychiatrists involved in solo practice, a significant percentage of APA members, often have little or no administrative support staff, further increasing the physician's responsibilities with regards to selection, implementation, and maintenance of the system, and decreasing the time available for clinical care.

The APA appreciates the efforts the Small Business Committee has made to address confidentiality concerns while developing an HIT infrastructure, which offers a great potential to raise the overall quality of care provided to patients. This goal can be met without breaching privacy protections and can assure patient trust if privacy is made a cornerstone of HIT development.

The APA further recommends the use of financial incentives such as grants or other support to help practitioners in solo or small group practices cover the costs of hardware and software.

Again, we thank you for the opportunity to testify today, and we hope the members of the Committee will consider the APA as a resource as this process continues.

[The prepared statement of Dr. Plovnick can be found in the appendix on page X.]

Chairwoman VELÁZQUEZ. Thank you Dr. Plovnick.

The Chair recognizes Mr. Johnson for the purpose of introducing our next witness.

Mr. JOHNSON. Thank you, Madam Chair.

I have today the pleasure of introducing Dr. Edward Gotlieb. Dr. Gotlieb is a pediatrician in private practice at the Pediatric Center in Stone Mountain, Georgia. He is a fellow both of the American Academy of Pediatrics and the Society of Adolescent Medicine.

He has served as the Chair of the Policy Committee for the Academy's Steering Committee on Clinical Information Technology, now the Council on Clinical Information Technology, on the Academy's Committee on Adolescent Centers, the past Chair of the George AAP Chapters Committee on Adolescents.

The American Academy of Pediatrics is a professional organization of pediatricians with more than 60,000 members trained to deal with the medical care of infants, children, and adolescents.

And we welcome you today to this Committee, sir.

Chairwoman VELÁZQUEZ. Welcome.

Dr. GOTLIEB. Thank you very much, Madam Chairman Velázquez, Ranking Member Mr. Chabot, and Members of the Committee.

STATEMENT OF EDWARD GOTLIEB, M.D., FAAP, THE PEDIATRIC CENTER, ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS

Dr. GOTLIEB. I am honored to represent the American Academy of Pediatrics before you. My name is Edward Gotlieb. I am a practicing physician, pediatrician, in Stone Mountain, Georgia. And you have heard my credentials.

Let me tell you about pediatrics. Sixty percent of pediatricians practice in small businesses. Pediatricians are asked by industry to pay extra for electronic health capabilities to deal with the complexities of pediatric care that were reimbursed by the government less well to provide these services than our adult care colleagues. Let me explain.

Pediatricians are different from other doctors because the major government program that pays for the health care of children is Medicaid, not Medicare. Medicaid has a major impact on children's care, paying for 40 percent of births in the United States and I believe 60 percent in Georgia.

Medicaid faces fiscal problems but not because of the more than 30 million children that are covered by the program. These children account for more than 50 percent of Medicaid's population but only 25 percent of its cost.

Pediatricians find it very costly to purchase health information systems. A real factor in our inability to afford these expensive technologies is the payment rates that pediatricians receive under Medicaid. Under Medicaid, payments for providing the same medical services average 69 percent of what Medicare pays. So the margins under which most pediatric practices operate are much more severe than those of our adult colleagues.

Furthermore, if incentives for adopting health information technology is structured to flow through the Medicare program, as is now largely the case, more than 60,000 practicing pediatricians would be excluded from the opportunity to qualify for these incentives. The already inequitable system of funding programs for children will only be worsened. This is not a good investment in our future.

Unfortunately, even if we do receive help to adopt health information systems in our practices, we face special constraints because of special needs of child care and the rules governing privacy for our patient population. Electronic medical records are frequently designed for adult care and do not take into account the specific needs of children.

There are a number of special functions that a pediatric health record requires that must be implemented in an electronic medical record. In their absence, pediatricians are hampered in their ability to properly document care.

Yet, the vendor community frequently asks us pediatricians to pay extra for these capabilities if they are willing to provide them

at all. Major areas in which these needs arise are in immunization documentation, immunization registry management, growth tracking, medication dosing, privacy for special pediatric populations, and in providing normative data by age, body mass index, or developmental stage.

Of particular concern in today's discussions of health information technology incentives are adolescent privacy concerns. The HIPAA privacy rule and its implementing regulations defer to the state and other applicable law on the issue of adolescent privacy. Laws about age of consent vary from state to state and according to the patient's presenting problem. The electronic health records need to be able to reflect this.

As an example, in many states, adolescents who present for the outpatient treatment of mental health disorders may consent to their treatment at an earlier age before they become 18 years old.

Pediatric practices typically have policies with respect to what portion of an adolescent's care should be handled with special privacy protections. EHR should be flexible enough to handle these practice-level policies.

The recording of patient and parental consent, child assent, and the permission to treat are frequently less straightforward for children and adolescents than for the care of adults. Separation of the patient's consent and the parent's or guardian's consent is particularly important in the areas of testing for drugs, screening for sexually transmitted illnesses, or in the case of abuse. Remember also that our privacy concerns are not limited to minors.

We pediatricians continue to care for young people through age 21 and in some cases beyond. My written testimony also focuses on other special cases: children in foster or custodial care, consent by proxy, adoption, guardianship, and emergency treatment.

Thank you for the opportunity to testify before you today.

[The prepared statement of Dr. Gotlieb can be found in the appendix on page X.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Gotlieb.

Our next witness is Ralph Hale. Dr. Hale is the Executive Vice President for the American College of Obstetricians and Gynecologists. He is a past President of the Association of Professors of Gynecology and Obstetrics and a past President of the Pacific Coast Fertility Society.

ACOG is a professional association of medical doctors specializing in obstetrics and gynecology in the United States. It has a membership of over 49,000 and represents 90 percent of U.S. Board-certified obstetrician/gynecologists.

Welcome.

Dr. HALE. Thank you, Madam Chairperson/woman. We actually like women. Actually, it is interesting that I am following Dr. Gotlieb—

[Laughter.]

Dr. HALE. —since Dr. Gotlieb usually follows me in the delivery room.

[Laughter.]

STATEMENT OF RALPH HALE, M.D., FACOG, EXECUTIVE VICE PRESIDENT, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. HALE. We appreciate very much the opportunity—

Chairwoman VELÁZQUEZ. President Bush does, too.

Dr. HALE. Yes. That is true. I have been the ACOG Executive Vice President since 1993, when I left the University of Hawaii to come here to Washington, D.C.

I can tell you that our organization is strongly supportive of health information technology. As a matter of fact, our last Executive Board meeting, which was just recently held in July, we had an expert come in and talk to us for over an hour. And the main thrust is, how can we get all ob/gyns in the United States into health information technology?

As part of that, our organization has made our antepartum record, and our women's health record free to any electronic vendor that would like to use them. We will prepare them. We will make them available to them at no cost because we feel this is important.

The problem with HIT is that it has not matured to the level where most of our Fellows who are in small practices can use these systems. They are costly. They are not interoperable. They cannot take their health record into a hospital that has a different platform base and use them. This is a problem we see: the lack of ability for us to move across the various platforms.

And while HIT will save the insurers a lot of money, it has yet to save our members money. The costs involved are still excessive, as you have heard from our previous testimony, and we run into problems with confidentiality. Confidentiality is very important because these are sensitive records. And in our specialty, as with Dr. Gotlieb, we deal with a lot of extremely sensitive issues. We need to make certain that these records, even though they may be transferred between providers, are flexible enough to accommodate state privacy laws and the HIPAA.

HIPAA, of course, is extremely important. And we are very supportive of HIPAA because many of our women have many issues that they would not like to have on the latest tabloid in the supermarket.

Forty percent, as you have already heard, of deliveries in this country are paid by Medicaid. And, yet, there is nothing in Medicaid that helps support an electronic medical record. And we fear that within the next couple of years, Fellows who do not use Medicaid electronic medical records will be punished.

While there is an increased need for HIT, physicians have less ability to afford these systems. This is a compelling reason for physician assistance in paying for HIT.

We all know that the clinical benefit of the electronic medical record is great. In one of our groups at the Massachusetts General Hospital they have an outstanding medical record which they have put together, which allows patients to be seen in any office related to their physicians.

And we need to bring that record into the hospital so if the patient has a problem in pregnancy, this record is there. The physician who sees the patient in the emergency room or sees the patient in the hospital can immediately pull up this record and can

take care of the patient for her care and for the care of her infant. Unfortunately, this is not true throughout the medical system and among all the electronic medical record vendors.

Representative Shuler has identified the problem. And all I can say is amen to what you ran into because that is what our Fellows see. The records are not adaptable across many, many areas. This is a problem.

I would like to say that H.R. 2377 is a good start to guide us forward in this as we develop incentives for physicians to purchase HIT and to seek consensus on important privacy issues. This is a massive undertaking that requires physicians to trust their investment in HIT and for the patients to trust that their sensitive health information is protected.

Thank you very much for the opportunity to testify. And ACOG is more than willing to assist you in any way that we can.

[The prepared statement of Dr. Hale can be found in the appendix on page X.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Hale.

And now the Chair recognizes Mr. Chabot for the purpose of introducing our next witness.

Mr. CHABOT. Thank you very much, Chairwoman.

Dr. Bort is a fellow Cincinnatian, as I mentioned before. He is also a Board-certified family physician and a fellow of the American Academy of Family Physicians.

He is Chairman of the Board of Directors of The Family Medical Group of Cincinnati. And after completing his residency at the University of Cincinnati in the Department of Family Medicine, he commenced private practice in 1986 with a physician partner. Since then, the Family Medical Group, which is a partner-owned practice, has grown to 12 physicians, 5 other health care professionals, and 86 employees overall, with over 28,000 patients, including me and my family, in 3 different Cincinnati locations.

One of Dr. Bort's major areas of interest is headache diagnosis and treatment as well as diabetes and other areas as well, but those are two of his special areas of interest.

Two years ago, the group implemented a fully integrated technology platform. Today every person in the group utilizes a computer.

Dr. Bort is a volunteer Assistant Professor of Family Medicine at the University of Cincinnati. He also serves on the Advisory Board of Crossroads Health Center in Cincinnati, which treats substance abuse.

Cincinnati Magazine included Dr. Bort in their summer edition this year, in 2008, as best doctors in Cincinnati edition. We welcome him here today and look forward to his testimony.

And all the other doctors have set a very high standard here, Dr. Bort. So we know you won't let us down.

[Laughter.]

Dr. BORT. Thank you very much.

STATEMENT OF THADDEUS BORT, M.D., CHAIR, BOARD OF DIRECTORS, FAMILY MEDICAL GROUP

Dr. BORT. Chairwoman Velázquez and members of the Committee, I am honored to be here today on behalf of family physi-

cians; my partners at The Family Medical Group of Cincinnati; Ohio; and, most importantly, our patients.

I am a Board-certified family physician and member of the American Academy of Family Physicians. I commenced practice, private practice, in 1986 with my partner, Dr. Timothy McCarren. Since then, as Congressman Chabot was kind enough to say, we have grown to 12 partners and 5 mid-level providers, and 86 employees. We have over 28,000 patients.

After waiting for years for the perfect EMR system, we decided in 2006 that it was time to invest in one. After investigating a number of systems, we purchased the Misys EMR system but found that converting our practice from paper to electronic records was an arduous process. Only our integrity and our desire to help our patients kept us on task. The report from the Institute of Medicine on the unacceptable number of avoidable medical errors stimulated our resolve.

During the first year of installing the EMR, we actually had to decrease our patient load by 20 percent until we became more comfortable with the system. Now, with two years experience, we realize that we deliver health care on a technology platform. Every employee uses a computer. And every patient encounter involves entering data into our EMR system. The experience has provided us some perspective on the cost, benefits, as well as the challenges associated with the use of EMRs.

Costs. When we decided to convert to EMR, we didn't anticipate the ongoing cost of developing and maintaining a system. We purchased our system at an initial total cost of over $228,000, which did not include the transfer of existing paper files to an electronic format, nor did not include the time and effort required for the entire staff to become proficient and lost revenue while in training.

However, we found that there is not only the up-front cost, as in the past year we paid over $258,000 to the EMR vendor. This is an annual expense that is not based on volume but the reality of maintaining a system.

One of the largest expenses was converting 25,000-plus paper charts to a format the EMR could use. This required scanning of important documents of each chart. We tried to do this on our own but then resorted to shipping the remaining charts to North Carolina to be scanned professionally, at a total cost of $80,000.

Benefits. Convenience, accuracy, efficiency, and completeness are among the benefits of the system. For example, our patients can schedule appointments or request a prescription refill, which is then sent directly to their pharmacy. When I am with my patient in an exam room, I am able to access lab results or check past history all with a click of a mouse. This fosters better patient care because of our ability to track measures, benchmarks, and standards.

We find privacy and confidentiality are enhanced with EMRs. With paper charts that were all over our office, there was no way to know who looked at the chart. Thus, it was near impossible to monitor HIPAA compliance. Now it is necessary to log on using password protection, and an audit trail is recorded down to the second.

Finally, one of the most important roles that effective HIT, like an EMR, can play is to implement what is called a "patient-cen-

tered medical home." This is a team-based health care model that emphasizes coordination of care that is particularly important for patients with chronic conditions, such as diabetes. The EMR is central to the operation of a primary care practice that serves as a patient-centered medical home.

Challenges. Our EMR uses an encrypted system to transmit information. While this acts to insure patient security, it also poses a great challenge. When our doctors visit patients at some of the hospitals, we are unable to access the patient's information in our office because the hospital system and our office system are not compatible.

Moreover, as family physicians, we interact with a variety of providers, such as my colleagues at this table: laboratories, radiology, consultants, hospitals, nursing homes, et cetera. Each of these providers has their own computer system, but because they are not interoperable, communication from these various providers still requires paper.

While I would like to say that we have achieved a paperless office, we continue to be inundated with paper. All day long our fax streams hundreds of prescription refill requests to us since there is no direct electronic communication between our system and the pharmacy or other providers.

The hospitals as well fax us reams of paper reports since thus far there is no standard for hospitals to electronically communicate with EMR. This amounts to several hundred sheets of paper, which we must scan into the EMR, then pay to shred.

Based on our EMR experience, I would like to offer two recommendations. Number one, due to the potential benefits but in recognition of the substantial cost associated with the EMRs, the investment and the utilization of HIT should receive some form of tax incentive or system of reward.

Number two, Congress should foster an environment that provides incentives for the private sector to hasten the interoperability of EMR systems, work flow, and clinical data to promote low-cost solutions to enable quality measurement and improvement.

In closing, both despite and because of our experience, I believe the benefits of EMR over paper charting are numerous and profound. But because of the substantial costs and time barriers, it is quite difficult for a small practice to convert to EMR. Yet, we recognize how EMRs can improve the quality and efficiency of our care.

We all share the goal of better outcomes at lower costs. Widespread use of health care information technology and electronic medical records is central to achieving that goal.

Thank you for inviting me to testify. And I look forward to your questions.

[The prepared statement of Dr. Bort can be found in the appendix on page X.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Bort.

Believe me, this has been quite a learning experience. And if there is something that I can say, it is that there is no easy answer. We all want to produce savings when it comes to the health care system and to produce and integrated system and the benefits

of health IT. Everybody talks about it. But how do we get there? That is the real challenge.

We hear about the costs of adopting EHR systems and the lack of benefit, of direct benefit, especially true for small practitioners.

Dr. Plovnick, I would like to ask you, in your estimation, what barriers to EHR implementation do psychiatrists face? And what are the unique challenges to the mental health profession?

Dr. PLOVNICK. A few barriers that come to mind offhand, there is not wide breadth of software options to choose from that are specific to mental health care in psychiatric treatment settings. So selecting a system that will work for the solo practice psychiatrist is a challenge.

As I mentioned, psychiatrists often have very small offices and little administrative support. So all of the work involved in selecting a system, putting it together, and then maintaining it falls disproportionately on the physicians themselves, which takes away from the time for clinical care.

The cost, as has been discussed by most people at the table today, has a particular impact on psychiatry, the solo practice in terms of the overall revenue. And the number of patients that psychiatrists see tends to be fewer than some other clinicians, which provides less opportunity to make up the cost savings for the expense of the system.

