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SUBCOMMITTEE ON REGULATIONS AND HEALTHCARE HEARING ON HEALTH IT ADOPTION AND THE NEW CHALLENGES FACED BY SOLO AND SMALL GROUP HEALTH CARE PRACTICES

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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CONTENTS

OPENING STATEMENTS

	Page
Dahlkemper, Hon. Kathy	1
Westmoreland, Hon. Lynn	2

WITNESSES

Blumenthal, Dr. David, National Coordinator for Health IT, U.S. Department of Health and Human Services	4
Fetzner, Mr. Jim, CEO, Comfort Care, Erie, PA	12
Jackson, Mr. Rob, CEO, Grove City Medical Center, Grove City, PA	15
Kressly, Dr. Susan, American Academy of Pediatrics, Warrington, PA	17
Stuckey, Dr. Charles, Executive Director, Pennsylvania Optometric Association, Harrisburg, PA, On behalf of the American Optometric Association	18
Edwards, Dr. Carladenise A., Chief of Staff, Georgia Department of Community Health, Atlanta, GA	20

APPENDIX

Prepared Statements:

Dahlkemper, Hon. Kathy	34
Westmoreland, Hon. Lynn	36
Blumenthal, Dr. David, National Coordinator for Health IT, U.S. Department of Health and Human Services	38
Fetzner, Mr. Jim, CEO, Comfort Care, Erie, PA	46
Jackson, Mr. Rob, CEO, Grove City Medical Center, Grove City, PA	50
Kressly, Dr. Susan, American Academy of Pediatrics, Warrington, PA	56
Stuckey, Dr. Charles, Executive Director, Pennsylvania Optometric Association, Harrisburg, PA, On behalf of the American Optometric Association	61
Edwards, Dr. Carladenise A., Chief of Staff, Georgia Department of Community Health, Atlanta, GA	65

Statements for the Record:

Association for Healthcare Documentation Integrity / Medical Transcription Industry Association, Modesto, CA	74
American Academy of Ophthalmology	92
Rural Hospital Coalition, Inc., Pride, LA	95
Lousiana Rural Health Information Exchange, Bunkie, LA	97
National Rural Health Association, Kansas City, MO	99
Rural Wisconsin Health Cooperative, Sauk City, WI	103
National Center for Policy Analysis, Washington, DC	105
PDX, Inc., Fort Worth, TX	109

SUBCOMMITTEE ON REGULATIONS AND HEALTHCARE HEARING ON HEALTH IT ADOPTION AND THE NEW CHALLENGES FACED BY SOLO AND SMALL GROUP HEALTH CARE PRACTICES

Wednesday, June 24, 2009

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

The Subcommittee met, pursuant to call, at 10:05 a.m., in Room 2360, Rayburn House Office Building, Hon. Kathy Dahlkemper [chairwoman of the Subcommittee] presiding.

Present: Representatives Dahlkemper, Altmire, Westmoreland, and Thompson.

Chairwoman DAHLKEMPER. This committee hearing is now called to order. Good morning.

With Congress and the administration prepared to modernize our health system, today's hearing is especially timely. In crafting health care reform, it is important to not only find ways to provide coverage to more Americans, but also to identify ways to reduce costs.

During a roundtable discussion and previous hearings, this committee heard how spiraling health care costs are squeezing small businesses. New technology in the form of health IT and electronic health records, or EHR, can go a long ways towards reducing these costs. Some experts estimate that wide-scale adoption of health IT would lead to an annual saving of $77 billion.

By streamlining data flow and increasing communication between providers, health IT reduces errors, increases efficiency, and can save patients' lives. However, implementation of health IT has not occurred as rapidly as we would have hoped. Smaller and solo health care providers have a particularly hard time when it comes to adopting health IT. Fifty-seven percent of physicians who are in practices with more than 50 doctors utilize electronic health records. By contrast, only 13 percent of solo practitioners are putting this new technology to use. This health IT gap is particularly significant when you consider that most treatment occurs in small practices. Eighty percent of all outpatient visits take place in medical practices with 10 or fewer doctors. Given these facts, it is clear we need to find ways to make this technology accessible for small doctors' offices.

Most physicians recognize that health IT is a critical investment. They know that HIT and EHR will not only save money in the long

term, but help them better meet patients' needs. The main problem is that integrating health IT and EHR into a medical practice is so expensive up front. The starting price tag on health IT system is $32,000 per doctor. This means the typical medical practice with three doctors pays close to $100,000. That is a big investment for any business, and for many physicians it is enough of a hurdle to stop them from purchasing health IT.

Like any new product, the price of health IT will drop as it becomes more mainstream and more practices purchase it. However, it is unclear when we will reach this tipping point and see prices dip to affordable levels. With the President and Congress moving forward swiftly with health care reform we cannot wait for the market alone to solve this problem.

The American Recovery and Reinvestment Act took some important steps to spur health IT adoption. Through Medicare and Medicaid payments, the new law rewards physicians who start using this technology. However, even with these incentives, many small practitioners will find it difficult to make the necessary initial investment.

That was why I am proud to be introducing the Small Business Physicians Access to Capital Act of 2009. This bill will establish a new loan program at the Small Business Administration, designed specifically for doctors who want to invest in health IT.

Ultimately, small and solo health care practitioners are small businesses. Similar to small businesses everywhere, one of their biggest challenges is accessing affordable capital. This legislation will help them find that capital.

It is my hope that we can explore solutions like these during today's hearing. If we can make health IT more affordable for physicians, we can make health care more affordable for everyone.

I would like to thank all of today's witnesses in advance for their testimony. I know that you are taking time away from your businesses to be here, and I look forward to hearing from you.

With that, I would like to yield to the ranking member, Mr. Westmoreland, for his opening statement.

Mr. WESTMORELAND. Thank you, Madam Chairwoman, and I thank you for convening this timely hearing on health information technology and small health care practices.

I would like to extend a special welcome to all of our witnesses and especially Dr. Carladenise Edwards, a fellow Georgian, whom I will introduce later.

As Congress considers health care reform legislation, health information technology will be an important component of that effort. This is a critical issue for the medical profession and particularly small medical providers. Some studies estimate that 75 percent of practices in the United States have five or fewer physicians.

Health IT is a useful tool for the management of medical information and its exchange among patients and providers. This technology can help to reduce errors, better manage chronic diseases, decrease paperwork and increase efficiency. Despite these benefits, fewer than one out of ten small medical practices have fully electronic health records.

Barriers to small practices adopting health IT such as cost and the risk of purchasing systems which may become obsolete remain.

This year's stimulus legislation included ambitious goals for the adoption of health information technology. It established Medicare incentives to providers who demonstrate meaningful use of health IT and penalties for those who do not, strengthened the HIPAA privacy rule—which, by the way, is one of the biggest reasons that health care is so expensive, according to a lot of providers I have talked to—and created a new patient right to be notified in the event of a breach. The Department of Health and Human Services will issue regulations regarding that law.

As we move forward, we hope that small manufacturers of health IT systems and their users, as well as small-practice physicians and hospitals, will be included in that dialogue.

The National Coordinator for Health IT, in consultation with the Hit Standards Commission, has been drafting standards in the certification for health IT. We are awaiting a definition of ″meaningful use,″ as this definition is critically important to those people providing.

In addition, while I believe that health IT has many benefits and we should encourage its adoption, small providers are concerned about interoperability, privacy, and security standards, and the fact that the HIT funding has not yet begun to be distributed. It is important that these concerns be considered.

Finally, I want to add a word about health care reform generally. Small companies are struggling. In a difficult economy, they are doing their best to stay in business. A mandate that employers must offer health insurance will simply add to their already stretched bottom line.