Chairwoman VELÁZQUEZ. Do you have any specific recommendation in terms of your profession in terms of what we can do here in Congress that will alleviate?

Dr. PLOVNICK. It is a hefty question. I think that the issue of standards that has been raised is true with psychiatry, as with any other profession.

Right now every system works on its own. And there is little opportunity for connecting between clinicians or within the inpatient setting. So assistance in providing interconnecting systems would be quite advantageous.

Chairwoman VELÁZQUEZ. Thank you.

Dr. Tally, I heard you loud and clear. The cost, the preliminary cost, $15,000, the $5,000 monthly maintenance fee, the 30 percent turnover, how we comprise continuity of care, the loss of productivity, not having systems interact with, communicate with each other. So the question of obsolescence is of particular concern to small practice specialists, who rely on fairly sophisticated systems.

Have vendors responded to this concern? And what steps in the health IT industry would help to alleviate this problem of investing in a system that may not be useable in five years?

Dr. TALLY. Madam Chair there is obsolescence and we are no different than any other industry because there are continual upgrades. We have to keep up with the technology.

We are not using a CT scanner that was developed in 1988. Now what used to take 30 minutes can take 12 seconds. EMR and all electronics must continue to evolve, which dictates that parts of it will become obsolescent. This includes the Internet, and that is the reason we actually chose to go on an entirely new platform.

It is a matter of how to adapt to this at an affordable cost. Our situation, in particular, is hampered by the fact that there is no company that would be willing to invest the amount of time to de-

velop a specific neurosurgical program. There are not enough practitioners to make it financially viable and we have complex templates that one would have to construct.

The Congress can act as a convener to orchestrate those involved to adapt certain standards. We are doing this currently with MRIs so that all MRI information has basic platforms that all of us can read. Currently that is not the case.

If we had a basic platform that we could all read, such as what we would now call interoperable, then, as progress develops and technology improves, then industry could simply tack on an additional feature. But the basic system would still be there.

And that is where I think that your role would be very helpful.

Chairwoman VELÁZQUEZ. Okay. Thank you.

Dr. Gotlieb, you point out that the average pediatrician's Medicaid payment is about two-thirds of what is received by adult care doctors for the same service. And this would seem to place pediatricians at a distinct disadvantage when it comes to health IT adoption.

What is needed from us, Congress, to encourage greater adoption of health IT by pediatricians?

Dr. GOTLIEB. Well, I think, first of all, if there were incentives, they need to pass through something other than Medicare because we have no access to those funds. The only funds that I have seen come through Congress recently is with the S-CHIP program, which could get us as much as $200 million over 10 years. And you guys have passed that. That has been vetoed twice. And it is sitting somewhere. So finding some way for us to get funds to do it would be a real help.

Another thing that is not an Academy position but an idea that I would like to suggest is you have done it with drugs, where you have given benefits to drug companies, to include pediatric research for medications. Maybe you could do the same thing with health information technology people and say, "If you have the functionality that pediatricians require, there is some benefit to you."

Chairwoman VELÁZQUEZ. Okay. Dr. Hale? No. Dr. Bort, let go with you first. Health IT security poses a significant challenge to physicians trying to access their patients' information outside of their office. You suggest standardizing electronic health record systems as a possible solution.

What steps at the federal or state level could create this standardization and ensure the security of records?

Dr. BORT. I guess the way I would approach this is that looking at the cell phone industry as an analogy, what is so frustrating to us, Madame Chairman, is that we have, all of us in the room have, a cell phone. And there is a multiple number of carriers. But if they did not communicate, it would be so frustrating because we couldn't talk to one another, even though we had the cell phones, et cetera.

And that is what we are living with, I believe, in HIT at this point because the security is not—I believe they are all encrypted in ways that I don't entirely understand. So it is not a safety as much as a communication problem that we are encountering that

leads us back to resorting to endless faxes and defaulting to paper, which is the lowest common denominator.

I believe this was mentioned earlier that HIT has lagged far behind the rest, for example, the business sector, where everybody lives on a Blackberry. We are not using that technology at this time in health care.

I have a couple of thoughts, that, first of all. It is a paradigm shift because we have all been on paper. And we have our work flow issues. So it is easy to do different paper patterns in that regard. But now we are bringing a paradigm shift with the computers. And that is a big step.

Now, if we would give computers, electronic prescribing, for example, to medical students, they would never have a paper pad or understand that. Since they have all been weaned on Game Boys, et cetera, that is no big step for them. They actually expect it.

So we are dealing with problems of what to do with those of us who have been used to paper for years and then the new generation, which I think is where the answer lies: the medical students. For example, we see students and residents from the University of Cincinnati. And when they come to us, we have asked for them to have a computer so they could access our medical record. That has not been possible.

As to your original point on the privacy and confidentiality, I have great confidence that the software managers know how to program that stuff aide make it safe. And, as I mentioned in my testimony, we have audit trails in our office.

Chairwoman VELÁZQUEZ. Okay. Now I recognize the ranking member. Thank you.

Mr. CHABOT. Thank you very much.

Chairwoman VELÁZQUEZ. Yes.

Mr. CHABOT. Dr. Tally, if I could just ask you a quick question? What year did you initially start your—

Dr. TALLY. We started the process in 1992.

Mr. CHABOT. '92. And the cost was $50,000 I think at that time?

Dr. TALLY. Back then.

Mr. CHABOT. That is what I was thinking because I know Dr. Bort said it was $228,000 in his practice. So we are basically talking '92 versus 2006.

And I think both of you mentioned that one of the initial things that you either hadn't anticipated or didn't appreciate was the maintenance of this system, monthly payments and upgrading it, and that sort of thing. Would you both like to just touch on that briefly maybe, Dr. Tally and Dr. Bort?

Dr. TALLY. Well, upgrading it is no different than the similarity which many people are familiar with, like opening up a Word document, Word 2003 versus Word '97. We all know that a Word 2003 will not decode a '97, which is why the Library of Congress is having so much trouble.

So innovation is great, but you have to keep up with it. And as you keep up with that, again, there has been no standardization.

As I was talking about with the Chairwoman, if you have a basic function, then you can add features on such as the cell phone analogy. You may have all of these features in the cell phone, but you still use a number. Even it has a voice recognition, it is a number

that transmits. So you have that basic function. You can add on any other "gee whiz" features that you choose.

But we should have all the vendors come to a common agreement that there is a platform with which we will persist. And then that will be the interoperable platform.

Mr. CHABOT. Dr. Bort, did you want to touch on that?

Dr. BORT. Well, it was a shocker to us because of the sticker shock of the initial outlay. But then the ongoing upkeep and enhancements as we got further into the system and dependent, to be honest, where we depend upon it. So we are obligated to upgrade it and make sure that we have the latest version because, for example, there are drug interactions.

Well, there are no drugs coming out monthly. So we have to make sure that our software when we are prescribing, eventually when we hope to do that via voice, that will help us to know that we are catching all of the possible reactions for patient safety.

Mr. CHABOT. And, Doctor, let me follow up, if I can. You had mentioned about what you believe Congress should do, how we can be helpful. And you had mentioned—and this goes along with the cost—perhaps some tax incentive that would help those that are doing it now and maybe those that are anticipating it in the future, maybe make it more likely for them to modernize.

I would assume that at this point in time the equipment that you purchase, you know, depending on how many years it is going to be good for, you can deduct that from the tax of the partnership or if you are a Sub. S or whatever you are individually, whatever.

What you would prefer to have, something that would be more of an incentive, a tax credit or something. Have you thought about that?

Dr. BORT. Well, I can't speak specifically as to tax credits, but I will say this, that, for example, what you all in Congress have done with the Medicare D incentives for encouraging us to go for E prescribing, I believe that is a step in the right direction. I think it is a small step, but that is, for example, an incentive that will help us with the costs that we are incurring.

As to the tax incentives, we are just struggling with the overhead. We are drowning in overhead. And this was one that we didn't foresee. It is one thing to deal with the overhead with our staff and salaries, benefits, et cetera. But now with the upkeep costs—and once we are down the road with this EMR system and committed to it, when they say that, you know, "This version is going to be necessary if we want to get results" down the road from the hospital, then we are obligated to take that step.

Mr. CHABOT. Thank you, Doctor.

Let me go to Dr. Plovnick and Dr. Hale next, if I could. I guess in the fields that you are in, both psychiatry and obstetrics and gynecology, you emphasize the privacy issues and the sensitivities that might be there if personal information gets out. And that would seem obvious.

I know up here, just as a member of Congress, I can tell you I was one member whose computer system got hacked into by the Chinese. And there were other committee chairs who got hacked in. We think the Chinese probably chose us because I am one of the Co-chairs of the Congressional Taiwan Caucus. And we have also

been pretty outspoken on human rights abuses in China. So we were one of the ones that got hacked in.

We had the incidence of an IRS agent recently who was snooping into the IRS returns of celebrities and things. So there is always a concern out there about information.

Are there any suggestions that the two of you might make to us or anything that we can do to improve the concerns that might be out there about privacy issues relative to the electronic records in the medical fields and your fields?

One or both.

Dr. PLOVNICK. Offhand there are two types of situations, where information could be disseminated. One is a security-related issue with hacking, as you mentioned, where an outsider gets into the system and accesses information. And there are a variety of technological solutions to prevent that in terms of encryption and password protection and protecting the information as it goes online. Any system with sensitive health information needs to have that level of protection.

Another situation where information can be accessed is actually be somebody who may have legitimate access within a system. That is in the situation of celebrity records being accessed. Those are often by people who do have access to the system, hospital staff or IRS staff, in the situation you mentioned.

So in that situation, having as strict a control over information as possible, having more than just all or none access to records but really limiting access to those who are authorized to use it and standards built in from the start that allow that level of protection really help protect sensitive information.

Mr. CHABOT. Thank you.

Dr. Hale?

Dr. HALE. Yes. Thank you, Representative Chabot.

Obviously externally you can have firewalls. You can have coded entry protection. One of the problems our fellows see is that, with no ability to transfer records from one platform to another platform the greatest breach of security happens when a contractor goes into the record to move it to another platform. You can't always say that that individual, who is transferring records from one platform to another will retain the information's privacy.

Just as you said, there are people out there who, even though they talk about how secure their record is, when they get to another platform, somebody has had to breach that security.

That is one of the problems we face with this lack of ability to move medical records. I hadn't originally thought about it, but I think the cell phone analogy is very true. Let me just give you an example that we have found.

As I indicated earlier, we have made our record available free of charge. We have an outstanding antepartum record for pregnant women. It is used by hundreds of thousands of pregnancies every year. We have said we will make it available to any electronic vendor that wants to use that record.

Yet we have a few vendors who are actually using it. We have others that are using part of it and want to use it. And why will they not use it? They don't want to make certain that anybody else could use it or that it is compatible with other groups because it

ultimately compromises their ability to retain business and threatens their profit margin. That is where we see the greatest difficultly.

If we had a consistent platform, our records could go to Dr. Bort's physicians. Obviously with Dr. Gotlieb, our records need to be compatible. And, yet, they are not. So every time you have to share that record with some other system, you run the great risk of loss of security. That is where one of our biggest problems is today.

Mr. CHABOT. Thank you.

Dr. Gotlieb, did you want to respond? Then maybe I will ask a question.

Dr. GOTLIEB. Could I, please?

Mr. CHABOT. Yes. Okay.

Dr. GOTLIEB. For pediatrics, there are state jurisdiction issues on privacy. So if I have to send a record to Alabama, which has privacy protections for the adolescents in my practice, the things are different in Alabama. So my computer would not only have to be interoperable, but it would have to take in specific legislation in a different jurisdiction. And once you start doing that, you get into great trouble.

Our trouble for a lot of folks is not trying to worry about whether the Chinese are going to break in but whether the parents are going to break in. You know, if I have a patient who comes to me with abdominal pain because her boyfriend is yelling at her a lot and I find out that she actually has appendicitis, I have to deal with the reality with an electronic health record, within a note, of protecting the psychiatric information in that visit with the physical information in that visit. I have to deal with the interface between the parents' right to know and the adolescent's right to privacy.

Mr. CHABOT. Thank you very much, Doctor.

I yield back, Madam Chair.

Chairwoman VELÁZQUEZ. Mr. Gonzalez?

Mr. GONZALEZ. Thank you very much, Madam Chair.

I am going to make some observations so that there is kind of a frame of reference. The medical profession I think needs to understand where this is legislatively and where it is all going so that you can become part of it so that your voices are heard, so that your considerations and your observations and your input are part of the final product.

I will put it this way. I believe that health information technology, electronic medical records, whatever you want to call it, that the train has left the station. And let me explain why.

One, I think the government has determined that it is an effective way of saving money. And for government, budgets are big things. And because the government has such a state financially in providing health care services, it will be heard.

Number two, I think the private sector is already on it. I think you all have your own experiences in dealing with private insurance companies of what they may insist in the way that you may submit for your billing and so on and what information. It is happening. You have got Google out there now that is providing some sort of a service regarding an individual who may want to create some sort of an electronic medical record file.

All these things are moving forward. It is just a question of whether we are going to take your real life experiences and factor them in. And I think that is totally essential or it is not going work. So you are needed. That is one thing that I want you to understand.

In my discussions with members of the medical profession and teachers and such, I don't know if it is generational. It is in a lot of other professions. I came from the legal one. And when we went from hard copy and my big law books and my CD-ROM, I went nuts. My mind wasn't even—I couldn't even digest the information. I was so used to the way that it was already. I mean, you all probably would shake your heads in agreement. It is the same thing.

I know that in medical schools and such, these recent graduates are pretty savvy when it comes to what is going on out there in the electronic world. They are fully embracing it. It is just a matter of whether you have the systems for these entering doctors to utilize.

The other observation, let us not confuse privacy with security. That is so important because, as members of Congress, we have a problem with that when we discuss legislation. We will always have concerns about privacy. Medical records privacy in the hierarchy of privacy concerns is at the very top because of the nature of it. I mean, we understand that.

But let us not go—security is another thing. That is the other component. We understand privacy and the precautions we are going to take and the policies. And we will have federal standards for that.

I also believe that in due course—and it is going to happen much sooner, and the medical profession has to be more nimble than other professions. I think electronic records are actually going to be part of a standard of care.

I think, Dr. Tally, you said it took ten years for doctors to finally say, "We are going to have stethoscopes." Maybe the stethoscope of the Twenty-First Century or something is electronic medical records, but it is going to be part. It is going to be a factor and a component as to say whether you are truly practicing state-of-the-art medicine in today's society because the question will always be posed, "Well, if you had had electronic medical records and you had had access to this because every other doctor does but you don't," I think there is a very, very serious question that we are going to have there.

I will agree with each and every one of you about interoperability, about federal standards. We are working on that. We are not just going to go in there and mandate or reward or punish someone for the lack of utilizing electronic medical records.

Without understanding the cost of it—and I am going to get into the cost in a minute. Yes, we will have standards. And then, of course, you can fine-tune it regarding what is the specialty. But I think also there is tremendous education that is lacking as to what you really need basically to probably comply with what the federal government is going to require.

Now, there are two ways of doing this: you know, positive or negative incentives. And we have been talking about it. There are all

sorts of these bills out there. One of them is mine with Dr. Gingrey. We have got tax incentive. We have got grants. We have got loans. We understand that. And we need to be providing that.

The other is obviously enhancing how we reimburse physicians when it is a federal dollar being paid for the health care that is being delivered. I believe in positive incentives, but you need to understand that there are those in government that believe that the negative incentive works just as well.

And we can go over if the Chairwoman would just give me some additional time to come back visit this, about how we are going to do that, the negative incentives are basically being punished for not complying with some sort of a standard in having electronic records.

And we have people in very high positions that believe that is the way to go. I disagree, but we really need for you to be part of this debate and removing all obstacles because it is coming, it is happening. Believe me, it would just be part of your practice. There is nothing you can do to delay it much because it is going to be implemented.

I know that I have gone over time, and I haven't asked the one question I want. So I will just yield back and see if the Chairwoman will give me—

Chairwoman VELÁZQUEZ. We will have a second round.

Mr. GONZALEZ. We will have a second round?

Chairwoman VELÁZQUEZ. Sure.

Mr. GONZALEZ. Thank you.

Chairwoman VELÁZQUEZ. Mr. Buchanan?

Mr. BUCHANAN. Thank you, Madam Chair.

I got in late, had another meeting, but I want to recognize Dr. Tally is from our congressional area. And I appreciate your effort, energy coming up here because I know all of the doctors are busy.

Again, I don't want to be redundant. Maybe it was said. But what is did you find your return on investment in terms of energy and time and the investment? I am sure you probably talked about it, but I hear so much about these electronic records. And it is going to save us a lot of money.

I am sure I agree with the congressman. That is the future. I was just curious as it relates to your practice. What have you found the efficiencies? Have you been able to have less employees or what has happened, in essence, as a result of putting your system in?

Dr. TALLY. Sure. Thank you.

I was just discussing this with my administrator, who has been through this process with me, this tripled process over the last 12 years. ROI, and even when I give some of the seminars on teaching it, is very difficult to link to a financial number because it is an ongoing cost of doing business. We just made the commitment years ago that this was going to be a better way to deliver health care.

ROI is more physician satisfaction. Are there cost savings? Clearly when we first did this system, our transcription costs dropped 90 percent. But, as someone pointed out, it is a paperless system, not a paper-free system. So you still have a lot of the world who sends you paper, even if you are electronic.

Now with voice recognition—and we are in the up front with doing voice recognition. This is going to give us some cost savings, even off the last ten percent. Technology has gone forward.

Am I going to get an ROI on that when you then calculate in the upgrade cost and cost of doing business, such as was mentioned when it was sort of a shock figure? It is going to be very difficult for me to tell any physician "Oh, this is how much it is going to save you" because, as costs of staff and everything else goes on, it may just keep you from going under faster in today's current market.

Mr. BUCHANAN. Yes. I think it is inevitable. I think the other thing that has been brought up just since I have been here is the whole generational thing. I know a lot of doctors in their 50s. And they are just hoping to get their retirement. They don't have to get involved. They know it is coming. But I am just interested to see how that is going to play out over time.

You know, it is one thing to have electronic records. It is more efficient. Then it is another thing to force people or encourage people, however you are going to do that, to change the way they have been doing things for 25-30 years. And we have a lot of physicians you know in our area that are in their 50s thinking about retirement in 10 years, 5 years. And I know it has been touched on a bunch here today.

What are your thoughts? Any additional thoughts on that?

Dr. TALLY. Our current thinking is if you are not thinking about practicing more than five years, don't bother because the transition of the costs and then trying to make it proficient enough for you in a small practice is probably not worth that with one exception. And that would only be that if you intend to sell your practice someday. Whoever buys your practice is going to want an electronic format, absolutely.

The unusual thing about who is willing to adopt and who is not is typical even among the neurosurgeons across the country. It has been somewhat of a dichotomy. I find just as many of those who are in their 45 or 50-year age group who want to embrace electronics and their junior partners do not want them to invest.

And, as someone said, we have all of these residents coming out who are used to the electronic format. They may well be because they were trained on one system, and they are used to that. But as soon as they get out into a regular practice, they are going to suddenly find a plethora of systems that won't cross-talk. And they will be experiencing the same frustrations that you have heard here today.

It is going to be just a gradual paradigm shift. And, unfortunately, it is going to take a lot longer than the vast majority of any of us would prefer.

Mr. BUCHANAN. Yes. I have been in business myself 30 years. We have implemented a lot of systems. It usually takes longer, costs more, but eventually it works its way in and becomes part of the culture of the business. So I think it is inevitable.

Thanks for coming. I don't want to take any more time of the Committee. Thank you, Madam Chair. I yield back.

Chairwoman VELÁZQUEZ. Thank you.

Dr. Hale, the Director of the Congressional Budget Office recently testified that withholding Medicare payments or creating some other financial levy are efficient ways to encourage EHR adoption. He went on to say that if you want to get to near universal health IT in the next five years, it has got to be the stick.

Do you agree that tying Medicare payments to EHR adoption is the best approach?

Dr. HALE. Interesting question. I read what the Congressional Budget Office said. And I think if you look at it from the bigger perspective, yes, the only way sometimes that you are going to get the carrot is when you have the stick.

The small practitioner is going to look at it just the opposite. They are going to say, "It is a cost factor which I cannot afford. And my only recourse to that is I will see no more Medicare patients." And I don't think we want that.

One of the issues, though, that we have not talked about with the electronic medical record—we have talked about the cost, we have talked about the efficiency—is patient safety. We have seen in our own specialty that those people who have adopted an electronic medical record, patient safety becomes a very critical issue and is very important because written notes, things like that that are not easily seem—we all know that it is easy to misstate what a prescription is. Patient safety is a big issue.

That is what we have tried to push in our own emphasis. We haven't tried to push penalties because doctors don't respond well to penalties and to forcefulness. We have tried to push patient safety in the office, patient safety in the hospital. The management of the patient, that is what is going to benefit you. And yes, it is going to cost more at first.

Wwhen I read what the CBO said and at least the Washington Post adaptation of what the CBO said, I think that many doctors would get their hackles up immediately and say, "Wait a minute. You are going to punish me for not having a record when I would like to adapt to something that is reasonable and cost efficiency" because I understand the young people like the record. But let me give you an example outside of patient care.

In our organization with our Executive Board, most of the physicians are at my age, maybe a little younger. But we have instituted totally paperless meetings. Everything is done by the computer. We thought people would object to it.

We recently decided to hold a meeting outside of Washington, D.C. And we were going to have to go to paper. And what was the biggest complaint we got? "It is not electronic. We want to go back to the electronic. We don't want all of those papers. We don't have to carry a folder."

So I think physicians are willing to adapt. As Mr. Buchanan said, I think physicians will adapt to it. I think they are willing to put it in. I think it is the factor of costs given the already reduced Medicare payment. Fortunately, the 10.6 percent didn't go into place.

So I think they are willing to do it, but they want to be able to show that it does work, that they can continue to see their patients, and that they have a compatible record. They don't want to pay for have a record today, spend the $40,000 to $50,000, and next

year be told "That record is obsolete. You have got to put another 40 to 50 thousand."

That is not only difficult for the physician. It is difficult for the patient. And it is extremely difficult for the staff.

Chairwoman VELÁZQUEZ. And, Dr. Hale, for this Committee, that is basically the most important issue. How can we help solo and small practitioners to adopt IT? And we will be looking into legislation that will provide ways to be able to provide affordable financing for the adoption of IT for small practitioners and solo practitioners. And we are going to be working to see if we could craft legislation that will provide the mechanism where we can use the Small Business Administration loan programs to help achieve that goal.

With that, I would like to ask Dr. Gotlieb, under the Medicare physician fee fix bill that passed here in Congress, are those physicians offered incentives to purchase if prescribing systems. Like most health IT funding if prescribing incentives are structured to flow through the Medicare program. This funding structure does not apply to Medicaid payments.

As a result, do you see pediatricians moving more slowly towards e-prescribing?

Dr. GOTLIEB. I don't think pediatricians are moving slowly toward it. It is an Academy policy that we approve of and urge our members to go to e-prescribing. Most of the things pediatricians do don't have a whole lot to do with money or we wouldn't be in pediatrics. We do it because it is the right thing to do. And e-prescribing would really be a help for us and others.

So we would certainly like to find some way to enhance the income to the practices. And e-prescribing would be a method to get it to us.

You know, if you went to the adult community and tried to drop Medicare by ten percent, you would have an insurrection. If you tried to give us 90 percent of Medicare, we would be dancing in the aisles.

[Laughter.]

Chairwoman VELÁZQUEZ. Okay. Thank you.

Dr. Bort? Dr. Bort, despite the challenges your practice has encountered implementing its system, you remain a strong supporter of health IT adoption. How did your previous experience as a health IT vendor make adoption simpler for your practice?

Dr. BORT. I believe you are referencing my experience with Pocketscript—

Chairwoman VELÁZQUEZ. Correct.

Dr. BORT. —that Steve Burns and I started, actually out of our pain. One day I was realizing that most of my day, a great part of my day was spent scribbling prescriptions on pieces of paper that flew out of the office. I wasn't sure how legible they were and how they were interpreted, drug interactions and so forth and so on.

So I have a passion for e-prescribing because the second largest paper transaction in our economy happens to be prescriptions, upwards of 4 billion. I know the number 3 billion was mentioned earlier, but I have seen data up to 4 billion pieces of paper with scrib-

bles floating around sometimes. Hopefully they make it to the pharmacy and they are filled properly.

Well, I think that, unfortunately, perhaps we are ahead of our time, as we were told. We were unable to sustain that back in 2000. But going from that step back into full-time practice, I was convinced that we had to draw a line in the sand sometime, we would never have the perfect EHR system out there that we had to start.

And amongst our group, there are 12 of us. And it has been somewhat of a bell-shaped curve. There are some early adopters, as was mentioned earlier by Congressman Chabot. A few of the partners surprisingly—and this was referenced earlier—some older, some younger, were really gung-ho for it. And that really drove the passion in our office to follow through with it. Others were less likely and less comfortable. We sort of had to drag them along.

But we looked at different options, such as voice recognition software, that one of my partners, middle-aged, two middle-aged and one younger doc, who preferred dictating and have voice recognition. So that has helped the adoption. I think once you make the commitment, there is no turning back.

One of the problems we have faced is what happens when the power goes down. What we have found has happened a few months ago, that we were helpless, that everything depended from the phone systems in our office to the front office, back office. And that was a big impairment. For a day or two, we had to resort to paper. And it was so archaic to fall back to that. And we realized that there is absolutely no turning back.

Chairwoman VELÁZQUEZ. Thank you.

Now I recognize Mr. Chabot.

Mr. CHABOT. Thank you, Madam Chair.

I, first of all, want to once again commend you for holding this hearing. This is really very important. It has been very enlightening to me and I am sure the staff that is here and the other members.

It is such an important issue. And most of the doctors that we are talking about really do fall right in the small business category, which is the jurisdiction of this Committee. And so it is a perfect thing for us to be talking about.

I also wanted to mention I can certainly relate to what Mr. Gonzalez said before relative to when practicing law, the challenge that there was when we went from paper and books and Westlaw and all of that to the computer. And then it was just sort of mind-boggling.

I had to sort of laugh when somebody hit McCain recently because he was sort of mystified by the Internet and technologies. And it might be to some degree an age thing, but you can sort of relate to it.

Rather than us moving forward with this, I think we would probably be wise to get input from our fellow colleagues who happen to have been medical doctors and practicing medical doctors before they got here, both the House and the Senate, both Republicans and Democrats, because we have quite a few. And I think we ought to also rely upon some of the things they have experienced and their instincts in this area.

Finally, rather than ask a specific question, I would just ask anyone who would like to comment, is there anything "I wish I would have made this point when I was testifying" or, you know, "I wish they would have asked me this. One thing we really didn't touch on, you know, that we probably should have in afterthought"? If there is any one thing that you just want to suggest that perhaps we look into if you want to comment? If we have covered everything, that is fine, too, because this has been a pretty comprehensive hearing.

And I will just go down the line. So, Dr. Tally, if there is anything you want to sum up with or bring up that we didn't talk about, for that matter?

Dr. TALLY. Thank you.

I think there are two issues. One, you just addressed, which is, unfortunately, right now a lot of comments are being made by those who neither build systems or actually have to operate them.

I liken this to the fact that I may enjoy the benefits of air travel, but Boeing is not asking me how to build a plane, and I am not telling the pilot how to fly or asking every pilot to be in a 747.

The second issue—and so asking those of us, the people who are going to build the systems and the people who have to use them, how to get—as you have said, that is critical to making sure we have some type of accepted usage throughout the nation.

The second thing is what has just become available, which is still going to be a huge stumbling block. And that is e-prescribing. It looks very good from the top down. The pharmacies and some of the big companies have done a great job establishing the freeway, but getting everybody a car on it right now is going to be the real challenge.

And right now one of the things that has held us back, as is many specialties, is because we do have to do a lot of prescribing of narcotics. What we do involves that a lot, the Schedule II drugs. And the DEA finally because of your efforts, you all managed to get the DEA to say, "Okay. We will allow you electronic prescribing."

They just established some rules, which are in my estimation right now a poison pill. There is in my estimation no way that under the current proposed rules that the vast majority of doctors will undergo the details and rigid rules that the DEA has proposed in order to do what they are already doing for other non-Schedule II drugs. We do this every day. And to get us to allow that rule or those types of encryption and onerous procedures when most of us would spend ten seconds writing a prescription, it will force many people to get off of it entirely.

So I know that this is a proposed rulemaking, but I would just ask you to look very closely at that process.

Mr. CHABOT. Thank you, Doctor.

Dr. Plovnick, anything?

Dr. PLOVNICK. Thanks for the opportunity.

Just to emphasize that a lot of concerns about protection of sensitive information have been raised at the table today. And the earlier the infrastructure is built in to protect that information, the easier it will be to incorporate it in a system.

If you have a wider degree of adoption than we currently have trying to plug in privacy protection of sensitive information at a

later stage, it will make the matter a lot more difficult. So now is an excellent opportunity to address those issues.

Mr. CHABOT. Thank you.

Dr. Gotlieb?

Dr. GOTLIEB. Since you asked, care of children in this country shouldn't be a partisan issue. In the last fiscal budget, when you remove military kinds of fundings and stuff and you look at what has happened, one percent of the budget went to children's issues of new spending. And I can get you the reference.

If we are really serious about taking care of the next generation, we need to start finding some ways to take better care of kids.

Mr. CHABOT. Thank you, Doctor.

Dr. Hale?

Dr. HALE. Thank you very much.

I would just like to reemphasize again the Gingrey-Gonzalez bill, H.R. 2377, that I think that is a very good first step because it increases the IRS tax deduction for HIT purchase. And it also doubles the depreciation in the first year. That will be a big help.

I would also like to say that my own personal health care is given to me by the Medical Faculty Associates at George Washington University, which is here. They have a very strong integrated HIT program. And if you need to see a program where doctors can write a prescription and you can walk down to the hospital pharmacy and pick it up or to the physician's office and pick it up and when you go in for your routine colonoscopy, which I did not too long ago, and have all of your record just routinely transferred over, they have a very good system, which is I think the type of thing we would like to see all of medicine have.

Mr. CHABOT. Thank you very much, Doctor.

And last, but not least, Dr. Bort?

Dr. BORT. Thank you.

First and foremost, I am a small business. And I live small business. I love small business. I think that is what drives our country. So bless you all for doing this important work.

One thing that was not mentioned earlier, it was told to me that we would be able to decrease the number of employees in our office when we went electronic. The good news is we got rid of 28,000-plus charts. We have some more space. But we have not been able to decrease full-time equivalents, which, again, is affecting our overhead.

I do believe voice-activated software programs are—that is the easiest thing that we are all used to. And there are a number of platforms out there that are being developed. And I believe that will be the most user-friendly personally. And I had mentioned earlier about putting this software and these devices in the hands of medical students and residents because that is the future for the children that we are hearing about and so forth in going forward, I believe. They are used to that technology, as was just mentioned by Dr. Hale.

Another example where this is being done well, I believe, is the VA system. Now when I get records from the VA on a patient, they are very concise and legible and very well done.

Thank you.

Mr. CHABOT. Thank you very much, Doctor.

I yield back, Madam Chair.

Chairwoman VELÁZQUEZ. Sure. Mr. Gonzalez?

Mr. GONZALEZ. Thank you very much, Madam Chair. And you don't know how much we welcome your input on this because I say if it is going to be successful, can't do it without the person on the ground that deals every day with the patient in how to best meet those needs.

I will give you a real quick example of something. And I don't know how we get past this other than we are going to set some minimum standards and such so that when you do make that investment, you are getting something that basically is understood by everybody, interoperability,—that is a given—and so on, but I have a small application software vendor in San Antonio. She is absolutely brilliant. She is wonderful and made quite an investment. So I go, and I get briefed by what she has to offer the medical profession in San Antonio.

I go to my cardiologist. And I am sitting there. And his wife is the office manager. So I just said, "Where did you purchase your electronic medical records?" And they tell me about this big, giant national firm.

So I said, "Well, do you know about" so and so "who is here locally?" And she is a local leader and everything else.

So "Yes." And they had made their presentation, and they considered it.

So I asked the officer manager, who is the real boss, the wife. And I asked her, "Why didn't you all buy that system?"