I feel strongly that exempting even some small firms will be an invitation to Congress to go back at some future point and include more of them in the mandate; and I am concerned that a national, government-run health care system could drive private insurers out of the market, reducing competition and raising costs.

Everyone in this room has been a patient, and everyone understands that for privacy and for respect of medical information, the most important issue for health care reform should remain the doctor-patient relationship. I would hope that health care reform will acknowledge this fact.

Madam Chairwoman, I appreciate you calling this important hearing, and I look forward to hearing the testimony of these witnesses.

Chairwoman DAHLKEMPER. Thank you.

I would like to introduce our first witness, Dr. Blumenthal.

Welcome.

Dr. David Blumenthal is the National Director for Health IT in the U.S. Department of Health and Human Services. As the National Coordinator, Dr. Blumenthal leads the implementation of a nationwide health information technology infrastructure. HHS is the government's principal Agency for protecting the health of all Americans and providing essential human services.

We look forward to your testimony.

STATEMENT OF DAVID BLUMENTHAL, M.D., M.P.P., NATIONAL COORDINATOR, OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH IT, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. BLUMENTHAL. Thank you, Madam Chairwoman.

Madam Chairwoman, ranking member Westmoreland, members of the subcommittee, I am David Blumenthal. I am the National Coordinator for Health Information Technology in the Department of Health and Human Services, and I am very pleased to testify before you today on the administration's health information technology activities and specifically how they impact small health care practices.

Health information technology, or HIT, allows comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of health information technology has the potential to improve health care quality, to reduce unnecessary health care costs and to improve population health.

The American Recovery and Reinvestment Act of 2009 included the Health Information Technology for Economic and Clinical Health Act, or HITECH act. The HITECH Act includes $2 billion in funding to the Office of National Coordinator to lay the groundwork for the adoption and meaningful use of HIT through infrastructure programs. It also includes an estimated $44.7 billion in incentive payments from Medicare and Medicaid to providers who are meaningful users of certified electronic health record technology.

Many physicians in small practices want to adopt HIT, but do not have the ability to invest upwards of $40,000 in the technology systems. By providing physicians and other health care providers with financial assistance for adoption and use of interoperable HIT, we will help reduce this burden.

Physicians, including those in solo or small practices, can receive up to $44,000 under Medicare in incentive payments for being meaningful users of certified electronic health records. The HITECH Act includes grant programs, as well as education and technical assistance opportunities, to health providers, especially those in small practices, to overcome barriers to adoption.

Meaningful users will become eligible for incentive bonuses in 2011. Beginning in 2015, the Recovery Act authorized penalties under Medicare for eligible professionals and hospitals that fail to demonstrate meaningful use of certified electronic health records. The qualification criteria for incentives are still in development and will be defined through regulation.

The HIT Policy Committee, which is the Federal advisory committee that provides recommendations to the National Coordinator, met on June 16th, 2009 to discuss proposed objectives and measures of meaningful use. This discussion focused on a vision of health care that outlined a progression from process measures in 2011 to outcome measures in 2015 for improved population health.

ONC and CMS are hosting listening sessions targeted at small health care practices so that HHS is informed of their questions and unique concerns as HITECH is implemented. The definition of

″meaningful use″ is a key step toward transforming our health care system.

In addition to the incentive payments, the HITECH Act authorizes grant programs that ONC can implement as health providers and communities adopt and become meaningful users of electronic health records. Two of these include regional extension centers and State grants to promote health information exchange, or HIE.

Currently, 21 percent of physicians have adopted an EHR. The adoption rate among small health care practices is significantly lower at about 13 percent. This discrepancy in the rate of adoption for the Nation and for small practices highlights the need for focused technical assistance for small health care practices.

The HITECH Act authorizes an HIT extension program to make assistance and education available to all providers with priority given to select providers, including individual or small practices and small group practices that are focused primarily on primary care.

HHS is actively working to get programs planned and implemented this year to support hospitals and eligible providers in becoming meaningful users of EHRs. The HITECH Act provisions of the Recovery Act provide a historic opportunity to improve the health of Americans and the performance of the Nation's health system through an unprecedented investment in HIT.

This initiative will be an important part of health reform as professionals and health care institutions, both public and private, will be enabled to harness the full potential of digital technology to improve and increase the efficiency of our health care system.

Madam Chairwoman, thank you for the opportunity to appear before you today. I would be glad to answer any questions.

[The statement of Dr. Blumenthal is included in the appendix.]

Chairwoman DAHLKEMPER. Thank you, Dr. Blumenthal.

I yield myself 5 minutes for questioning.

Dr. Blumenthal, you talked about the meaningful use requirements as this was defined obviously in the stimulus— well, it isn't defined; that is why we are looking to defining it—and you state in your testimony that you expect to publish a rule by late 2009.

This is midway, through June, now. How has your office approached defining this issue? What steps will you take if you are unable to make that deadline? Will you make that deadline by the end of this year?

Dr. BLUMENTHAL. The regulation will actually be a CMS regulation, because CMS is tasked with providing the incentive payments to physicians and hospitals under the law. So CMS will actually run the regulatory rulemaking process.

Their plan right now is to have that regulation ready to put in the form of a notice of proposed rulemaking by the end of this calendar year, and we will be advising them on that definition and helping them come to a conclusion about it.

We have a continuing process that we have outlined. We are going to hold another hearing of our Health Information Technology Policy Committee on July 16th. That group heard from a working group on a definition of ″meaningful use″ on June 16th. We are still in the process of a public comment period on that definition, which I want to make clear was a definition proposed by a

working group of our advisory committee, not by the Department; and that advisory committee, after the July 16th hearing, we hope will make some recommendations to the National Coordinator.

There will then be a period of open comment on that definition, and then the process of rulemaking will begin formally; and we hope that that a notice of proposed rulemaking will be available by the end of the calendar year.

Chairwoman DAHLKEMPER. Who is involved in the working group? Can you give me a few examples?

Dr. BLUMENTHAL. The working group was actually created by the Recovery Act. Its membership was very explicitly defined. GAO appointed the large bulk of the members, Members of this body, and the Senate appointed additional members and the Secretary appointed three members. And it represents a broad group of stakeholders, hospitals, physicians, insurance companies, consumers, so it is a very broad and very clearly defined membership in the law.

Chairwoman DAHLKEMPER. Okay.

Since the certification process can be slow, some providers will be unable to adopt certified EHR systems when the incentives for the Recovery Act become effective.

What steps is HHS taking to encourage the Commission on Health Information Technology to develop and implement standards more quickly?

Dr. BLUMENTHAL. We are comprehensively reviewing the certification process. We were asked to do that under the law. We will be making recommendations concerning what the certification process should be. The Certification Commission For Health Information Technology has been tasked with doing certification in the past. We will be looking at its role going forward. We certainly hope that that process will be capable of certifying very many—certainly more than sufficient number of records, so that physicians and hospitals will have ample time to adopt certified records. That is certainly the goal of our office. And we hope to be able to design a process that allows innovation, the certification of new and innovative products, as well as the certification of products that already exist on the market.

Chairwoman DAHLKEMPER. The Recovery Act did not extend HIT funding to a large number of health professionals who operate in the Medicare and Medicaid program. However, many expect HHS to compel these providers to adopt HIT if they are going to continue offering Medicare and Medicaid services.

If HHS takes this step, should there be some relief or financial incentives for these providers as well?

Dr. BLUMENTHAL. I hear in your question an assumption as some point we may compel the adoption of health information technology. I want to make clear that that is not contained in the Recovery Act right now. And so I think it is somewhat speculative to talk about what would happen if that were to happen in the future. That is not a plan on the books right now in the Department.

Chairwoman DAHLKEMPER. There is no—you are not looking at compelling others to do this at this point?

Dr. BLUMENTHAL. No. No.

Chairwoman DAHLKEMPER. My 5 minutes is up. I will now recognize the ranking member, Mr. Westmoreland, for 5 minutes.

Mr. WESTMORELAND. Thank you, Madam Chair.

Dr. Blumenthal, when this legislation was signed and put into effect, how long had this legislation been in the system, the HITECH legislation? Or was this something that was just created?

Dr. BLUMENTHAL. Well, Congressman, there were a number of bills that had been close to passage in the past. As a matter of fact, bills similar to this legislation had passed the Senate and had actually passed the House and had failed to get agreement in conference. So many of the provisions were familiar to the health committees that had jurisdiction over this area.

Now, my history is not authoritative in this regard, so I can only tell you what I observed at that time as a nongovernmental—

Mr. WESTMORELAND. How long have you been with the Department?

Dr. BLUMENTHAL. Since April 20th, sir.

Mr. WESTMORELAND. So not that long?

Dr. BLUMENTHAL. Not that long.

Mr. WESTMORELAND. The HIT policy committee, what is the makeup of that? I don't know if you were talking about the advisory committee a while ago or the HIT committee.

Dr. BLUMENTHAL. Well, we would be glad to get you the roster of that group if you would like to see it.

Mr. WESTMORELAND. Is it 10 people?

Dr. BLUMENTHAL. Twenty-three people.

The great bulk of that membership was specified in law. The process of appointment was specified in law, and 20 of those 23 were appointed either by the GAO or by the leadership of the House and the Senate.

Mr. WESTMORELAND. And the membership, what is it made up of? I mean, what professions? What backgrounds?

Dr. BLUMENTHAL. Physicians, consumers, nurses, people who run neighborhood community health centers, people who are members of the health insurance community, people who are experts on privacy and security, and people who are experts in public health. There are some members of the Federal Government, representatives of the Department of Defense, the VA, the Office of Science and Technology Policy.

It is designed to be broadly representative of the stakeholders who are playing a role, who have to be part of the process of health information technology adoption.

Mr. WESTMORELAND. How about any people from the IT community?

Dr. BLUMENTHAL. Yes, we have people who have developed and sold health information technology—the chief executive officer of a company called EpicCare and another gentleman who has started and run and sold two HIT companies.

Mr. WESTMORELAND. How many companies provide the IT service to physicians and hospitals and providers?

Dr. BLUMENTHAL. I don't have an exact number for you. I can get you that number.

But I can tell you that the certification commission in the past has certified well over 100 ambulatory care products, so there are at least 100 discrete providers of health information technology. It is a very competitive market.

Mr. WESTMORELAND. And I am assuming that the goal of this is that all of it will be interoperable.

And with over 100 different companies providing the service, have we got any committee or anything that is looking into how they are working together to try to do that, and is that something that they are going to willingly do? Because you know that will take some information trading, I guess, to be able to do that.

Dr. BLUMENTHAL. Well, Congressman, the House and Senate equipped us with two committees to advise the Office of National Coordinator. One is the policy committee which we have been discussing. There is another called the Health Information Technology Standards Committee.

The critical element in communicating between different software are the standards that the software has to meet so that the information in both is recognizable to each system. And the Health Information Technology Standards Committee is tasked with advising the office on the standards that are required for interoperability.

They have met twice as well. They have to, by statute, provide—not they, but the office, with their advice. The Department has to provide an interim final rule by the end of the year on the standards that are required for certification. So we are under considerable time pressure to get those standards up and ready.

We held a meeting of the standards committee yesterday and they are providing invaluable advice. It is a complex, difficult undertaking, but we are hoping that the fact that the ″meaningful use″ definition that was outlined by the Congress does require interoperability will focus the vendors on that requirement and also focus the purchasers, small practices and large, hospitals, both individual hospitals and groups of hospitals, on the interoperability provisions and capabilities of their software that they are purchasing.

Mr. WESTMORELAND. I see my time is up and I hope the chairlady will allow us to have one more round of questioning.

Chairwoman DAHLKEMPER. I now recognize the gentleman from Pennsylvania, Mr. Altmire.

Mr. ALTMIRE. Thank you. I wanted to follow up on Mr. Westmoreland's question on interoperability.

One of the problems, as I am sure are aware, with health IT with regard to government entities is the VA and DOD. Completely interoperable. When somebody completes their military service and goes to the VA, the VA receives a PDF file by e-mail that is—you cannot manipulate the data in any way; someone has to actually sit down at the computer and type in what might be 30 years of medical data, because they can't transition over.

And one of the concerns I have with implementing health IT across the country is that there are a lot of hospital systems providers in this country that are doing the right thing now without government money; they are spending their own money and resources to get health IT off the ground. And I am concerned about having a situation develop across the country that will be similar to what the DOD and VA have. Where you have systems that cannot communicate with each other.

I am wondering if you have commentary on how we can prevent that from happening. I don't want to be in the position where this money gets rolled out, and we penalize the people who have already done this on their own by saying, Sorry, you are not compatible with the system that we want you to use.

Dr. BLUMENTHAL. We don't want that to happen either, Congressman. And our view is, if we can provide the standards that allow interoperability and the models of working interoperable systems—which we have been doing through work that we are doing on the National Health Information Network—that if we can provide that, then providers will be motivated to take advantage of those standards and also those mechanisms to achieve interoperability.

There have been in the past some technical obstacles. We think those can be overcome, that vendors could overcome them if purchasers demanded that they provide the capability.

There has not been an incentive of the kind that we now will have under Medicare and Medicaid for individual physicians or institutions to demand that interoperability be a feature of the electronic health records that they purchase.

Some of those vendors will be able to retrofit or add on interoperability capability. Some may not. And in the latter case, it may be necessary for some providers to seek an alternative vendor. But they will have funding from Medicare and Medicaid to help them to do that.

Mr. ALTMIRE. How far away do you think we are and how realistic is it that in the near future—my district in Pittsburgh, Pennsylvania—that someone from my district on private insurance will be able to travel to Portland, Oregon, show up at the hospital and have their records pulled up?

How far away in the future is that?

Dr. BLUMENTHAL. Well, I wish I had a crystal ball to be able to answer that question, and I don't. It is our goal to develop that kind of interoperable health system as soon as we possibly can. And I think that that capability will be in existence in a matter of a few years for some types of providers, especially large institutions.

But to say that it will be universally available in a particular number of years, I think would be hard to speculate about.

Mr. ALTMIRE. Thank you.

And it is not much time, but I would be happy to yield my remaining minute or so to Mr. Westmoreland if he has another question.

Mr. WESTMORELAND. Thank you very much.

And I wanted to go to the ″meaningful user,″ the definition. You mentioned that you all had a meeting, I think on June 16th. I think you mentioned an open comment period?

Dr. BLUMENTHAL. Yes.

Mr. WESTMORELAND. Okay. And so when is that up? When is the comment period—

Dr. BLUMENTHAL. The 26th of June. It has been open for 10 days, from June 16th to June 26th.

Mr. WESTMORELAND. And this was an open comment period on the definition or what the definition should be?

Dr. BLUMENTHAL. It certainly could involve that.

The explicit invitation was to comment on the working document that the committee produced, which outlined a set of ″meaningful use″ definitions.

Mr. WESTMORELAND. Okay.

Now, who all was—I mean, you are getting this input from all the medical community—IT providers, hospitals?

Dr. BLUMENTHAL. Well, sir, we don't know yet all of who will comment, as we are collecting that input. And if you would like to know more about who has commented, we would be glad to get you that information.

[The information is included in the appendix.]

Mr. WESTMORELAND. I think that is interesting, because that is so critical a term to this whole process. And for a 10-day period—you know, that is not a long time.