She said, "Well, because my husband," the cardiologist, "wanted something with all the bells and whistles."

I said, "But did the local vendor, what they offered, meet the needs?"

And she said, "Yes. We don't really use all the bells and whistles that my husband wanted, but that is the way he is about cars, too."

[Laughter.]

Mr. GONZALEZ. So I am just saying that I think there are some basic systems out there. And I know they need special tweaking because of cardiologists, just like a neurologist. It is going to be different from the family practitioner and so on. But I think that it is out there.

The question that I have is, how are you making your voices heard? Each of you who is in a specialty obviously has an organization, an association. Are they coming together and identifying the special needs of your specialty in making sure that that is being reflected?

I don't know. Look, the American Medical Association is engaged. Don't get me wrong. And that is the big umbrella. But I am just talking about something that Dr. Tally has made reference to a couple of times. And that is, again, tailoring things to make sure that they meet your needs.

So just quickly if you will tell me what efforts are being made within your own specialty, with your own group, within your own association to be able to communicate your special needs?

Dr. TALLY. Well, as you said, every specialty is different. It is somewhat based on size. The American Association of Family Practice has done a fabulous job. They have a very intense IT depart-

ment that has done a great job of promoting them. I am strongly in favor of that because that is where you, the congressmen and the government, need to work. And it is primary care.

People like me, we are one percent of the physicians. Getting us up and running is a challenge for our association. And we have our own internal committees. And, as you have seen, I am also working with the AMA for this. The bulk if you can get anything to do 90 percent of the work, our challenge is to get 90 percent of the people who give 90 percent of the care. And that involves family practice, ob, pediatrics. The rest of us will come along in time.

So the time and the effort to be spent by Congress, vendors, associations is where the vast majority of health care is being given, just like for the areas where we spend most of our money in Medicare: CHF, MI, diabetes, pneumonia. That is where the bulk of the savings has to come. And that is where HIT will deal its greatest benefit.

Mr. GONZALEZ. Good point.

Dr. PLOVNICK. At the American Psychiatric Association, we have a committee of members specifically focused on electronic health records. They are early adopters who picked this up now. And a part of what they do is articulate some of the needs that they have for software in their various psychiatric practices. And this information is made available to members on the Web site and in other forums.

And we actually have members who have adopted software. They have an opportunity to share their experiences with software on their Web site so that members can learn from other psychiatrists who have already adopted the systems. That is some of the activity of the APA.

Dr. GOTLIEB. The American Academy of Pediatrics has many policy statement, position papers on what we need. We are not talking about pie in the sky stuff. We have specific issues that can be dealt with with such a small part of what the vendors considered to be their market, that they have a real interest in not listening to us sometimes.

We are required in the State of Georgia to report immunizations to the immunization registry. I was on a committee with the State American Academy of Pediatrics going to the vendors one by one and them telling us "Yes, we will do this. Give us yet another $100,000 per practice just to integrate your EHR or your practice management system into that. And we will be glad to think about it in the next iteration of the software."

We have things that we can offer. It is out there. I would be glad to present it.

Mr. GONZALEZ. Thank you.

Dr. HALE. I am fortunate at the American College of Obstetricians and Gynecologists, I am the one that makes the decision as to where we are going. And our Executive Board has directed that one of our top priorities is to have all of our Fellows using an electronic health record.

At our annual clinical meeting, we now bring in as many as 24 different vendors and make them available so our Fellows have the opportunity to meet them.

We are pushing it very hard. We would like to see by the year 2015 that every ob/gyn in the country is using electronic health records. I don't think we will succeed, but that is our goal. Unless you have a goal to reach for, you will never get there.

Dr. BORT. As a family doc in the trenches of primary care,—as I like to say, that is where I live and work,—I know how important it is to our small business.

When I think back, I can't recall any edition of the American Academy of Family Physicians that hasn't had some article, either encouraging us, instructing us, or putting together guidelines to help us implement EHR into make us realize that it is imperative that we embrace these standards.

The most important concept that is developed is that of the medical home. And for the medical home concept to work where you see your family physician for your health care needs, the EMR is actually mission-critical to having that come to fruition.

Mr. GONZALEZ. Thank you very much, Madam Chair.

Chairwoman VELÁZQUEZ. Okay. Well, again let me take this opportunity to thank all of you for taking time to come before this Committee.

And let me say that we know that there are different legislative proposals moving through different committees. Just Wednesday the Energy and Commerce Committee reported out the H.R. 6357. And the Ways and Means also is considering legislation as it pertained to IT. And I just want to make sure that this Committee plays a role in making sure that the perspective and the challenges faced by small practitioners are heard. And we will do everything that we can.

So, with that, let me just say I ask unanimous consent that members will have five days to submit a statement and supporting materials for the record. Without objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 11:50 a.m., the foregoing matter was concluded.]

NYDIA M. VELAZQUEZ, NEW YORK
CHAIRWOMAN

STEVE CHABOT, OHIO
RANKING MEMBER

Congress of the United States
U.S. House of Representatives
Committee on Small Business

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STATEMENT
of the
Honorable Nydia Velázquez, Chair
Committee on Small Business
Full Committee Hearing on:
"Cost and Confidentiality: The Unforeseen Challenges of
Electronic Health Records in Small Specialty Practices"
Thursday, July 31, 2008

In the last few decades, information technology has revolutionized virtually every American industry. Today, previously complex and time consuming tasks can be easily accomplished with the click of a mouse. But-- as with any large-scale shift or system overhaul-- the adoption of new technology comes with certain growing pains. Nowhere is this more true than in our nation's health care sector.

By the year 2014, the National Information Technology Coordinator expects the U.S. to have a nationwide network of electronic health records. Today, several bipartisan proposals supporting this network are working their way through Congress. Both Democrats and Republicans recognize the value in HIT. After all, it promises to not only control costs, but also to improve quality. That is an especially appealing prospect, given the skyrocketing price and declining value of modern health care.

In today's hearing, we will discuss the value of HIT, and also explore the various concerns surrounding its use.

If properly implemented, HIT can streamline the flow of complex health care data. In doing so, this technology will improve communication between doctors and hospitals. And given the inherent complexities of medicine, a well-structured communication network is of the utmost importance.

But despite growing support for health care technology-- particularly in the form of Electronic Health Records, or EHR--small practices have been reluctant to take it up. Whereas 57 percent of large care centers use EHR, only a handful of solo practitioners do. This is partially due to the high cost of implementation.

When all is said and done, the price tag of EHR installation comes to over 32 thousand dollars per physician. Meanwhile, monthly maintenance fees run close to 12 hundred dollars. By the time hidden costs have been factored in, final estimates can be 44 thousand dollars per doctor, with upkeep fees of 85 hundred dollars a month. For small health care providers with limited resources, these upfront costs are enough to break the bank.

In addition to the weighty financial obligation, a series of legal and privacy concerns have deterred small health practices from adopting HIT. As a practical matter, electronic information can be transmitted and reviewed more easily than paper files. In light of this fact, some health professionals worry that HIT holds potential for health care fraud. At the same time, others are concerned that the technology might conflict with confidentiality issues outlined in the Health Insurance Portability and Accountability Act, or HIPAA.

Finally, some specialty doctors--like neurosurgeons and pediatricians--are unable to find appropriate HIT systems. Oftentimes this technology caters only to mainstream medical practices, leaving the smaller, more specialized businesses behind.

Health Information Technology has the potential to revolutionize American medicine. But unfortunately, a series of concerns are blocking large scale implementation. There is no silver bullet solution to America's broken health care system. There are, however, a number of ways to address the issue. For one, financial incentives to HIT users would help spur uptake. So would strengthening privacy regulations for health records.

As we move forward in the quest to improve health care coverage and cut costs, we can look to current technology and future innovation. And yet in doing so, we must be sure to act with caution. Otherwise, we risk jeopardizing both small providers and the health and security of their patients.

With that, I'd like to thank all the witnesses in advance for their testimony. I look forward to their insight on the matter, and now yield to Ranking Member Chabot for his opening remarks.

U.S. House of Representatives

SMALL BUSINESS COMMITTEE

Representative Steve Chabot, Republican Leader

Thursday, July 31, 2008

Opening Statement of Ranking Member Steve Chabot

Cost and Confidentiality: The Unforeseen Challenges of Electronic Health Records in Small Specialty Practices

Good morning. Thank you, Madam Chair, for holding this hearing on an important topic. I'd like to thank each of our witnesses who have taken the time to provide this Committee with their testimony. I'd like to extend a special welcome to fellow Cincinnatian, Dr. Thaddeus Bort, who I will introduce later.

Over the past 30 years, nearly every sector of the American economy has undertaken a sweeping transformation in the way information is collected, managed, and transmitted. As a result, productivity and efficiency consistently has increased. Yet today, health care - one of the most significant sectors of the American economy - has not made this transformation. However, this is beginning to change.

Some of the most serious challenges facing health care today – medical errors, inconsistent quality, and rising costs – can be addressed through the effective application of health information technology. Linking all elements of the health care system improves information available to physicians, boosts quality, enhances preventive care, and reduces errors.

On April 27, 2004, the President signed an Executive Order which established the position of the National Health Information Technology Coordinator within the Office of the Secretary of the Department of Health and Human Services and announced his commitment to the promotion of health information technology to lower costs, reduce medical errors, improve quality of care, and provide better information for patients and physicians. In particular, the President called for widespread adoption of electronic health records and for health information to follow patients throughout their care in a seamless and secure manner.

A September 2005 report by the RAND Corporation estimated that $77 billion annually would be saved if 90 percent of physicians adopted health information technology. The report also estimated another $4 billion in savings from reductions in prescription errors. A new report indicates more than 35 million prescription transactions were sent electronically in 2007, a 170 percent increase over the previous year.

Despite documented advantages and federal support, physician adoption of health information technology has been slow. Research indicates that concerns about high cost, uncertainty of return on investment, and worry over the usability and obsolescence of new technologies rank highest among reasons surveyed physicians have not yet adopted health information technology. Doubts about the privacy and security of patient data, practice compliance with the Health Insurance Portability and Accountability Act of 1996, and the potential for inappropriate disclosure of patient information to third parties rank just behind financial concerns.

Health information technology is a complex issue. The decision to implement health information technology in a small medical practice is considered an act of courage by many physicians. It will impact their workflow, staff, patients, and practice finances. Successful adoption of health information technology including electronic medical records will require evaluation, selection, planning, implementation and effective use of the technology. Early adopters agree that there are multiple benefits but recognize a cultural change is required.

Madam Chair, I look forward to working with you on this important issue. Again, I thank each of you for being here today and I yield back.

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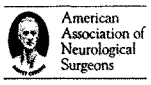

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Statement of

Philip W. Tally, MD

on behalf of the

American Association of Neurological Surgeons

and the

Congress of Neurological Surgeons

before the

Committee on Small Business
U.S. House of Representatives

July 31, 2008

On the Subject of:

Cost and Confidentiality: The Unforeseen Challenges of Electronic Health Records in Small Specialty Practices

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Testimony of Philip W. Tally, MD
Before the House Committee on Small Business
Hearing on "Cost and Confidentiality: The Unforeseen Challenges of Electronic Health Records in Small Specialty Practices."
Thursday, July 31, 2008

Good morning Chairwoman Velazquez, Ranking Member Chabot and Members of the Committee. Thank you for inviting me to appear today to discuss the challenges small physician specialty practices face in adopting electronic medical records. My name is Doctor Philip W. Tally and I am one of three neurosurgeons in a small, full-service neurosurgical practice in Bradenton, Florida. I am here today on behalf of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, which represent 4,000 neurosurgeons in the United States. I also currently serve as the Chairman of the Florida Medical Association's Health Information Technology Committee and I am a member of the American Medical Association's HIT Advisory Panel. I'd like to spend my time with you this morning telling you my story about how we integrated electronic medical records (EMR) into our practice, some of the challenges we faced, the costs we incurred and, ultimately, the benefits we have reaped both for our practice and our patients.

Our practice was the fifth medical practice in the country and the first neurosurgical practice to go fully "paperless." In 1992, after looking at different electronic systems for several months, we decided to purchase a text-based system. Implementing this new system was no easy feat. We could not simply plug in the machine and flip the switch. Because these systems are typically set-up in a one-size-fits-all manner, it required approximately 1,000 hours to configure our system and create neurosurgical templates since there were no existing specialty-specific programs. All tolled, implementing this first system required about one year of preparation time to purchase, configure and implement the hardware and software.

The costs of setting up and maintaining this system were also fairly significant. We spent approximately $50,000 on the initial setup, which was amortized over 18-24 months. They system also required regular maintenance and upgrades, which cost approximately $5,000 per month. During the early years, our vendor continued to create new systems and

upgrades for both the EMR and practice management programs and neither upgrade was seamless. Every "improvement" resulted in some unintended consequence that required a software engineer's time to repair.

In addition to the direct financial expense our practice incurred when we first implemented our EMR system, we also experienced additional costs. Implementing this system was particularly difficult on the staff and not everyone was pleased to move to this new practice paradigm. These changes, coupled with the daily stress of working in a busy full-service neurosurgical practice, simply proved too much for staff. We had a 30 percent staff turnover rate, which was considered standard, as staff had difficulty in adapting to and learning entirely new office procedures and methods. This produced problems with continuity of patient care and loss productivity in the practice as we went the through process of hiring and training new staff.

As our practice transitioned to an electronic format, we also had to keep the paper records in addition to our EMR system. Interoperability was not even a concept at that point and there was no "talking" between systems. Every paper document had to be scanned and transferred into the EMR or practice management portion of the record.

Notwithstanding these challenges, once implemented, the physicians and our staff recognized the benefits of going paperless. The efficiency of the practice increased significantly. Staff no longer had to go searching for paper charts to answer patient phone calls and they could quickly get information to the neurosurgeons. Our ability to review and create new charts allowed us to spend more time with our patients. We improved our communications with other physicians since the completed patient record was never misplaced, it was always legible, and all test results resided in a distinct "folder" within the electronic medical record.

In 1997, we converted to a Windows-based system. This required us to use a graphical user interface (GUI), so our data could be "seen" in the Windows environment. At that time, most systems were built around a central server, limiting the amount of work that could be accomplished by office staff. We therefore spent considerable time and money

converting all terminals to be PC compatible, which allowed multiple staff to work within the same program and even on the same medical record at the same time. This significantly expedited patient care since the "back office" was able to ascertain patients' insurance coverage, obtain prior-authorizations, schedule tests, and process insurance claims simultaneously. As a result, patient satisfaction was very high.

Maintaining this system for the past ten years has been a challenge. Hardware has failed, servers have been "hacked", security requirements (particularly HIPAA) are onerous and keeping a full-time information technology (IT) employee in a competitive job market has been difficult. Our software maintenance costs have typically been $1,000 per month, per physician. Increasing capacity for the volume of data is also a challenge. Our system now has up to 8 terabytes (8,000 gigabytes) for charts, we have 6 million scanned documents, and 300,000 x-rays/scans for 50,000 patient encounters.

The UNIX-based system with the GUI is now out-of-date and once again our practice has had to move to a new model. We are using an ASP model based on the ".net" platform. We believe this new environment is the future, but again, implementing this new generation of EMR cost about $40-50,000 to purchase the hardware and software, and practice's monthly maintenance costs are approximately $3,000. This equipment has a 3-5 year lifespan, which means we will have to reinvest $25,000-30,000 in a few years. Neurosurgery is the most complex template to construct, and as with our original system, we have spent a full year working with our vendor to customize the software to apply to a neurosurgical practice. Even with our practice's lengthy history and experience with EMR, this upgrade has been a costly and difficult process, with considerable loss of productivity. Furthermore, and notwithstanding our experienced eyes, after we purchased this system we have found flaws in the vendor's product. These include problems with the billing, prescribing, and documentation elements of the system.

Madam Chairman, as you can see, our practice has been ahead of the curve in adopting EMR. Unfortunately, most physicians have not shared our same experience. Despite the fact that electronic medical records have the potential to improve the delivery of health care, most physicians have been slow or reluctant to adopt these systems. Indeed, in

the July 3, 2008 issue of the *New England Journal of Medicine*, a report entitled "Electronic Health Records in Ambulatory Care – A National Survey of Physicians," found that only 4 percent of physicians reported having an extensive, fully functional electronic records system, and only 13 percent reported having a basic system. We therefore have a long way to go, and it is estimated that a 3-4 year timetable for broad EMR implementation is "optimistic" at best. Perhaps the new electronic prescribing provisions that were enacted in H.R. 6331, the "Medicare Improvements for Patients and Providers Act" will help encourage physicians to implement this entry level mode of EMR. I would point out, however, that over 70 percent of the 3 billion prescriptions written every year are by primary care and emergency physicians – the two groups with the lowest adoption rates of EMR. In addition, despite the government's assurances that e-Rx is ready and waiting, there remain significant implementation issues, such as: end-user (pharmacies) familiarity and compatibility, new (and fatally flawed) DEA rules for Schedule II drugs and rigid rules that may make compliance by most neurosurgical practices difficult.

Congress can help pave the way to widespread adoption of health information technology by passing legislation that will ensure the implementation of standards for interoperability and by providing financial assistance and incentives to physicians and practices. Congress must also be mindful that we cannot rush this process or force physicians to adopt EMR using a "stick" approach, as this will only create more resentment among physicians. Remember, it took over 10 years for the stethoscope to be widely accepted as a medical tool! While it will take time, medicine is on the right path in promoting this conversion. There is general agreement that the implementation of health information technology will improve patient safety, enhance quality of care, result in more efficient medical practice and better health outcomes should follow. We should not deviate from this premise, nor should we rush launching a complex system to satisfy political or administrative goals.

Thank you for the opportunity to share my experience and thoughts with you today. I would be happy to answer any questions.

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Testimony of the American Psychiatric Association

Regarding "Cost and Confidentiality: The Unforeseen Challenges of Electronic Health Records in Small Specialty Practices"

Presented to the House Small Business Committee

By
Robert M. Plovnick, MD, MS
Director, Department of Quality Improvement and Psychiatric Services
American Psychiatric Association

July 31, 2008

Members of the House Small Business Committee, I am Robert Plovnick, M.D., M.S., the Director of the Department of Quality Improvement and Psychiatric Services at the American Psychiatric Association (APA). My department oversees preparation of psychiatric practice guidelines, development and assessment of performance measures for psychiatric services, monitoring and participation in national activities on electronic health records, and APA activities in addiction psychiatry. It is an honor for the APA to present this testimony to the Committee regarding "Cost and Confidentiality: The Unforeseen Challenges of Electronic Health Records in Small Specialty Practices."

The APA is the nation's oldest medical specialty society representing more than 38,000 psychiatric physicians nationwide. Our members serve as clinicians, academicians, researchers, and administrators. They work within a variety of systems of care including multi-specialty groups, emergency departments, in-patient settings, and small private practices. The development of health information technology (HIT), and corresponding Federal and State laws and regulations involving the collection and transmission of health data, are a matter of great interest and concern to the APA, our members, and their patients. The APA has one committee of members solely focused on various aspects of electronic health records (EHRs) and educating members on this topic, and a second committee solely focused on privacy and confidentiality concerns.

Carefully structured, a nationally uniform HIT infrastructure has great potential to improve the overall quality of care provided to patients, inform health professionals of the latest standards of care, and improve efficiency in communicating important health care information. When used effectively, electronic health records can enable clinicians to enhance the quality and efficiency of health care through mechanisms such as reducing fragmentation and improving continuity of care across settings and conditions, improving access to information on prior treatment, and improving administrative efficiency.

However, there are two significant challenges to widespread adoption and implementation of EHR systems that the APA would like to highlight in our testimony today. As the assurance of confidentiality is at the core of any effective patient-physician relationship, it is essential to protect the privacy and security of individually identifiable health information. Electronic health information exchange could erode patient trust and impede clinical care if it facilitates dissemination of sensitive information without sufficient precautions being taken to protect privacy. Second, a significant percentage of APA members operate in solo, private practices in which the up front costs of implementing a health IT or EHR system present a considerable barrier to adoption.

Privacy Background

Protecting and strengthening the confidentiality of the patient-physician relationship is critical to providing the highest quality medical care. This is particularly true with respect to psychiatric care because of ongoing inequity in insurance coverage, employment discrimination, and social stigma for people with mental illness.

Both the Supreme Court and the U.S. Surgeon General have acknowledged this. In 1996, following a half century of discussion in the courts and the legal community, the Supreme Court, in Jaffee v. Redmond established an absolute privilege in federal courts for information disclosed by a patient to a psychotherapist. This privilege is similar in nature to the revered attorney-client privilege. In Jaffee, the Supreme Court held that "effective psychotherapy depends upon an atmosphere of confidence and trust...for this reason the mere possibility of disclosure may impede the development of the confidential relationship necessary for successful treatment." In 1999, explicitly citing the Jaffee decision, the U.S. Surgeon General in his report, "Mental Health: A Report of the Surgeon General," wrote, "the Court's language, in a decision creating a psychotherapist privilege in federal court, appears to leave little doubt that there is broad legal protection for the principle of confidentiality." The Surgeon General concluded, "People's willingness to seek help is contingent on their confidence that personal revelations of mental distress will not be disclosed without their consent." We believe any national HIT system must acknowledge these findings, and ensure confidentiality. The privilege established in Jaffee underlines the importance of the psychotherapist-patient relationship, encourages individuals struggling with mental health issues to seek treatment, and is therefore a fundamental and indispensable component of patient care. Additionally, among the most important provisions of the 1996 Health Insurance Portability and Accountability Act (HIPAA), is a non-preemption requirement that ensures that State laws which are more protective of privacy than HIPAA's basic requirement are not voided. The non-preemption protection is an essential feature of HIPAA. Any uniform federal standard should maintain all existing state protections in order to provide for the strongest possible protection of privacy and avoid any loss of privacy protections that currently exist.

In 2006, the U.S. Government Accountability Office (GAO) released a report, upon request of Senate Finance Committee Chairman Charles E. Grassley, highlighting "significant weaknesses in electronic access controls and other information system controls" within HHS and CMS. The report, entitled *Information Security: Department of Health and Human Services Needs to Fully Implement Its Program (GAO-06-267)*, concludes that the medical and financial privacy for Medicare, Medicaid, and other program enrollees is vulnerable to fraud and abuse. The report cites an insufficient information security program and inconsistent implementation as the key reasons for the security failures. This report underscores the need for strict safeguards and guidelines when implementing a national HIT infrastructure.

An unintended consequence of EHRs is that patients may be discouraged from seeking treatment or sharing information due to concerns that their information will be improperly disseminated. Effective treatment in behavioral health, as well as other disciplines of medicine, often requires patients to share sensitive information such as sexual history, drug use history, pregnancy history, and HIV status. If confidentiality cannot be assured, patients will be reluctant to share information that is critical for their care. According to HHS[1], two million Americans with mental illness do not seek

[1] Federal Register. (December 28, 2000) Vol. 65, No. 250. Rules and Regulations 82779.

treatment due to privacy fears. A 2007 Harris Interactive Poll[2] found that 17 to 21 percent of patients withheld information from their health professionals because of worries the information might be disclosed. These rates are likely to be even greater if information exchange is electronically enabled and the confidentiality and security of health information cannot be assured. The trust required for a productive therapeutic relationship is undermined by accounts of healthcare workers who inappropriately view electronic records of celebrity patients, as well as by the loss or theft of laptops or CDs containing large quantities of health related information.

As already noted, breaches in the privacy of sensitive medical data, including that relating to mental health and substance use disorder treatment, can have significant personal and professional consequences for individuals. Even the possibility of privacy violations erodes an individual's expectation of confidentiality in medical encounters and undermines the sharing of medically essential information with one's physician. Apologizing and making improvements once data is lost is not a sufficient response. Rather, privacy and security provisions must be keystones to the development of a nationally uniform HIT infrastructure. As opposed to having to choose between making the entire record or none of the record available electronically, there are many approaches that could help protect the patient-physician relationship and optimize the advantages of the electronic health record environment. Examples include: ensuring that the strictest security protections and auditing are employed, providing transparency as to who has access to medical information, and giving patients and clinicians a degree of control as to who can access sensitive information. The APA applauds the leadership of the House Energy and Commerce Committee, particularly Chairmen Dingell and Pallone, Ranking Members Barton and Deal, and Representatives Waxman and Markey for incorporating several privacy and security provisions into their HIT legislation, H.R. 6357, the PRO(TECH)T Act. The APA remains concerned about S. 1693, the Wired for Health Care Quality Act in the Senate as it does not contain strong or consistent privacy and security provisions and may in fact inadvertently threaten privacy.

The Costs of Implementing Health Information Technology for Small Practices

Despite the widespread recognition of the potential health IT holds to increase efficiency and quality health care delivery, system adoption rates remain low. According to the Congressional Budget Office, only about 12% of physicians have adopted health IT systems. A recent study in the New England Journal of Medicine[3] found that only 4% of physicians had adopted fully functional EHRs, and those that had tended to be in larger practices. Consistently, cost is cited as the largest barrier to wider adoption. Although estimates vary widely, studies report that the total costs for implementing office-based EHRs range from $25,000 - $45,000 per physician. Subsequent annual costs for maintaining the system range from $3,000 to $9,000 per physician per year.[4] These

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[2] Harris Interactive Inc. (March 26, 2007). Poll #27.

[3] DesRoches CM, et al. "Electronic health records in ambulatory care -- a national survey of physicians" N Engl J Med 2008; 359: 50-60.

[4] Congressional Budget Office. (July 24, 2008). *Evidence on the Costs and Benefits of Health Information Technology.*

expenditures are amplified for smaller practices, which typically pay more per physician than larger offices where there are more physicians to share the costs. Psychiatrists involved in solo practice, a significant percentage of APA members, often have little or no administrative support staff, further increasing the physician's responsibilities with regards to selection, implementation and maintenance of the system, and decreasing the time available for clinical care.

Conclusion

The APA appreciates the efforts the Small Business Committee has made to address confidentiality concerns while developing an HIT infrastructure. A national HIT infrastructure offers a great potential to raise the overall quality of care provided to patients, increase patient safety, keep health professionals informed about the latest standards of care, and improve efficiency in communicating important health care information. These goals can be met without breaching privacy protections, and can assure patient trust if privacy is made a cornerstone of HIT development. The APA further recommends the use of financial incentives such as grants or other support to help practitioners in solo or small group practices cover the costs of hardware and software. Assurances that standards will be set prior to full implementation, so that physicians won't have to purchase new systems if the standards change, are also necessary.

Again, we thank you for the opportunity to testify today and we hope the members of the Committee will consider the APA as a resource as this process continues. I am happy to answer any questions.

American Academy of Pediatrics

Edward Gotlieb, MD, FAAP

Practicing Pediatrician

Representing the

AMERICAN ACADEMY OF PEDIATRICS

Statement for the Record before the House Committee on Small Business Hearing

"Cost versus Confidentiality: The Unforeseen Challenges of Electronic Health Records in Small Specialty Practices."

July 31, 2008

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Thank you very much, Chairwoman Velasquez and Members of the Committee. I am honored to represent the American Academy of Pediatrics before you.

My name is Edward Gotlieb and I am a practicing pediatrician in Stone Mountain, Georgia. I have a strong interest in health information technology as it relates to pediatrics and in adolescent privacy. I have served as an Executive Committee member of the Academy's Council on Clinical Information Technology as well as on the Academy's Committee on Adolescence.

Pediatrician Concerns about Implementing Health Information Technology

Sixty percent of pediatricians practice in small businesses. But we are different from other doctors because the major government program that pays for the health care of children is Medicaid, not Medicare. Medicaid has a major impact on children's care, paying for 40% of births in the United States. More than 30 million children are covered by Medicaid. Medicaid faces fiscal problems, but not because of the children that are covered by the program. While more than 50% of the people covered by Medicaid are children, these children account for only 25% of the cost of the program.

Pediatricians provide the best care that we can for our patients, and many of us are using a variety of tools to improve care. Pediatricians find it very hard to purchase health IT systems on our own. A real factor in our inability to afford these expensive technologies is the payment rates that pediatricians receive under Medicaid. American Academy of Pediatrics' surveys show that payment rates under Medicaid average 69% of Medicare. Let me say that again – the average pediatrician is paid by Medicaid only around 2/3rds of the average payment received by adult doctors from the government for the same service. Thus, the margins under which most pediatric practices operate are much more severe than those of our adult colleagues.

The conclusion that I hope you draw from what I've told you so far is that if incentives for health IT adoption are structured only to flow through the Medicare program, more than 60,000 practicing pediatricians will be excluded from the opportunity to qualify for these incentives. The already inequitable system of funding programs for children will only be worsened. This is not a good investment in our future.

Importantly, Congress has passed legislation and overridden a Presidential veto as part of the recent Medicare Improvements for Patients and Providers Act of 2008. This will help pediatricians in private practice because many private payer contracts are based on Medicare rates. But the bill also includes two important health IT- related provisions. One, based on the E-Meds legislation introduced on the House side by Representative Allyson Schwarz, provides incentives to physicians to purchase E-Prescribing systems by paying these physicians more under Medicare. Another expands a large demonstration project to incentivize the use of health IT by paying more to primary care practices that submit medical home codes. Even though our Academy originated the idea of the "Medical Home" in 1967,

neither of these provisions applies to pediatricians, whose patients are generally not part of Medicare.

Pediatricians are concerned that Congress has not overridden the veto of the SCHIP reauthorization, which would have some real impact on the adoption of health IT systems in pediatrics. Title IV Section 401 of H.R. 976, versions of which the House and Senate have both passed twice, would address pediatric health information technology by making available more than $200 million in grants to help spur the development and adoption of health information technology systems in pediatrics and also to measure and improve the quality of pediatric care.

SCHIP reauthorization must become law, and soon, especially in the face of shrinking state Medicaid budgets. If pediatricians do not receive real funding assistance, we may not be able to adopt health IT as quickly as the national healthcare system needs.

Special Concerns for Pediatric Electronic Health Records

Even if we do receive help to adopt health IT systems in our practices, pediatricians face special constraints because of the rules governing privacy for our patient population. Child health care providers often find that clinical information systems have diminished usefulness in pediatrics because EHRs are frequently designed for adult care and do not take into account the specific needs of pediatrics. There are a number of special functions that a pediatric health record requires that must be implemented in an EHR. In their absence, pediatricians are hampered in their ability to properly document care. The EHR vendor community frequently asks us to pay extra for these capabilities, if they will provide them at all. The major areas in which these needs arise are in immunization documentation, immunization registry management, growth tracking, medication dosing, privacy in special pediatric populations, and providing normative data by age, Body Mass Index, or developmental stage.

Privacy Concerns for Adolescents and other Special Pediatric Patients

Of immediate concern in today's discussions of health information technology incentives are adolescent privacy concerns. The HIPAA Privacy Rule and its implementing regulations defer to state and other applicable law on the issue of adolescent privacy. Commentary to the final regulations explained that state law governs disclosures to parents. In cases where state law is silent or unclear, the regulation would preserve state law and professional practice by permitting a health care provider to use discretion to provide or deny a parent access to such records as long as that decision is consistent with state or other law. HIPAA also allows the minor to exercise control of protected health information when the parent has agreed to the minor obtaining confidential treatment. HIPAA also allows a covered health care provider to choose not to treat a parent as a personal representative of the minor when the provider is concerned about abuse or harm to the child. Finally, HIPAA states that a covered provider may disclose health information about a minor to a parent in the most critical situations. Disclosure of such information is always permitted as necessary to avert a serious and imminent threat to the health or safety of the minor.

Providers of care to adolescents have worked diligently in their states to create workable solutions within the constraints that the state determines. But as you might assume, the worthy goal of computer data interoperability creates challenges in this context. Laws about age of consent vary from state to state and according to the patient's presenting problem. Adolescents who present for the outpatient treatment of mental health disorders, for example, may consent to their treatment at an earlier age than the age of majority in many states. Some states also have laws regarding parental notification whereby their interpretation is based on the patient's age and presenting problem.