Dr. BLUMENTHAL. That is not the only time they will have, Congressman. After our next meeting on July 16th there will be another open comment period; and then when the notice of proposed rulemaking is listed, there will be a 60-day comment period. We want this to be an open and responsive process.

Mr. WESTMORELAND. That is like the old ″Once the horse is out of the barn, it is too late to close the gate.″ From my experience with these comment periods, once the committee gets into their mind what they are going to do, you can comment about anything and it is not going to change the fact.

The best time to get in is at the front, rather than the end of it. But thank you.

Chairwoman DAHLKEMPER. I will open up for another round of questions, so that we can continue this. There are some important issues to bring up here.

I wanted to ask you, Dr. Blumenthal, for many physicians—and I get this complaint all the time from physicians in my area—the Medicare and Medicaid reimbursements are already low. And the penalties could further diminish these payments for practices that do not transition to electronic health records.

I am afraid in my home State we are going to see physicians turning away from treating anyone who is on Medicaid or Medicare and avoid that financial burden.

So, has HHS examined how these penalties will affect patient care and access to care?

Dr. BLUMENTHAL. Well, Madam Chairwoman, I think that the first point I would like to make is that the American physicians and hospitals now have available $45 billion to support the adoption of health information technology that they didn't have before the Recovery Act. So that is an enormous new investment by the American taxpayer in making this technology possible to adopt.

In 2015, those who have not could be the subject of penalties. That is true. It is 1 percent the first year, 2 percent the second year, and 3 percent the third year. It is certainly our hope that those penalties will never go into effect and that the great majority of providers will have become meaningful users by 2015.

Chairwoman DAHLKEMPER. But 1 percent, 2 percent, 3 percent, do you have any idea whether those will be physicians from small practices versus physicians from larger practices? I think the testi-

mony and some of this questioning going forward is that those who are in single practice or two or three docs in practice have a much more difficult time financially.

Dr. BLUMENTHAL. Sure. I understand that.

We obviously don't know 6 years from now exactly who will have become a meaningful user and who will not. And we will, of course, be examining that as time goes on.

I do want to point out that the law makes special provision for technical assistance to small practices and through the extension center mechanism that we are planning to implement in the near future. This is very real, hands-on support and help for adopting electronic health records and learning to be a meaningful user of that record.

So that is part of the $2 billion that we have available to provide technical assistance to small practices and small hospitals. And we are working very hard figuring out how best to use that money right now.

Chairwoman DAHLKEMPER. Is there any provision for more of the funding going towards those practices percentage wise?

Dr. BLUMENTHAL. It is certainly possible that we could do that. The law draws attention to small practices and primary care physicians.

Chairwoman DAHLKEMPER. Who would make that decision?

Dr. BLUMENTHAL. The Secretary would.

Chairwoman DAHLKEMPER. Is there any talk of that currently?

Dr. BLUMENTHAL. I think we are looking at all the options, Madam Chairwoman. And that is certainly on our mind; we understand that small practices carry an extra burden.

Chairwoman DAHLKEMPER. Okay. I am going to yield at this point to Mr. Westmoreland.

Mr. WESTMORELAND. Thank you.

Dr. Blumenthal, I know you have only been there a short period of time and didn't have any input into the language of the bill, but why would 13 members of this HIT policy committee be appointed by the Comptroller General?

Dr. BLUMENTHAL. Sir, I really can't get into the minds of the folks who wrote this legislation.

Mr. WESTMORELAND. I can't either. I don't know of anybody in this room who could, really. I guess the interesting part is just the makeup of this board and exactly what is going on.

But each State, I am assuming, is going to get some money to help them communicate with these health records also; is that right?

Dr. BLUMENTHAL. That is correct. The Appropriations Committee directed us to spend $300 million—at least $300 million on grants to States to encourage health information exchange.

Mr. WESTMORELAND. And then the 44,000 that will go to the physicians or the health care providers, when do you see that money—how long do you think it is going to take to get the program started?

Dr. BLUMENTHAL. The first incentive payments become available in 2011. So we are devoting ourselves to laying the groundwork so as many physicians and hospitals as possible can be eligible for those funds in 2011.

Mr. WESTMORELAND. And your Department will be the one administering that? They are actually apply to your Department?

Dr. BLUMENTHAL. They actually will apply to the Center for Medicare and Medicaid Services because they will be eligible for incentive payments in Medicare and Medicaid funding, and that is the authority of CMS, rather than my office which is devoted to developing policy and programs around health information technology.

We don't control the Medicare and Medicaid programs.

Mr. WESTMORELAND. And as far as the security goes, you know, we have foreign countries hacking into our grid system and doing things. And, you know, with the few HIPAA requirements and stuff, who is going to be responsible if somebody hacks into this system and people's medical records get out?

Because, you know, if somebody drops a chart off of a cart or leaves it laying open in a hospital, that is one person. You hack into a system, you are talking about millions of people.

Who is going to bear that responsibility? Is it going to be the doctor? Is it going to be the person that wrote the IT program? Is it going to be the government? Who is going to be responsible for that?

Dr. BLUMENTHAL. Well, that is an excellent question; and we are very, very committed to making this system as private and secure as possible. We are exploring ways to increase its privacy and security, and the liability for any breaches falls, as I understand it, to the organization that holds the information.

And we are going to have a very diverse information system in this country, as we have a very diverse health care system. So I imagine that it will depend on who is responsible in the particular case for collecting and holding that information.

But if you would like more information on that, I would be glad get back to you.

Mr. WESTMORELAND. Your Department is going to be responsible for the rules and regs, right? I mean—

Dr. BLUMENTHAL. We are going to be responsible for some of the rules and regulations. A lot of what we are going to be doing is giving guidance to the States who often develop privacy and security laws. That is—in this country, HIPAA puts a floor under this, but the States can supersede HIPAA regulations and create additional regulations, and they often do.

Mr. WESTMORELAND. If they do, then I could see where they could be responsible for the difficult thing, but if they just go with the Federal Government's HIPAA regulations, who is going to bear the responsibility for these—

Dr. BLUMENTHAL. Congressman, I would like to get back to you on that because I would like a legal opinion on that.

Mr. WESTMORELAND. That is fair enough.

Dr. BLUMENTHAL. I have to apologize, but I have a 10:45 obligation on the Senate side. I informed your staff of that as we were preparing for this hearing.

So with your permission, I will leave a little bit early. If there are other questions that you would like me to answer, I am sure that we could get back to you in writing.

Chairwoman DAHLKEMPER. Dr. Blumenthal, I thank you for being here today, and I thank you for your time. And I am sure you will be available, and if anyone on this committee has further questions that we could contact you and your staff.

Dr. BLUMENTHAL. Certainly.

Chairwoman DAHLKEMPER. Thank you.

We have been called for a vote, and it looks like it is going to be one vote. And so I think we are going to—we can run over and vote and come right back and then we will resume the hearing with the second panel when we return from voting.

The committee stands in recess.

[Recess.]

Chairwoman DAHLKEMPER. We want to thank the second panel for your patience.

Chairwoman DAHLKEMPER. We will reconvene the hearing. And I would ask the witnesses to please watch your clocks; you will have 5 minutes to deliver your prepared statements. The time begins when the green light is illuminated. When 1 minute remains, the yellow light will come on, and the red light when the time has expired. You have a button that says ″Talk″; make sure that you hit your button and shut it off with your statement.

I would like to introduce our first witness, and it is Mr. Jim Fetzner, the CEO of Comfort Care and Resources in Erie, Pennsylvania, my hometown. Mr. Fetzner is working on service innovation and health care IT initiatives in his company. Founded in 1997, Comfort Care is a home-based care provider that offers flexible, cost-effective solutions so that elders may live in their homes regardless of physical and social needs.