Practices that serve adolescents typically have policies with respect to what portion of an adolescent's care should be handled with special privacy protections. For instance, in some jurisdictions, the adolescent must give explicit permission for the parent to review his or her records. These privacy protections may require the flagging of protected information. Therefore, EHR systems should support privacy policies that vary by age and according to presenting problem and diagnosis, and be flexible enough to handle the policies of individual practices, consistent with applicable law in the jurisdiction. Furthermore, if an EHR system handles record-keeping for consent for treatment, it should provide for the recording of assent for treatment from an underage adolescent or child combined with parental informed permission. It should also provide for consent for treatment from an adolescent combined with a record of parental involvement. The separation of the patient's consent and the parent's or guardian's consent is particularly important in the area of testing for drugs, or in the case of abuse. Screening for sexually-transmitted illness is another area in which the records of patient and parental consent, assent, and permission may be less straightforward than in adult care.

It is particularly noteworthy in this context that concerns about the privacy of information for sensitive health concerns are not limited to adolescents who are minors. Even those adolescents who are adults, that, is, over the age of 18, and many other adults, have concerns about maintaining the privacy of information about sexually-transmitted illnesses, pregnancy, mental health, and substance abuse. These people often wish to ensure that other family members – a parent, child, or spouse -- will not have access to such information without their agreement. We pediatricians continue to care for young people through age 21, and in some cases, beyond. The concerns of our young adult patients are as important to us as the concerns of our adolescent patients who are minors.

Children in Foster or Custodial Care

When a child is removed from the care of his or her parents, as in the case of foster care, complex issues of confidentiality of medical information arise. Licensed foster parents may consent to routine medical and dental treatment for minors placed with them pursuant to a court order or with the voluntary consent of the person having the legal custody of the minor. Pediatricians document the authority of a foster parent to give consent to medical treatment by obtaining a copy of the court order. Parents who no longer have custody may still have the right to access their children's medical records and be involved with health care decisions unless their parental rights have been terminated. EHR systems that purport to manage consent for treatment and information access need to be able to record these details. Systems

must be developed so that the appropriate individuals have access to the relevant information and those who should not have access do not.

Consent by Proxy

Children often present for non-urgent health care in the company of an adult who is not the custodial parent or guardian. The best way to prevent confusion about consent for care in this situation is to record the custodial parents' wishes as to which adult can consent to which elements of the child's care and under what limitations. EHR systems that manage consent for treatment should support this kind of data-recording.

Adoption

Records of children who are undergoing adoption proceedings or who have been adopted may need special privacy handling, as in a case where state law offers special protections for the identity of adoptees. The EHR systems should allow flagging of these data for special privacy protection. In some states, the pre-adoption record may need to be separated entirely from any post-adoption record by using two distinct patient identities.

Guardianship

The identity of a child's guardian and guarantor, although most commonly the parent, can become complicated outside the bounds of the "typical" two-parent household. The EHR system must provide the flexibility to indicate the broad variety of adults in the child's life who may play some role in medical or financial decision making. The system should draw a distinction between the patient's guardian and his or her financial guarantor. In those cases in which a court has appointed a guardian for a minor, the ability of the guardian to consent to medical treatment depends upon the type of treatment being sought and the scope of authority the court has granted. If more than routine care is required, the pediatrician should document the authority of the guardian to give consent by obtaining a copy of the official certified letters of guardianship. The EHR system should support this record-keeping.

Emergency Treatment

When EHR systems support the recording of consent and assent for treatment, they should be flexible enough to allow for the emergency treatment of minors, in which the parent or legal guardian may be absent, and the usual procedures for consent must change

In conclusion, as the Small Business Committee continues its debates and discussion around developing incentives for the adoption of health information technology systems, please keep in mind the special needs of the children. Pediatric practices operate under tighter margins, are not directly supported by the Medicare system, and have more burdensome privacy considerations that we pediatricians must address every day in our practices. Thank you very much for the opportunity to testify before you today.

Testimony of

Ralph W. Hale, M.D., F.A.C.O.G.
Executive Vice President
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Cost and Confidentiality: The Unforeseen Challenges
of Electronic Health Records in Small Specialty Practices

Before the House Small Business Committee

July 31, 2008

Thank you, Madam Chairwoman, for inviting testimony from the American College of Obstetricians and Gynecologists (ACOG), representing our 53,000 physicians and partners in women's health, on confidentiality and cost concerns physicians in small practices face in the adoption of health information technology (HIT). The Committee has addressed this issue several times on behalf of small and solo practice physicians, including your March 2007 subcommittee hearing. We appreciate your commitment to understanding the implications of HIT for small specialty practices and for all of your work in the health care arena.

My name is Dr. Ralph Hale. I am an obstetrician-gynecologist, have served ACOG for many years in various volunteer capacities, and have been ACOG Executive Vice President, in charge of all its operations, since 1993.

America's health care system is at a crossroads in the development of HIT. In today's paper records system, a typical patient will receive screenings, tests, and procedures from multiple health care providers, often with little coordination or communication between these providers. Adoption of electronic medical records (EMRs) can help make sense of our increasingly fragmented health care system, improve patient safety, increase efficiency, and reduce paperwork.

We know we need to move to HIT, and HIT capability is maturing, but has it matured to the point where physicians, especially those in solo or small practices, feel confident in making such a large capital investment? Not yet.

HIT systems are not yet interoperable across small practices, insurers, and governmental agencies. Information privacy is too often treated as an afterthought. And HIT systems are very expensive, both in purchase dollars and in lost patient care hours.

These are some of the many issues that must be carefully addressed before we achieve a tipping point in adoption of electronic recordkeeping. Today I'll address two of the largest barriers to health IT adoption among ob-gyns and other physicians in solo and small practices: costs and confidentiality.

Costs

The system-wide benefits of HIT are many. Insurers will save by reducing unnecessary tests, patients will benefit from better care coordination and fewer medical errors. But these advantages don't necessarily translate into savings or revenue for physician practices.

Instead, physicians face Medicare and private insurance payment cuts. Little financial assistance is available for HIT investment. And uncertain interoperability standards and rapid technology changes can very quickly make this year's investment obsolete. Many physicians in solo and small practices are understandably reticent to take the HIT plunge.

The initial cost of purchasing HIT for a small practice is typically at least $50,000 per physician. Physicians face additional, ongoing costs in staff training and hardware and software updates as well. And it's important for the Committee to realize that while some assert that physicians can easily recoup HIT investments through greater efficiency and the ability to see more patients, many physicians see significant efficiency losses for months after upgrading to an EMR system.

In the last decade, insurance companies have pressured ob-gyns to compress office visits into a few short minutes. For many ob-gyns, the promise of EMRs is not to enable us to see more patients in the same day, but to take more time and provide better care to our patients. HIT can help us make those office visit minutes more meaningful, rather than shaving a few more minutes off of our time with our patients.

Bipartisan legislation approved last week by the Energy and Commerce Committee, H.R. 6357, the Protecting Records, Optimizing Treatment, and Easing Communication through Healthcare Technology Act of 2008 or the PRO(TECH)T Act, acknowledges the need for financial assistance with this investment, and we encourage Congress to increase support for start-up and ongoing costs associated with HIT.

Confidentiality

Confidentiality is critically important as medical information moves from paper charts to EMRs. Sensitive records of millions of Americans need to be protected and ethical dilemmas involving patient autonomy must be resolved. ACOG holds patient privacy and the confidentiality of a patient's medical records in the highest regard and respects the fundamental right of an individual patient to make her own choices about her health care. Protecting our patients' health information is of paramount importance.

Security Within the Physician Office

Within the physician's office, electronic recordkeeping can make a patient's record more secure. Even with the best office procedures, there is no way to know if an unauthorized person has taken a peek at a patient's paper file. HIT systems can block unauthorized viewers and keep track of when and by whom a record was viewed.

HIT systems should be compatible with HIPAA, and flexible enough to accommodate state privacy laws, a particular concern for ob-gyn care of adolescents. Every state has different laws regarding the age and to what care an adolescent may consent without a guardian's permission. Most state laws allow part of the record to be shared with only the adolescent and other parts with the parent. In addition, some services may require parental notification. HIT systems must integrate these complicated rules.

Balancing Patient Privacy and a Physician's Need to Know

The Value of a Complete Health Record

With interoperable, sharable electronic records, all physicians treating a particular patient can have the full story. A patient's paper record kept in her physician's office often shows only a slice of a patient's medical history, potentially missing important information from the patient's other physicians, including medication allergies, test results, and the results of particular therapies.

Without a shared electronic record, a physician relies on the recollection of each patient, which is often unintentionally incomplete. A patient may be uncertain about the name or dosage of a medication, not remember the date of a screening exam, or not have results of lab tests ordered by another physician.

Physician access to the full story with sharable EMRs is important to the care of all patients, and can be particularly relevant for patients with inconsistent contact with health care providers, including the uninsured and Medicaid beneficiaries. Often, these patients get their care in various settings, including physician offices, community clinics, and emergency departments. Since Medicaid and uninsured patients have greater instances of chronic diseases, they may greatly benefit from sharing medical information.

Respect for Patient Privacy

There are compelling reasons why physicians should have access to sharable, complete medical records. But there are also compelling reasons, based on respect for patients' privacy and rights to make their own health decisions, for limiting physician access to some patient medical information.

Some patients choose anonymous HIV testing or confidential testing for other sexually transmitted diseases (STDs) in order to keep test results out of their regular medical records. A woman may go to a family planning clinic for some care needs, but see her regular ob-gyn for other care. A woman may not want to tell anyone, including her regular physician, that she was treated in the emergency department for physical injuries from domestic abuse.

In many cases, the clinical benefit derived by a physicians' knowledge of very sensitive personal health information, like pregnancy termination in the distant past or an STD in college, may not be not significant enough to outweigh the patient's need for confidentiality and privacy.

And, even the best EMRs are not a substitute for talking with patients.

Finding the Middle Ground

To what degree should patients have control over the content of their EMRs? At one end of the continuum, patients would have no control over the content of or access to their records, and all the patient's physicians would have full access to all of the patient's medical information. At the other extreme, a patient may wish to block access to or delete important information from his or her medical record, leaving physicians with only some information.

ACOG has strong concerns about allowing patients to delete information from the record entirely. HIPAA allows patients to correct inaccurate information, but not to demand changes for other reasons. Allowing patients to alter a medically-accurate record would cause physicians to distrust all medical records.

Blocking access to selected information gives the patient significant control over her record, but may also limit a physician's ability to provide the best patient care. A treating physician is put in a very vulnerable situation as he's aware that some information is blocked from his view, but he has no knowledge of why, what that information is, or how it might affect his treatment decisions.

Patients are not always the best judges of what information is important. For instance, if a pregnant woman has a cat, her ob-gyn will want to inform her of the risk of toxoplasmosis, a potentially serious condition. Or a physician might want to know the weight of a patient's baby at birth, since birth weight of more than 9 pounds increases the patient's risk for diabetes. An ob-gyn can help a woman who has been the victim of domestic violence and becomes pregnant understand that pregnancy often triggers escalated partner violence and help her get the help she needs.

H.R. 6357, under the leadership of Chairman John Dingell, is a good start to guide us forward, while we develop financial and other incentives for physicians to purchase health IT and while we continue to find solutions to important privacy issues.

This massive undertaking requires physicians to trust their investment in health IT and patients to trust that their sensitive health information is protected. Success of a national health IT system depends on both.

We applaud your commitment and leadership on this issue, Madam Chairwoman, and look forward to working closely with you and the Committee.

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Statement of Thaddeus M. Bort, M.D.

July 31, 2008

U.S. House of Representatives, Committee on Small Business

Dear Chairwoman Velázquez and members of the committee, I am honored to be here today on behalf of family physicians, my partners at The Family Medical Group in Cincinnati, Ohio and most importantly, our patients. For over twenty-two years my partners and I have been dedicated to high-quality patient care and to discovering strategies to continually improve or facilitate that care.

I am a board-certified family physician, and member of the American Academy of Family Physicians, who commenced private practice in 1986 with my partner, Timothy McCarren, M.D. Since then, The Family Medical Group (TFMG), a partner-owned practice, has grown to twelve physicians, five mid-level providers, eighty-six employees, with over 28,000 patients in three locations, serving people in southwestern Ohio, Southeastern Indiana and Northern Kentucky. To put those numbers into perspective we are on track to exceed 150,000 patient visits in 2008. We handle 10,000 phone calls and there are over 50,000 hits on our website each month.

Over the past eighteen years we became familiar with the concept of electronic medical records (EMR) but elected to wait until "the perfect EMR system" was created at a very low cost. It became apparent that both of these prospects were unlikely to be achieved in the near future.

In 1999, frustrated by all the paper burden that we deal with in medicine, I brainstormed with a brilliant software developer, Steve S. Burns, and after raising some funds we co-founded Pocketscript ®, one of the very first e-prescribing companies. I reduced my clinical practice by 50% and we strove to create a user-friendly wireless e-prescriber utilizing a hand-held device. Pocketscript eventually grew to a company of seventy-five employees but struggled to get "traction" amongst physicians for a variety of reasons. Many did not wish to take the time to learn how to use a hand-held device (a paradigm shift from a paper prescription pad). Others found it too complex. Fortunately, there were many early adopters who caught on immediately and helped us to improve our product. Over time we simplified the system to use voice commands (the easiest and least intimidating format). We partnered with health plans to stimulate use, and added additional features such as checking for formulary coverage which continues to be a burden to medical offices. Regrettably, this was around the time when funding was evaporating for technology companies and we were unable to raise the necessary capital to grow Pocketscript. In 2002, we were forced to lay off most of our employees and I returned to full time practice.

As in most ventures, we learned from our failure. First of all, we discovered that prescriptions are the second largest paper transaction in our economy, upwards of 4 billion little pieces of paper with illegible writing fraught with error. Secondly, we learned that it is very difficult to change the habits of busy practitioners unless it will save them time or money. Our goal was to do both but it was not attainable. In spite of the early adopters cheering for us, I feel the answer is to place these devices in the hands of medical students and never let them have a paper pad. That would only work if some entity would provide the hand-held devices to the medical students. Current medical students are a savvy new generation that not only embrace the electronic technology but prefer it, excel at it having grown up using electronic devices, and have come to expect it.

Despite the failure of Pocketscript, in 2006 TFMG determined it was crucial to invest in an EMR system to meet the future needs of our patients. After investigating a number of systems, TFMG purchased the Misys® EMR system for the front office and back office. Converting our practice from paper to electronic records was an arduous process at best. Only our integrity and our desire to help our patients kept us on task. The report from the Institute of Medicine on the unacceptable number of avoidable medical errors stimulated our resolve. During the first year of installing the EMR, we actually had to decrease our patient load by 20% as we gradually became more comfortable with the system. One of my partners was incredibly frustrated by the time-consuming process, so Misys arranged for him to have voice recognition software in lieu of keyboard entry. He has found this far more efficient.

We have come to realize that we deliver healthcare on a technology platform. Every person in our organization uses a computer. Every patient encounter involves entering information into our EMR system. After over 2 years of experience, it has given us some perspective on the use of Electronic Medical Records primarily in three areas: Cost, benefits, and challenges.

Costs

When we decided to make the change we never anticipated the ongoing cost of developing a system and maintaining standards of care using technology. To give you some perspective on that, when we purchased our system it was at a total cost of over $228,000.00. This initial price did not include the transfer of paper files to an electronic format. It did not include the time and effort required for the entire staff to learn a new system. It did not include the added energy expense, the additional training, the lost revenue while in training, and the frustration that this can cause. However, there is not only the up-front onetime cost. From July 1 of 2007 until June 30, 2008 we paid over $258,000.00 to the EMR company. This is an annual expense that is not based on volume, but the reality of maintaining a system.

One of the largest expenses was converting 25,000 plus paper charts to a format the EMR could use. This required the scanning of important components of each chart. We tried valiantly to do this on our own (spending about $25,000) then resorted to shipping the remaining paper

charts to North Carolina to be scanned professionally at a cost of $55,000. In addition, because we are required to keep all paper charts indefinitely, we are, currently, paying for off-site storage.

We realize that the cost of doing business in the new economy is an investment into technology. The challenge that we face is the increase in cost does not match the reimbursement that we receive through Medicare and other health insurance plans. If the recent bill on Medicare funding would not have passed we would have had a loss of somewhere between $150,000- $200,000 in income to our practice. For a business our size it would have had a significant impact upon our operation.