Welcome to Washington. Thank you for being here Mr. Fetzner.

STATEMENT OF JAMES P. FETZNER

Mr. FETZNER. Thank you Chairwoman Dahlkemper, Ranking Member Westmoreland and members of the committee for allowing me the opportunity to testify today regarding health care information technology and Title XIII of the American Recovery and Reinvestment Act of 2009. I consider it an honor to be a part of the process of moving our health care system into a new and critically important generation of technology and service delivery.

My name is James Fetzner, Chief Executive Officer of Comfort Care and Resources. Currently, we serve three counties and hundreds of patients, enabling them to age in place. Our company was started in 1997 by my mother, Beverly Fetzner, with only a pager, a passion, and a belief that there is nothing that is done in a nursing facility that cannot be done better at home. At that time, and unfortunately still, in some places this philosophy is a radical idea; however, it has informed my vision as CEO.

As a result, we continue to push the forefront in long-term care, working with multiple technology incubators, university centers, State departments and local agencies. With these partners, we will create an integrated and interoperable HIT-enabled service delivery system that will drastically reduce the cost of long-term care.

It is from this perspective as an entrepreneur, not as a clinician or practitioner, that I offer my testimony on HIT.

While Title XIII makes mention of additional settings and is intent on facilitating standards for these settings, the clear emphasis and investment is focused on the adoption and meaningful use of certified EHR. While this is certainly necessary, it is not sufficient. Meaningful use will not be realized until new, high-value information is incorporated into work flow and decision-making.

When a cardiologist can see a trend analysis for daily vitals of a congestive heart failure patient living independently at home is when meaningful use will exist. This type of meaningful use does not occur by investing in certified EHRs alone. This occurs when an entire provider network is connected and coordinated around that patient's plan of care. For information to be delivered to and from the front lines of care in our homes and communities a seamless ecosystem must emerge. Enterprise integration will be critical as information will need to pass to and through multiple providers.

Providers such as skilled home health agencies, nonmedical home care agencies, area Agency on Aging case management and others will need to utilize and contribute to that information before it comes to rest in EHR at a primary care physician's office. Additionally, triggers and alerts will need to be designed for each individual patient to allow anomalies to jump out from the steady stream of data that will be created.

If we simply digitize information that exists through EHRs, the margin of value from HIT will be limited. Significant value will be achieved when new high-value information can be delivered, assimilated and leveraged for clinical and operational decision-making.

The most valuable information will be delivered from the front lines of care where we did not have access to it before from our nurses and from our nursing assistants. This is more challenging by the day as the front lines of care are becoming dispersed and disintegrated.

Nearly every person's home is part of the health care system at some point and the home's role will only increase with cost containment measures requiring early discharges and less institutionalized care.

It is clear to me that if we look to the future of the health care system, the entry and exit points will no longer be our hospitals and doctors' offices, but rather they will be individual homes. Whether that be a patient utilizing the Internet to check and update their personal health information or clients for whom we monitor and deliver information to their doctors and families, the starting point will be home. Therapy, recovery, and end-of-life care will continue to shift towards home to match patients' desires in a more cost-effective, high-quality way.

With advances in technology, we can confidently move forward to redefine the health care system knowing that the past insurmountable problems of time and distance will be overcome. No longer will patients need to adjust their lives to fit our health care system, but rather our health care system will conform to each individual. For long-term care, this will mean long overdue deinstitutionalizing of seniors.

I am honored to be a part of the solution and thank you for your time; and I look forward to your questions.

Chairwoman DAHLKEMPER. Thank you, Mr. Fetzner.

[The statement of Mr. Fetzner is included in the appendix.]

Chairwoman DAHLKEMPER. Our next witness is Mr. Rob Jackson, who is the CEO of Grove City Medical Center in Grove City, Pennsylvania, also in my congressional district.

And welcome to Washington.

Mr. Jackson is responsible for the oversight and development of an integrated health system in the center. The Grove City Medical Center currently is licensed to operate 95 acute-care beds and 20 skilled nursing beds.

I appreciate you coming down from the Third District and I look forward to your testimony.

STATEMENT OF ROBERT C. JACKSON, JR.

Mr. JACKSON. Good morning. I am Robert Jackson, Chief Executive Officer of Grove City Health System. Grove City Health System is composed of Grove City Medical Center, which is a 95-bed community hospital; Wolf Creek Medical Associates, which is a multispecialty physician group practice; and a charitable foundation called Grove City Health System Foundation.

We are the nearest health care facility to the intersection of Interstate 79 and Interstate 80 in northwestern Pennsylvania. From a geographical perspective, we are 1 hour due north of Pittsburgh and 1 hour and 15 minutes due south of Erie. Our hospital serves a primary service area of 55,000 people containing the communities of Grove City, Mercer and Slippery Rock, Pennsylvania. About 100 physicians have privileges at our hospital with 35 of them considered to be active members of the medical staff.

In order to provide a framework to analyze my testimony, I need to explain where we are as far as our journey towards electronic medical records. Our health system has spent close to $2 million in software, hardware and training costs to accomplish an integrated system among our facility and our medical staff. I would like to explain briefly some of the pros and cons that we see related to the adoption of an electronic medical records in the semirural and smaller provider environment.

Not everything is made better with automation; however, EMRs offer physician offices the opportunity to streamline office procedures and share information among staff members in an incredibly efficient manner. Use of an EMR brings a higher level of patient safety and regulatory compliance to a practice. For example, with its ability to review a drug through volumes of information to identify any potential pharmaceutical interactions or other allergies that the patient may have, the patient and the physician can have greater confidence in the prescribing of that pharmaceutical for their condition.

The documentation capture with an EMR is more detailed and provides a easily searchable repository of information and patient's history at the physician's fingertips. Hospitals and physicians have begun sharing information electronically at the local level, but what is astounding to consider is the potential of the information that can be exchanged and how it can improve the health of our Nation.

However, that is not to say there is not a downside. The introduction of EMRs to the hospital and physician practice environment adds cost to patient care. A private practice office is potentially looking at $50,000 for initial investment in hardware and software, group practices in the neighborhood of $200,000, and as I mentioned, the hospital and its affiliates have spent close to $2 million. This is just to get started. It does then also require monthly maintenance and service contracts, which again adds cost without additional revenue.

Initial implementation of an EMR has the potential to reduce the throughput of a practice up to 50 percent in some cases. Considerations need to be made for those staff that may not be able to learn how to use the EMR or may choose not to.

The use of EMR also affects the sacred relationship between the physician and the patient. Patients need to feel like they have been heard when they have a visit with their physician. The introduction of this technology into the patient care relationship can be disruptive to that relationship.

Incentives make sense when you begin to think about what a physician practice would have to give up in order to have an EMR. As physician practices grow in the number of providers their employ, the use of an EMR increases efficiency and makes it a worthwhile endeavor. However, as a one- or two-physician practice, you would think long and hard before making this decision.

I would like to touch briefly on where this all may be going. The physicians and hospitals that care for me on a regular basis both have EMRs. The question is, how does that help me when I need emergency services when I am visiting Washington, D.C.? Providing incentives through the ARRA is a great step to move those physicians and other health care providers, who may have been on the fence, forward. Nevertheless, at the end, what we have we created? There will be physicians on a myriad of systems, and in some cases they will be able to transfer information with the hospitals they work with.

As EMR adoption is a central tenet of cost savings in the redesign of the health care system, there needs to be a plan on how this will actually improve the health of individuals and not just provide another mechanism to penalize the reimbursement of health care providers. The impact of EMR adoption is significant regardless of the size of the health care provider. The group that has the greatest risk is the small, independent physician practice.