Benefits

What are the benefits of this system? Presently, a patient who has registered on our website can schedule an appointment. If the appointment that they scheduled is an annual physical three months from today, but they are in need of a prescription re-fill on a cholesterol lowering drug, they would be able to request a re-fill on line and it would be sent directly to their pharmacy. When a patient is before me in an exam room I am able to access lab results, check past history, all at the click of a mouse. In its ideal state, an EMR system will result in better patient care because of our ability to track measures and standards as recommended by standards set forth by the Center for Disease Control, American Diabetes Association, the American Heart Association and other agencies that help formulate standards in health care.

The EMR helps safeguard patient confidentiality far more than the old paper charts that were all over our office. There was no way to know who looked in a chart thus, it was near impossible to monitor HIPPA compliance. Now it is necessary to log on using password protection and an audit trail is recorded down to the second. This past year we had a HIPPA violation and thanks to the audit trail we were able to identity the offender. It also enabled us to identify EMR users who were innocent of violations. The audit informs us who has viewed a medical record, when it was viewed, and which part of the record was viewed.

A potential benefit that I foresee is that patients who go out-of-town would be able to take their medical information with them on a chip or at least permit out-of-town medical providers access to that information.

Finally, one of the most important roles that effective Health Information Technology, like an EMR, can play is to implement what is called a "patient centered medical home." This is a team-based health care model that emphasizes coordination of care that is particularly important for patients with chronic conditions. Physicians who treat patients who live with chronic diseases like diabetes or asthma need to be able to help their patients monitor and track their medications, physical activities, nutrition, insulin levels and weight, and similar daily indications of their health. The EMR can consolidate this information and input from other

physicians and health care providers, like physical therapists and nutritionists, who see the patient. It can include lab results and flag danger signs or potential drug interactions and can schedule appointments as the patient requires. With effective technology that interacts with other medical sites, the physician's health care team can help the patient prevent acute conditions and reduce unnecessary medical expenditures.

Challenges

The electronic medical records in our office use an encrypted system to transmit information. While this acts to insure patient security it also poses a great challenge. Every one of the doctors in my practice still make rounds at hospitals. When we are visiting patients at the hospital we are unable to access the patient's information from the office because the hospital system and our office system are not compatible. Imagine if you called a constituent in your district but because you have two different mobile phone providers you could not speak to one another. The technology has provided us with both access and barriers at the same time.

As family physicians we interact with a variety of providers: laboratories, radiology, consultants, hospitals etc. Each of these providers has their own computer system, but unfortunately they are not able to communicate with each other. Currently, transmission of information from these various providers still requires paper. It seems that the various systems should be able to interface thus improving delivery of data and quality of patient care. If there was a system that interacted, just as our cell phones and search engines do, we would improve the quality of patient care.

At this time I would like to say that we have achieved a paperless office, but we continue to be inundated with paper. All day long our fax streams hundreds of prescription refill requests to us since there is no direct electronic communication between our system and the pharmacy. It remains an unused tab on my computer screen. I anxiously await the day when I can touch the "e-prescribe" button, or better yet send a prescription via a voice-activated process. Without complete solutions that meet physicians' needs, they continue to resort to tedious, inefficient faxes.

The hospitals as well fax us reams of paper reports since thus far there is no standard for hospitals to electronically communicate with EMR. This amounts to several hundred sheets of paper that we must scan into the EMR, then pay to shred.

Following pharmacies and hospitals, we receive myriad faxes from laboratories, insurance companies, and nursing homes. It is as if each entity speaks a different language and we can only translate on paper since there is no computer-to-computer communication. Recently,

we began getting some lab results reported directly into our EMR but it is as of yet quite cumbersome.

Recommendations

1) ***The investment and utilization of information technology should receive some form of tax incentive or system of reward.***

As more and more programs want to demonstrate quality initiatives in health care, it is important that systems be put into place to help support these initiatives. For example, if you are asking us to deliver quality diabetes care (our practice has been recognized by the National Committee for Quality Assurance through the Diabetes Physician Referral Program), then our compensation from both the Center for Medicare and Medicaid Services should reflect our ability to deliver and measure quality patient care. I believe the new Medicare Part D incentives for e-prescribing are a start but we still need to be able to communicate. Until health care financing rewards quality and efficiency, instead of volume and procedures, the return on investment in primary care for information technology, especially advanced information technology that significantly improves quality, will be marginal at best.

2) ***Create an environment that provides incentives for the private sector to standardize EMR systems, workflow, and clinical data to promote low-cost solutions to enable quality measurement and improvement.***

We know that technology is always a catch –up ballgame. No one can every stay ahead of it. But practices such as The Family Medical Group can find direction in the further development of EMR. We know that 80% of medicine in the Greater Cincinnati region is offered by practices our size and smaller. If so much of our care will be dedicated to the 51 % of Americans with a chronic disease and our aging population receiving Medicare funding, then insurance reimbursement based on Medicare funding measures will insure that health care providers are purchasing the right type of systems.

In summary, it is my feeling that the benefits of EMR over archaic paper charting are numerous as identified above. EMR is legible, improves confidentiality, is portable, provides access to electronic references, permits e-prescribing (limited), checks for drug interactions which improves safety, makes the coordination of care more feasible, and also allows for data analysis which we believe will help us improve the quality of care that we strive to provide.

The two largest barriers to entry are cost and time due to established work flow patterns. Small practices are, for the most part, struggling to meet overhead and cannot afford to spend tens of thousands of dollars to convert to EMR. I believe many of the smaller practices will either merge with other groups, sell to hospitals or close. It is imperative that we start educating

our medical students to use EMR . They are already tech savvy and , hopefully, they can avoid the pitfalls of paper charting altogether.

Chairwoman Velázquez and the entire committee, I am humbled to be here before this important body considering the important questions facing the delivery of health care to my fellow citizens. It is with great humility that I walk in and out of exam rooms each day in my practice encountering patients and their families as they face the challenges of their own health care. We know that in the patient – doctor relationship it is when we see one another as partners that we will bring about a better outcome. I am here, and I speak on behalf of my partners, to say that we want to work with all of you in bringing about the health care that all Americans deserve: *patient-centered, evidence-based, high-quality health care* that will serve the common good.

STATEMENT FOR THE RECORD

OF THE

AMERICAN COLLEGE OF PHYSICIANS

TO THE HOUSE COMMITTEE ON SMALL BUSINESS

"Cost and Confidentiality: The Unforseen Challenges of Electronic Health Records in Small Specialty Practices"

July 31, 2008

ACP, representing 126,000 internists and medical students, is the largest medical specialty society and the second largest medical organization in the United States. ACP commends Chairwoman Nydia Velazquez and Ranking Member Steve Chabot for holding this hearing on the adoption and use of HIT. We commend the Committee for specifically focusing on the challenges of the use of health information technology in small physician practices.

Introduction

The Institute of Medicine's (IOM) 2001 Report, "*Crossing the Quality Chasm – A New Health System for the 21st Century*," suggested that up to 98,000 Americans die each year as a result of medical errors. The report introduced the notion that many of these lives could be saved through information technology. Since then, numerous studies and other policy experts have confirmed that full adoption and utilization of HIT has the potential to result in major gains in health care quality of care and patient safety.[1] Some studies have also concluded that HIT can achieve very substantial reductions in health care costs.[2] Even skeptics who are less certain about the ability of HIT to lower costs recognize that providing physicians and other clinicians with access to information systems to help them manage and coordinate patient-centered care, especially for patients with multiple chronic diseases, offers the potential of achieving gains in quality and overall savings.[3]
The Congressional Budget Office (CBO) May 2008 paper "Evidence on the Costs and Benefits of Health Information Technology" states that HIT generally refers to the use of computer applications in the practice of medicine. It notes that those applications (including clinical decision support and electronic prescribing) can be housed in an electronic health record (EHR).[4] While physicians can use individual HIT applications independent of an EHR, use of an EHR is often used to measure HIT adoption.

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[1] DesRoches, Catherine, et al., "Electronic Health Records in Ambulatory Care—A National Survey of Physicians", New England Journal of Medicine, July 3, 2008.
[2] RAND Health, "Health Information Technology: Can HIT Lower Costs and Improve Quality?," Research Highlight, at http://www.rand.org/pubs/research_briefs/RB9136/RAND_RB9136.pdf.
[3] Sidorov, Jaan, "It Ain't Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs," Health Affairs, July/August 2006.
[4] Evidence of the Costs and Benefits of Health Information Technology, Congressional Budget Office, May 2008.

Benefits of Health Information Technology

The benefits of HIT that are most often cited are: avoidance of medical mistakes; storage and preservation of medical data; avoidance of medical errors; reductions in malpractice premiums; and improved quality outcomes.[5] We elaborate on each of these benefits below.

- *Medical Mistake Avoidance/Provision of Recommended Care*: The use of clinical-decision support tools at the point of care has the potential to offer a tremendous advantage to both physicians and their patients by facilitating recommended evidence-based preventive, acute, and chronic care. Examples of this benefit include alerts about vaccinations, anti-coagulation reminders, diabetes, hypertension, thyroid and anemia screening in the elderly, health maintenance and preventive care measures. HIT can also be an important conduit for providing clinicians with unbiased information on the comparative effectiveness, clinical as well as cost, of different treatments, a topic that the ACP has addressed in some detail in a new position paper on comparative effectiveness.
- *Storage of Other Encounter Data*: An often-cited example is the disappearance of paper medical records and charts following Hurricane Katrina. Having medical data stored electronically assures the safe keeping of complete medical histories that can be difficult to duplicate from memory. In addition, when patients become incapacitated, storage of the data can be critical.
- *Medication Error Avoidance*: The use of electronic prescribing (e-prescribing) offers promise because it eliminates problems with handwriting legibility and, when combined with decision-support tools, automatically alerts prescribers to possible interactions, allergies, and other potential problems. E-prescribing can also increase appropriate use of generic drugs. We note, however, the e-prescribing systems will be more effective if they are integrated with fully functional electronic health records.
- *Quality Improvement, Patient-Centeredness, and Care Management*: As noted earlier, HIT offers the potential to help physicians improve overall health care quality by having evidence-based clinical decision support at the point of care, generating patient reminders, providing access to more complete information, and reducing drug interactions. It can also have the benefit of preventing unnecessary and duplicative testing, helping patients achieve improvements in their own health care, delivering patient centered services (such as remote monitoring, secure access to email consultations), and reducing fragmentation in health care services that may increase costs and result in poorer outcomes. Further, it can shorten hospital stays or help avoid them altogether. It also enhances the ability of physicians to track and measure the quality of care they provide to their patients.

Status of Physician Health Information Technology Use

Despite the tremendous upside associated with HIT, relatively few physician practices have it—with small practices having the lowest rates. A 2006 review by the Robert Wood Johnson Foundation found that approximately 24% of physicians in ambulatory practice have an EHR, with a solo physician practice adoption rate of only 13% to 16%.[6] A 2006 ACP member survey demonstrated that practices with five or fewer physicians have a significantly lower EHR adoption rate (18%), than

[5] Sidorov, Jaan, "It Ain't Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs," Health Affairs, July/August 2006.
[6] The Robert Wood Johnson Foundation (2006), Health Information Technology in the United States: The Information Base of Progress, chapter 3, p. 26.

practices with 20 or more physicians (58%).[7] Other studies have shown that while EHR use is rising slowly, adoption by small practices continues to lag.[8]

Barriers to Physician Health Information Technology Use

The barriers to the acquisition and use of HIT, especially for small physician practices, are numerous, with the major obstacles described below.

- *Substantial Cost in Acquiring and Maintaining the Technology*: Depending on the size of the practice and its applications, acquisition costs, on average, $44,000 per physician. The average annual ongoing costs of maintenance and support are about $8,500 per physician.[9] Physicians cite these costs are the largest adoption barrier.[10] In addition, there are costs associated with training and lost productivity. In a 2005 study, 14 small practices implementing a HIT system experienced a decline in revenue because of lost productivity of $7,500 per physician.[11] Collectively, investment and maintenance is a financial commitment that spans the life of the practice. This obstacle is especially acute for physicians in small practices, where three-fourths of all Medicare recipients receive outpatient care.[12]
- *HIT Savings Accrue to Others and Not the Physician Making the Investment*: Public and private payers generally realize the financial benefit associated with HIT use, which can come in the form of a reduction in duplicative or unnecessary care, the avoidance of costly medical errors, a reduction in hospital days, an improvement in quality outcomes, and lower administrative costs.
- *Lack of True Interoperability*: Physicians lack confidence that an EHR will be able to communicate with an information system used by another clinician, hospital, laboratory, or other entity. Manual integration of information from disparate sources requires additional work and prevents full using EHRs to their full capability. This situation discourages EHR adoption.
- *Medicare and Other Payment Systems Generally Incentivize Volume over Quality*: Paying physicians on a per-procedure or per-service basis encourages volume and actually may act as a disincentive to acquire information systems that can result in the more efficient provision of services. For example, a physician receives less financial compensation if he or she refrains from conducting a test known to be duplicative because of HIT. Medicare payment policies for the most part are, at best, neutral on acquisition and use of HIT, except for some limited reporting of "structural" measures in the Physician Quality Reporting Initiative (PQRI) and several Medicare demonstration projects that provide reimbursement incentives for HIT. Medicare also systematically undervalues primary care services, making it particularly difficult for primary care doctors whose practices may be struggling and near the breaking point to spend the money needed to acquire HIT.

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[7] American College of Physicians, E-Health and Its Impact on Medical Practice. Philadelphia: American College of Physicians; 2008: Position Paper.
[8] Jha, Ashish K., Ferris, Timothy G., et al., "How Common Are Electronic Health Records in the United States? A Summary of the Evidence," Health Affairs, web exclusive October 11, 2006.
[9] Miller, Robert, West, Christopher, et al., :The Value of Electronic Health Records in Solo or Small Group Practices." Health Affairs, Vol. 24, No. 5, September/October 2005.
[10] DesRoches, Catherine, et al., "Electronic Health Records in Ambulatory Care—A National Survey of Physicians", New England Journal of Medicine, July 3, 2008.
[11] Miller, Robert, West, Christopher, et al., :The Value of Electronic Health Records in Solo or Small Group Practices." Health Affairs, Vol. 24, No. 5, September/October 2005.
[12] Center for Studying Health System Change, "Most Medicare Outpatient Visits Are to Physicians With Limited Clinical Information Technology," July 2005.

- *Uncertainty Surrounding Medicare Physician Payments*: The flawed mechanism for updating Medicare payments to physicians, the Sustainable Growth Rate (SGR) system, is a complicating factor. The system—and its need to be perpetually corrected, makes planning for significant practice investment a challenge. We appreciate the congressional action, despite the budget challenge and other obstacles, to avert what would have been a devastating 10.6% across-the-board cut in physician payments that was set to begin on July 1, 2008 and substituting the additional 5.4% cut slated for 2009 with a 1.1% increase. This action provides some stability and buys time to fashion a long-term legislative solution. The relatively modest increase, especially considering rising practice costs, and the uncertainty regarding payment updates beyond 2009 make it difficult for practices to make the investment in EHR and other HIT. ACP also recognizes and appreciates that the Children's Health and Medicare Protection (CHAMP) Act—reported out of the Ways and Means Committee, with the support and leadership of Chairman Stark, and that passed the House of Representatives in 2007—would have provided further relief from the SGR cuts and improved payments for primary care services had it become law.

In sum, for many physicians, the business case to invest in EHR/HIT simply does not exist. Even so, there are physicians who have become early adopters even though the economic case for doing so is poor.

The Need for Congressional Involvement

The complex issues surrounding financing, assistance with redesign of practice workflow, and ongoing technical support and training must be recognized and addressed for the goal of widespread adoption and use HIT to be realized. ACP strongly believes that the Congress has an important role to play in overcoming the challenges posed by these issues, particularly pertaining to physicians in small practices.

Both Medicare and the private sector have recently provided some incentives to facilitate HIT adoption and use. Unfortunately, the programs are limited to far too few physicians. These experiences do, however, demonstrate physician interest and provide reasonable assurance the physicians will respond to adequate incentives. This should provide Congress with a level of comfort that physicians will use incentives if they are made available to more physicians.

The Bridges to Excellence (BTE) program that encourage practices to maintain structural capability, including HIT components, aimed at improving patient care provides an example of physician practices responding to financial incentives. BTE is a coalition that encourages leaps in quality of care by recognizing and rewarding health care providers who demonstrate that they provide safe, effective, efficient, and patient-centered care. The BTE program pays physicians who are recognized under the National Committee for Quality Assurance (NCQA) Physician Practice Connections Physicians Office Link (PPC-POL) program as having the systems to improve care up to $50 per patient per year. Over 1,500 physicians are recognized through the NCQA PPC program, with an average practice size of 5 physicians. This shows that small physician practices are responsive when financial incentives are aligned with the transition to this type of care.

Beginning January 2008, BTE started to make bonus payments to practices in eligible areas that earn NCQA PPC-POL or PPC Patient Centered Medical Home (PPC-PCMH) recognition, plus the required recognition for other condition-specific modules (e.g. diabetes, heart/stroke). This is evidence of the growing interest of the PCMH and the willingness of the private sector to provide incentives to encourage practices to pursue PCMH recognition.

Recommended Financial and Other Incentives

Many physicians' small practices will be unable to acquire and use HIT without sufficient financial assistance from the federal government. Leaving behind these practices, from which the majority of Medicare beneficiaries receive their care, will prevent the goal of widespread use of fully integrated technology from becoming a reality.

We caution Congress, though, against trying to mandate HIT use, especially given the lack of financial incentives to help practices. For many small practices, an unfunded mandate to acquire and use HIT could literally put them out of business. It is also does not make sense to mandate HIT given that issues relating to interoperability, standards, and functionality have yet to be fully resolved. Mandates are not sensitive to differences in practice resources, patient case mix, staffing ratios, geographic locations, ownership, and a myriad of other factors that will affect the ability of practices to acquire and use HIT. A practice that is part of a large academic system, large group practice, or owned by a hospital is very different from a small physician-owned practice.

We instead recommend that Congress establish targeted financial incentives aimed at facilitating HIT in small practices. Specifically, ACP recommends that the Congress take the steps below to provide the financial incentives necessary to facilitate widespread HIT adoption and use.

- *Establish an Add-on Payment for Evaluation and Management Services*: The College recommends establishing an add-on code for office visits and other evaluation and management (E/M) services when the visit is supported by qualified HIT systems. The payment mechanism should make it possible for the physician to report that the E/M service was supported by HIT. The amount of the add-on should relate to the complexity of HIT adopted by the practice. For example, Medicare could establish three levels or tiers of HIT adoption, similar to the NCQA PPC-POL module. The level of the add-on then would depend not only on whether the physician had the information systems in their office, but how those systems are used to improve patient care. A practice that had only a simple stand-alone e-prescribing system and patient registry would be paid less than one that had a fully functional EHR with e-prescribing, patient reminders, clinical decision support at the point of care, and the ability to measure and report on clinical performance measures imbedded in the system.
- *Include Reporting of Structural HIT Measures in Quality Reporting Programs*: Medicare should reward physicians who incorporate either some or all aspects of HIT and participate in reporting on endorsed quality measures as part of the PQRI. We note that the PQRI currently includes a small number of structural measures, and beginning in 2009, Medicare will begin providing bonus payments to physicians who are able to report that they are using an e-prescribing system.
- *Pay Physicians a Care Coordination Fee if they Acquire and Use the Information Systems Needed to Function as a PCMH and Regularly Report on their Performance.* The ACP recommendations on the PCMH are discussed in depth later in this testimony.
- *Assist Small Physician Practices with the Initial Investment to Acquire HIT*: Congress should make available grants, loans, and/or tax credits to help practices currently least able to purchase the necessary HIT hardware and software. ACP notes, however, that the impact of these incentives is limited absent changes in Medicare payment policies to create incentives for HIT use.

- *Ensure Clear Guidance on the "Safe harbor" Exception to the Self-referral Prohibition*: The law allows hospitals and other entities to assist physicians in acquiring HIT. The CBO May 2008 paper, "Evidence on the Costs and benefits of Health Information Technology", notes that three federal agencies are establishing rules related to this safe harbor and the lack of present clarity can be an impediment to HIT expansion.
- *Explore Mechanisms to Assist Practices in Implementing HIT*: Physicians face significant challenges in selecting, integrating, and optimizing HIT. The National Ambulatory Medical Care Survey (NAMCS), an annual, government-funded, nationally representative survey of all ambulatory visits to physicians whose practices are not hospital-based, includes questions about EHR use. While the NAMCS found nearly 24% of physicians using EHRs, further analysis determined that only 9% are using an EHR with at least the four key functionalities identified by the IOM.[13] Congress should facilitate resources that provide support throughout the HIT implementation continuum that will make selection less daunting, minimize productivity throughout implementation, and result in optimal use. The College urges Congress to review the recommendations/options in the October 2007 "eHealth Initiative Blueprint: Building Consensus for Common Action," which is available at http://www.ehealthinitiative.org/blueprint/eHiBlueprint-BuildingConsensusForCommonAction.pdf.
- *Support the Establishment of Standards to Facilitate Interoperability and Reporting Quality Data*: ACP strongly supports efforts by those in the Administration and the Congress to speed the adoption of uniform standards for HIT. In order to oversee the ten-year initiative to achieve widespread adoption of EHRs that President Bush announced in 2004, the Administration created the Office of National Coordinator for Health Information Technology (ONC). ONC and related initiatives are working toward establishing the standards necessary to provide physicians with confidence that their investment in HIT will be supported by sustainable processes and infrastructure that enable them to use HIT to the optimal benefit of the patient and system efficiency.
- *Support for Information Exchange Projects that Promote Interoperability*: Congressional support for state and regional health information exchange efforts will move toward the true interoperability needed for physicians to use EHR products to their maximum potential and to achieve the greatest benefit to the health care system.

Patient Centered Medical Home as a Means to Facilitate HIT and its Associated Goals

ACP, like many others, believes that use of HIT alone will not enable the health care system to deliver improved quality in a way that maintains or lowers costs to its full potential. The College believes that HIT in the context of a Patient Centered Medical Home will yield the greatest benefit. ACP worked with the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA) to jointly establish principles that define the PCMH. The PCMH is a delivery model that involves a patient with a relationship with a personal physician who works with a practice team to provide first contact, whole-person, continuous care. The PCMH model is based on the premise that the best quality of care is provided not in episodic, illness-oriented care, but through patient centered care that emphasizes prevention and care coordination. A PCMH practice must demonstrate that it has the infrastructure and capability to provide care consistent with the patient's needs and preferences. The PCMH joint principles call for enhanced payment to support the practice transformation and increased value to the patient and the health care system.

[13] Institute of Medicine, "Key Components of an Electronic Health Record System: Letter Report," July 2003.

ACP, AAFP, AAP, and AOA, as the four organizations that represent a significant number of primary care physicians, worked with the National Committee on Quality Assurance (NCQA) to establish an independent process by which physician practices can be recognized as a PCMH. The NCQA established process, the Physician Practice Connections-PCMH (PPC-PCMH) module, requires practices to meet core requirements and attain a minimum score to be recognized as a medical home. Practices that meet these core requirements and achieve at or above the minimum total score are identified as one of three progressive levels of PCMH. The highest level of medical home, a Tier 3 PCMH, is generally associated with the greater use of HIT.

Having a process by which an independent, third-party determines whether a physician practice is a PCMH is one reason why the model has gained considerable traction over the past few years. Assurance that practices are transforming to meet the full needs of patients has contributed to the decision of many employers, health plans, consumer organizations, policymakers, and other health care stakeholders to embrace the model. It is our understanding that CMS intends to use a recognition process to identify the medical home practices that participate in the Medicare medical home demonstration project authorized by Congress in 2006 and enhanced through the Medicare legislation that become law earlier this month.

In its June 2008 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that it establish a robust PCMH pilot project that focuses on practices that use significant HIT.

We appreciate the Congress's support of the PCMH and urge it to consider additional payment reforms that incentivize the adoption and use of HIT in the context of the PCMH. We specifically recommend that Congress:

- *Provide Additional Funding to the Centers for Medicare and Medicaid Services (CMS) to Expand the Medicare Medical Home Demonstration to More Practices and States.* ACP appreciates the $100 million in increased funding for the Medicare Medical Home Demonstration that was included in H.R. 6331 but believe that even higher funding levels would enable the PCMH model to be expanded nationwide and evaluated as a national pilot rather than a limited demonstration project. We also believe that Congress should consider working from the medical home demonstration language and funding that was in the CHAMP Act as a basis for expanding the model into a national pilot. ACP cautions the Subcommittee, however, not to delay the existing demonstration even as it considers additional legislation to expand and test the PCMH on a national scale.
- *Require that the Secretary Transition to a New Payment Methodology for Qualified PCMH, should the Medicare Medical Home Demonstration be Successful in Improving Quality or Achieving Savings or Both*: The alternative PCMH payment structure should pay PCMH recognized practices, including practices recognized through the NCQA PPC-PCMH voluntary recognition process or other equivalent process as determined by the Secretary, for the clinical work and practice expenses associated with providing care coordination services, consisting of the following:
    - Prospective, risk-adjusted per beneficiary per month PCMH fee for each beneficiary that chooses that practice as their PCMH to cover the work and practice expenses involved in providing care consistent with the PCMH model (e.g. increased access, care coordination, disease population management and education) that are not currently covered under the Medicare Physician Fee Schedule. Such prospective, risk-adjusted per beneficiary payment should be set at a level and magnitude that is sufficient to support the acquisition, use and maintenance of clinical information

systems needed to qualify as a PCMH and that have been shown to facilitate improved outcomes through care coordination.
  - The Secretary should consider the impact of qualified PCMHs on reducing preventable hospital admissions, duplicate testing, medication errors and drug interactions, and other savings in Medicare Parts A, B (including Part B services not included in the Medicare Physician Fee Schedule) and apply a portion of the aggregate estimate of such savings to determining the aggregate amount of payment for the PCMH fees that would then be provided to qualified practices. Should aggregate actual savings after three years be higher than the estimate, the Secretary should apply a portion of such additional aggregate savings to fund the PCMH fee.
  - Performance-based bonus fee determined by meeting specified clinical, patient satisfaction and efficiency benchmarks.
  - Continued fee-for-service payment for evaluation and management services.
- *Require Separate Medicare Payment for Designated Primary Care Services and Services and Capabilities that Promote Patient-centered Care:* Congress should mandate that the Secretary pay for care coordination services provided by a primary or principal care physician to a beneficiary. Medicare should make separate payment for a comprehensive care coordination service described in a yet-to-be-defined procedure code(s). Medicare should also make separate payment for discrete services defined by existing procedure codes that describe a clinical interaction with a beneficiary that is inherent to care coordination, including interactions outside a face-to-face encounter. These services should include:
  - Care plan oversight;
  - Evaluation and management provided by phone;
  - Evaluation and management provided using internet resources;
  - Collection and review of physiologic data, such as from a remote monitoring device;
  - Education and training for patient self management;
  - Anticoagulation management services; and
  - Current or future services as determined appropriate by the Secretary.

Estimating Savings from HIT Use and Other Promising Projects

ACP believes that much of the additional expense involved in funding the financial incentives it recommends in this statement can be covered by the anticipated savings that the improved care can generate. Congress should develop a mechanism to assess the system-wide savings that HIT and other innovative delivery and payment reforms, such as the PCMH, that aim to improve quality generate. Savings can be used to help fund Medicare's assistance to physicians with initial HIT investment and on-going maintenance.

In addition, we are encouraged that the Department of Health and Human Services is in the process of assessing the system-wide savings expected to be generated through the EHR demonstration project and the Medicare medical home demonstration project. HHS intends to fund the enhanced payments to physicians participating in the EHR demonstration project through the system-wide savings that it expects it to generate. HHS is determining the savings it expects the improved interventions that result from the Medicare medical home demonstration project will generate. It will use the expected savings to fund payments to individual physicians in PCMH practices for the enhanced services they provided to better coordinate patient care. Congress should monitor these important efforts to assess the impact of HIT and other promising reforms across the entire Medicare program, as opposed to the historical tendency to assess changes within individual components of the Medicare program.

We are troubled, however, by the CBO view, expressed in its May 2008 paper, that HIT will not likely reduce overall health care spending and that incentives may actually increase spending in the absence of mandates. This position goes against the views of many other experts who believe that HIT, especially if used to support patient-centered care coordination by primary care physicians, can improve quality and achieve efficiencies that decreases overall spending. The CBO position may itself become one of the greatest barriers to HIT adoption if it results in Congress being unwilling to provide the financial incentives needed to support HIT.

We also note that most other industrialized nations have decided that it is necessary and appropriate to make large public investments in HIT. ACP recently published a position paper in the College's peer-reviewed journal, the *Annals of Internal Medicare*, that compared the United States' health care system with those of other industrialized countries. Citing data from the Commonwealth Fund and other sources, the paper found that compared with countries with well-performing health care systems, the United States lags seriously in the implementation of EHR systems in office practice. Compared with primary care doctors in six other countries, U.S. physicians are among the least likely to have extensive clinical information systems. In 2006, nearly all primary care doctors in the Netherlands (98%), and 79% to 92% of doctors in Australia, New Zealand, and the United Kingdom, have EHR systems, while the rate was only 28% in the United States (and 23% in Canada). Most doctors in countries with high rates of EHR systems routinely use them to electronically order tests, prescribe medications, and access patients' test results. Compared with doctors in the U.S. doctors in these countries are more likely to receive computerized alerts about potential problems concerning drug dosages and interactions, have reminder systems to notify patients about preventive or follow-up care, and (except for the Netherlands) receive prompts to provide patients with test results. More than 60% of the doctors in the four countries with high EMR use, as well as those in Germany (where 42% have EMR systems), say it is easy to generate lists of patients by diagnosis or health risk; in contrast, only 37% of U.S. doctors say it is easy, and 60% say it is somewhat difficult or worse to generate such lists. Likewise, doctors in countries with high rates of EMR systems are two-to-four times as likely to say it is easy to generate lists of patients who are due or overdue for tests or preventive care; only 20% of doctors in the United States report that it is easy.[14]

Privacy and Security Concerns

ACP recognizes that patients have a basic fundamental right to privacy that includes the information contained in their own medical records—whether in electronic or paper form. ACP has long recognized the need for appropriate safeguards to protect the privacy and security of patient data. Trust and respect are the cornerstones of the patient-physician relationship and are key to quality health care. Patients who trust their physician are more like to fully participate in their treatment and comply with their care plan.

We strongly believe that physicians—already governed by strict ethical codes of conduct, state professional disciplinary codes, and the Hippocratic oath—have a duty and responsibility to protect patient privacy. Patients need to be treated in an environment in which they feel comfortable disclosing sensitive and confidential health information to a physician they can trust. Otherwise, there may be a chilling effect for patients to fully disclose the most sensitive of information (conditions or symptoms), thereby reducing the effectiveness and timeliness of treatment, or, they may avoid seeking care altogether for fear of the negative consequences that could result from disclosure. While physicians must have access to clinically relevant information to safely and

[14] "Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries," ACP position paper, *Annals of Internal Medicine*, January 2008.

effectively treat patients, patients must have assurances that adequate firewalls against unauthorized individuals gaining access to sensitive data are in place. Congress must ensure these safeguards are present.

Conclusion

The barriers to HIT adoption in physician practices can best be overcome by building financial incentives into Medicare and other programs. Supporting small practices with their initial acquisition costs and including an add-on payment for services documented and facilitate by an EHR will provide an infusion of funding that small practices need to invest in and maintain HIT. It also sends a signal that the federal government is committed to facilitating this goal. Financial incentives to facilitate the promising PCMH delivery model provide a mechanism to further HIT adoption and use in the context of an improved delivery system that further achieves these goals. PCMH practice recognition that is inherent in the model provides assurance that the practice has acquired and uses HIT in an optimal manner. Collecting, analyzing, using, and reporting how care compares to vetted measures of clinical quality is also inherent in the PCMH model.

ACP is pleased that the House Committee on Small Business is examining the issues pertaining to HIT adoption and use. We strongly believe Congress has a very important role in promoting HIT adoption and providing the necessary initial and ongoing funding mechanisms to assist small physician practices. The benefits of full-scale adoption of interoperable HIT will be significant, leading to a higher standard of quality in the health care system. Unfortunately, without adequate financial incentives, small physician practices will be left behind the technological curve and their patients with them.

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