As we travel along our journey through to an EMR environment—and eventually, we hope, an EHR environment—the incentives will help us get there. However, the plan for health care redesign happening concurrently with this initiative needs to be considered as the implementation of an EMR cannot be only a cost savings strategy and not one to help patient care.

Chairwoman DAHLKEMPER. Thank you, Mr. Jackson.

[The statement of Mr. Jackson is included in the appendix.]

Chairwoman DAHLKEMPER. I would like to introduce Dr. Susan Kressly, a Board Certified pediatrician and a Fellow of the American Academy of Pediatrics. She has a private practice in pediatrics in adolescent medicine in Warrington, Pennsylvania.

The American Academy of Pediatrics was founded in June 1930 and has approximately 60,000 members. Another fellow Pennsylvanian; it must be Pennsylvania day here.

Welcome.

STATEMENT OF SUSAN KRESSLY, M.D., F.A.A.P.

Dr. KRESSLY. Thank you very much, Chairwoman Dahlkemper and members of the committee. Thank you for your leadership and representation of the Third District of Pennsylvania. Many children in northwest Pennsylvania have been helped by the votes you have cast in favor of the reauthorization of SCHIP and ARRA. The Academy also applauds your attempts to find innovative solutions to help IT funding.

My name is Susan Kressly. I am a practicing pediatrician in Warrington, PA. I am honored to represent the American Academy of Pediatrics before you today.

On behalf of nearly one-third of America's population who cannot vote, I would like to express my gratitude to this committee for allowing me the opportunity to give children a voice. After 15 years in a large group practice, in 2004, I started my own small business convinced that there had to be a better way to create a medical home using technology. I wanted to increase practice efficiency, so I could spend more time listening to my patients.

My desire to provide higher quality medical care was enabled by the ability to collect and analyze meaningful data, such as patients who are overdue for preventive or follow-up care. My HIT allows me to practice medicine in a way that I always envisioned I could. I know what is possible. More pediatricians need help implementing similar technology.

Currently, pediatricians are the lowest adopters of HIT of all physician groups. Sixty percent of pediatricians practice in small businesses like mine. Many of us have found it difficult to purchase health IT systems on our own. A big factor in our inability to afford expensive technology has been the reduced Medicaid payments that most pediatricians receive. According to AAP surveys, Medicaid payments average around 70 percent of Medicare rates and vary widely from State to State. If a typical Medicare provider sees 20 patients per day, a Pennsylvania Medicaid provider must see 30 patients to earn the same amount.

And Congressman Westmoreland, Atlanta is the same.

In New York, the Medicaid provider burden jumps to 40 patients and my exhausted colleagues in Chicago must see 50. With Medicaid now covering more than 30 million children, this pace is simply unsustainable.

The Academy greatly appreciates the funding included in ARRA for pediatricians to purchase health IT. Unfortunately, the statute creates disparities between practices that are paid by Medicaid versus Medicare. First, ARRA funds flow differently for the two programs. ARRA requires practices to maintain a minimum percentage of Medicaid patients in order to qualify for incentives under that program. This requirement is not imposed on practices receiving Medicare payments. The Academy believes that this requirement should be repealed so that the Medicaid and Medicare incentives are comparable.

Second, the definition of ″meaningful use″ is treated differently for Medicare versus Medicaid programs. Medicare is defining a single national standard under which a practice will qualify for ARRA incentives. On the Medicaid side, it appears that States can create their own definitions. As a result, within a brief time there could be 56 different definitions of ″meaningful use″ in the various State and territorial Medicaid programs.

One-third of doctors practice near State lines. Under the current statute they might need to qualify under two or more States' meaningful use rules. I cannot imagine a single EHR vendor who will be willing to write 56 different meaningful use reports for medical practices to submit to their States.

The Academy believes that a single national standard for pediatric meaningful use is not only achievable, but essential for measuring and improving the equality of health care for all children. We stand ready to work with the appropriate agencies to create such a uniform definition.

We would also urge you to consider one other issue that could have immediate impact on the advancement of child health IT. There had been much talk about HIT interoperability. Every State maintains a central immunization registry, and the CDC has defined robust interchanged standards for these systems. Yet only a small handful currently offer real-time interoperability with EHRs and almost none of them talk to each other. Why? Because States lack resources to upgrade their systems and implement those standards.

As a result, my pediatric colleagues and I have limited access to this critical public health information. The collected data sits in massive repositories just beyond our reach, when it could be put to meaningful use in short order.

This shovel-ready project has significant value to each and every practicing pediatrician as well as promoting public health goals by improving immunization rates and preventing misuse of health care dollars due to inappropriate or duplicate immunizations.

Thank you very much for the opportunity to testify before you today. We appreciate this committee's efforts to help small pediatric practices continue our vital mission to provide high-value medical care to the Nation's children. I will be happy to entertain any questions.

[The statement of Dr. Kressly is included in the appendix.]

Chairwoman DAHLKEMPER. We have been called over for another vote. We will have time to get two testimonies in and then we will go vote and then we will come back for the questions.

So I would like introduce Dr. Charles Stuckey. Dr. Stuckey is the Executive Director of the Pennsylvania Optometric Association in Harrisburg, Pennsylvania. The Pennsylvania Optometric Association is the professional organization for over 1,250 doctors of optometry in Pennsylvania. He is testifying on behalf of the American Optometric Association. The AOA represents 36,000 doctors, students, assistants and technicians in the optometry industry.

Welcome, Dr. Stuckey.

STATEMENT OF DR. CHARLES J. STUCKEY, O.D.

Dr. STUCKEY. Thank you and good morning.

My name is Charlie Stuckey. I practiced as an optometrist for 23 years in Pennsylvania, and I am currently the Executive Director of the Pennsylvania Optometric Association representing more than 1,250 Pennsylvania doctors of optometry. Today, it is my honor to testify on behalf of the American Optometric Association and its 36,000 members nationwide, many of whom have traveled to Washington, D.C., today to participate in the AOA Congressional Advocacy Conference.

We appreciate this opportunity to provide the House Small Business Subcommittee on Regulation, Health Care and Trade with our views and recommendations regarding the challenges to greater adoption and use of health information technology facing physicians, specifically doctors of optometry, and other health care providers.

AOA agrees with many analysts and policymakers that health IT is an important ingredient for improving the efficiency and quality of health care in the United States. The electronic health record, or EHR, is the central component of health IT, and when used effectively, can enable providers to better organize patient data, replace lengthy record processes, help deliver better coordinated care among a patient's team of health care providers, prevent errors, and cut overall health care costs.

AOA was pleased that optometrists were included when Congress incorporated a provision of the American Recovery and Reinvestment Act of 2009, or ARRA, to spur greater adoption of health information technology by providing substantial financial incentive to help physicians purchase and implement health IT. AOA members appreciate the valuable opportunity to obtain this unprecedented assistance; however, significant barriers to widespread adoption and use remain.

ARRA explicitly states that for a physician to be a meaningful user of health IT and be eligible for incentives, the EHR that he or she uses must be certified. Yet, to date, the only federally recognized certification body is the Certification Commission for Health Care Information and Technology, CCHIT, which has not developed a certification for eye care EHRs. While AOA's concerns focus mostly on eye care, we believe that our situation will not be unique as other medical specialties with specialized EHR systems seek to develop certification through CCHIT.

The AOA and others lobbied for a path to certification which led CCHIT to place eye care on the road map for a 2011 launch. We continued to argue that it was essential for the eye care specialty to have an accelerated time line for launch so that eye care professionals would be able to adopt certified EHRs and be able to use them meaningfully by 2011. We were delighted to learn earlier this month that the Commission is open to an eye care EHR certification launch in 2010, but the limiting factor to add specialty areas of certification was resources.

Today, the AOA would strongly recommend that the Office of National Coordinator endorse and support the expansion of areas of CCHIT certification to ensure that ARRA incentives serve their intended purpose of spurring widespread adoption of health IT. In addition, we would urge that as policymakers and certifying organizations move to define meaningful use; we would caution against

a one-size-fits-all approach. Just as different providers need different types of EHRs, the meaningful use of EHRs can vary. The bottom line should be improved results for patients.

In addition to certification concerns, the AOA is troubled that some provider colleagues are not currently eligible for HIT adoption incentives and may be left behind as the nationwide HIT system develops. While ARRA provides incentives to doctors of optometry and other Medicare physicians, the legislation does not address the need to ensure the inclusion of a large and diverse group of providers which comprise a significant part of our health care delivery system.

AOA fosters a multidisciplinary team approach to care. The AOA urges the leaders in Congress to ensure that all clinicians are included as we get to work on developing a nationwide health IT network. This is particularly important for optometrists and other clinicians who are small businesses and need to be able to plug into local and regional networks.

Thank you for the opportunity to represent the concerns of thousands of owners of small business optometric practices before you today. Thank you.

Chairwoman DAHLKEMPER. Thank you, Dr. Stuckey.

[The statement of Dr. Stuckey is included in the appendix.]

Chairwoman DAHLKEMPER. And now I would like to recognize Mr. Westmoreland to introduce our last witness.

Mr. WESTMORELAND. Madam Chairwoman, it is my pleasure to introduce Dr. Carladenise Edwards, who is the chief of staff of the Georgia Department of Community Health. DCH is the Georgia State agency responsible for health care planning, financing and regulation, and provides health care for approximately 2 million people. Dr. Edwards serves as a principal advisor to the Commissioner of Community Health on health care policy.

Prior to her current position, Dr. Edwards was the Executive Director of the South Florida Health Information Initiative, a regional health information organization designed to improve health care quality, access, and efficiency through technology.

She also served as the first Executive Director of the Florida Governor's Health Information Infrastructure Advisory Board. Dr. Edwards earned a B.A. In sociology and an M.S. In education from the University of Pennsylvania. She holds a doctorate in medical sociology from the University of Florida.

Welcome to the subcommittee, Dr. Edwards. We look forward to your testimony.

STATEMENT OF CARLADENISE ARMBRISTER EDWARDS, Ms.Ed., Ph.D.

Ms. EDWARDS. Thank you and good morning, Chairwoman Dahlkemper and Ranking Member Westmoreland. Thank you for the opportunity to testify on a subject that I am exceptionally passionate about, health information technology.

My name is Carladenise Armbrister Edwards, and as the Chief of Staff for Georgia's Department of Community Health, as the ranking member has said, I am responsible for the health care for over 2 million Georgians.

Our department provides health care through the Medicaid program, the State employee program; and we ensure compliance with health care regulations across the State. On July 1, we will also assume responsibility for public health, emergency preparedness and health care regulations.

Prior to serving as the Chief of Staff for Georgia's Department of Community Health I actually founded my own business, The BAE Company. My father, Lieutenant Colonel Anthony Armbrister, Marine Corps, Retired, and I built the business with the intention of helping other small businesses achieve their strategic goals through business development, implementation of technology, change management and system redesign strategies. So, therefore, I come before you not only with some knowledge and experience in health information technology implementation, the impact on State government, but also with some experience in small business ownership.

First, I would like to talk to you a little bit about the impact of health information technology on health care providers and the benefits and drawbacks of the Recovery Act from the perspective of a large government employer who contracts with health care providers for the Medicaid and State health benefit plan.

As you can imagine, the State of Georgia has a vested interest, a $12 billion interest, in ensuring health care services are provided in the most cost-effective and efficient manner possible. We want to make sure that our employees have access to quality health care so that we have a strong, productive work force; and we want to make sure that beneficiaries have access to health care at the lowest possible cost to the State. Therefore, we are strong proponents of health IT.

Georgia's Department of Community Health is actively participating in the advancement of health information technology and transparency projects in several ways. First, we have established a health transparency Web site that provides health care consumers with information that allows them to identify providers by location, cost and quality. It also gives them the opportunity to evaluate health plans. We think it is critically important that consumers actively participate in understanding the opportunities that come from health information technology and managing their own health care.

The Department is also providing grants to large and small health care providers to implement health information technology systems in their practice. However, due to State budget constraints, this program is at risk of being discontinued, despite the fact that we have seen the financial benefit to implementing interoperable health information exchange that can reduce duplication, improve patient safety, and increase access to care through the use of telemedicine and electronic prescribing.

Thirdly, Georgia's Medicaid program is in the process of creating a technological solution that will be Web based and allow Medicaid providers secure access to an electronic health records system in a virtual environment. We are hoping that this will help avoid or eliminate some of the challenges that the previous panelists have spoken about relating to the cost of purchasing, hosting, and main-

taining a hardware and software solution. In many cases, that is not viable for a small physician practice.

And lastly, but not finally—I just don't have time to tell you about everything that we are doing—DCH is working collaboratively with private and public partners to sustain Georgia's electronic health record partnership. We are trying to position ourselves to serve as one of the regional extension centers that the coordinator spoke of earlier through the HITECH Act.

We also look forward to being able to disseminate loans to small physician practices and grants to providers through the HITECH Act, as well as creating the opportunity for training and technical assistance which is so very much needed in order to assure compliance with the rules and regulations as well as the new HIPAA provisions.

Georgia is looking forward to the opportunities presented in the HITECH Act, but we are aware of the drawbacks—primarily the drawback being failure. Frederick Douglass once said that power does not concede without demands. The failure will come from consumers' inability to advocate on their own behalf. And those consumers are consumers of health care as well as the providers and the small businesses who consume the resources that our health care industry provides. So we think it is critically important that we provide the incentives and that we are able to advocate for consumers as well as small businesses at the State and Federal level.

Thank you for this opportunity.

Chairwoman DAHLKEMPER. Thank you, Dr. Edwards.

[The statement of Ms. Edwards is included in the appendix.]

Chairwoman DAHLKEMPER. And I appreciate your patience and the committee now stands in recess.

[Recess.]

Chairwoman DAHLKEMPER. The committee is now called to order. Thank you for your patience.

We will get through the questioning. I am going to yield myself 5 minutes now, and we will yield each member 5 minutes. And if we have time, we will go through a second round, if needed. But that will help us get through the questions in case we are called back for another vote shortly.

Dr. Edwards, I wanted to talk to you a little bit about your experiences there in Georgia. And you testified that your government's role has been addressing barriers that prevent the use of health technology. From your experiences in Georgia, do you find that cost is generally the greatest barrier?

What barriers are you seeing in Georgia? I want perspectives on how you see what you have done in Georgia, how your experiences could be utilized in our looking at a system that would cover the entire country.

Ms. EDWARDS. Thank you for the question.

Finance for small physician practices is one of the significant barriers. Many of the practices say that it is cost prohibitive to adopt. But the initial investment is not so much the fear as it is the long-term sustainability and then the fear of reduction in service and their ability to provide services in an economical way.

So cost is defined in several ways. One, you have to come up with the money to invest in the system, and two, you have to sustain

that system. But then you also have to change your business practices to accommodate a new way of practicing medicine.

So the second barrier really comes from whether or not there is a desire or willingness to have an interoperable system that shares information and ultimately, in some cases, reduces duplication and utilization of unnecessary health care services.

And so the fight, or the tension, between making a system more efficient and then being able to make money creates this conflict and, sometimes, a barrier to adoption.

And so we found both in Georgia where, for small physician practices, it could simply be the upfront cost; but for larger health systems, it is a lack of a desire or willingness to want to share information that creates the efficiencies that ultimately reduces health care spending.

Chairwoman DAHLKEMPER. Right now we have a fee-for-service system. So the more service you can give, the more money you can make. And let me ask you then, as you look at that, being one of the barriers, do you see the barriers at all broken down by maybe age of the practitioner or do you see it broken down by specialties? Are there any differences there?

Ms. EDWARDS. Age is interesting. I have actually had in my small business practice where I am helping them implement technology, providers say, I will either retire or die before you make me use a computer. So I say, Okay, I don't know which one is going to come first, but your business manager has already made the investment.

So I have had older physicians say they are just not inclined to want to use technology as part of their practice. So that is a barrier in some cases, although that is a stereotype.

There are some who are more than willing and able to do that.

On the other end, as it relates to specialty—and Dr. Stuckey spoke to this very, very well and profoundly—the EHR companies and the vendors have been focused on ambulatory care in a comprehensive way, but failed to recognize that different doctors practice medicine differently. And what they chart and record and the information they need varies from one specialty to the next.

And I have had with my practices that I have worked with barriers to adoption because the system doesn't accommodate OB/GYN charting, pediatric growth charts or any other specialty. Oral screenings, they don't have the capacity to chart that information in the system and therefore the physicians are less likely to adopt.

So both of those, age as well as specialty, have been barriers to universal adoption.

Chairwoman DAHLKEMPER. But then there are also some intrinsic problems with how we are developing these systems that is not user friendly to all the different specialties that you might be dealing with?

Ms. EDWARDS. Correct. It is not one-shoe-fits-all.

Chairwoman DAHLKEMPER. Do you think we are going to be able to achieve that in what you have seen so far? You have been working on this for a while Georgia.

Ms. EDWARDS. I am an optimist, and I think we can. If you think about banking and cell phones there are a gazillion different types of cell phones and we are still all able to talk to each other. There

could be that many different types of EHR systems that are able to talk to each other if the demand is there. If we, as consumers, demand to have a more efficient system that is interoperable, that allows us to travel and have access to our information when we need it and where we need it.

Chairwoman DAHLKEMPER. Mr. Jackson, you are one of the early adopters of HIT. How much time and money do you estimate it takes you to train an employee? You did bring up that there are some staff that you don't think will be able to utilize these systems once they are in place.

Mr. JACKSON. Yes, our experience has been that there have been staff members in some of the offices that we have integrated that have elected not to learn the new system because it was so different from what they had spent the previous 20 years doing.

In terms of training, I think you are looking, from a dollar and cents wise, minimally probably $2,500 to $3,000 per individual to have them functional on a system such as we are using within our hospital.

Chairwoman DAHLKEMPER. Are smaller practices going to be able to overcome those kinds of financial challenges as you look at that?

Mr. JACKSON. I am concerned about that, as I view it from the standpoint that—as I mentioned in my testimony—you are talking really about asking small practices to disrupt their operation. So not only are you going to lessen their throughput, you are going to put additional burden of hardware and software acquisition and the opportunity costs of training both from the time you take the individual out of being able to assist the physician and the actual hard dollars in training where you have to buy that, most likely, from the HIT company that you contracted with.

Chairwoman DAHLKEMPER. What do you think could be something that we could do here in government to help assist that?

My father, who lives in Erie, traveled to Detroit to see my sister, had some medical issues there; went to Ft. Worth to my brother's, had some medical issues there; stopped in Memphis to see my daughter, had some medical issues there; and ended up in the hospital in Indianapolis on his way back through Detroit on his way back to Erie.

Obviously, we have a person like him, who is 85 and still traveling around the country. Obviously, when we are talking about controlling costs and not having to have different tests in every city he goes to is going to be a huge saver in the end.

I see the value of this, but what do you think we could be doing here?

Mr. JACKSON. From a government standpoint, I think there needs to be standardization of the information, how it is stored, how it is transmitted. And I think we have to explore at some point the thought of a central repository and that, instead of making it all individually based on the individual physician, either base it on the individual consumer or give a large repository where multiple nodes have access to centralized records.

Chairwoman DAHLKEMPER. I said I was going to limit myself to 5 minutes. I have gone over, but I wanted to give everybody a chance in case we are called back for votes.

I want to yield to Mr. Westmoreland.

Mr. WESTMORELAND. I thank the chairlady for that.

Just a quick—have any of you filed anything to what ″meaningful use″ is? Okay.

That is an interesting point that was brought up about the chairlady's father; and I want to ask Dr. Kressly this:

I know you are a pediatrician, but say somebody comes in that is from another State, and we have this up and running and there is a problem getting the information off or maybe they can't locate a different system or whatever they are trying to compile, all of this information, and it takes a while to do it.

And this person is in the emergency room, and they need immediate care, and that care is given to them or whatever. An hour later all of these records come in, and they find out that they did something totally wrong, but they had to do a quick assessment of what was going on.

You know, I think it is hard for everybody to get their heads around this and what is going to be involved to get these records down to something that can actually be very beneficial for the use.

Mr. Fetzner there was talking about, it is going to start in the home. It is going to eventually get down to the home, somebody being monitored there. So what are the complications that could arise from these medical records and what kind of care a doctor may be hesitant to give without these records, his having these records, if the system was in place?

I know now he basically just has to work from what tests he can do immediately and that. But if these records were available, how hesitant would a doctor be to go in and try to do something—acute care—without these records?

Dr. KRESSLY. It is an interesting question. I believe, first of all, that physicians always act with whatever information they have in front of them at the time. I don't think that the electronic record makes any difference than the paper record. In my experience, if you are in the emergency room and someone comes in and you call for their old records, they come up a half an hour later—

Mr. WESTMORELAND. This is somebody that has no old records.

Dr. KRESSLY. You are at an disadvantage even in your own hospital if somebody is looking for the paper record that is 40 feet deep.

I am hoping that physicians will not alter the way they think, in that providing care with the best information they have at hand.

The other thing that everyone should be aware of we talk a little about interoperability and exchange of information. There are actually some pretty good basic standards written already that the leading vendors are starting to implement.

And physicians really do not want everything. I mean, I don't have time, whether it is on paper or in an electronic record, to sift through a lot of data. There are couple of hot-ticket items—problem lists, current medications, history of surgeries, things that don't take a sophisticated amount of data exchange—that would affect how we treat medically.

And I am not sure that you do that different electronically than you do with a phone call to the physician who might have seen them before, or whether a patient brings a thumb drive with their personal medical record and we can get it that way.

Mr. WESTMORELAND. Now you are the doctor, you have got the medical records, and I don't know how long it is going to take you to go through them.

Do you depend on what you observe or what the medical records and what other physicians have said about the different conditions that the patient may have?

Dr. KRESSLY. You do it multifactorily. You take every information into consideration and you act as quickly as you need to, based upon the information that you have at hand. And sometimes you look back and you alter what you have already done and there are things that probably not implicated.

But we have a better chance with the hot-ticket mistake items as far as medication interactions and medication allergies, a problem list, if we can condense them and get them quickly electronically, I do believe that has potential to save care, and physicians would act in the patient's best interest with more data than we have now.

Mr. WESTMORELAND. Thank you.

Dr. Edwards, given your unique perspective on the State level, and also being a small business provider level, what do you see the proper role of the Federal Government versus the State being in this case for our citizens?

Ms. EDWARDS. I see the role of the Federal Government as being one that knocks down barriers or tries to create opportunities that would allow State government as well as local practitioners to advance the adoption and utilization of EHR.

We typically say health care is local. Most people do receive health care in their community by their local provider, and so that individual, as well as that community, should be able to make decisions about what is in its best interest.

The Federal Government, I think, has an obligation to create standards and ensure compliance, but at the same time not create barriers or inhibitors to us moving forward with systems and processes that really serve the interests of the consumers and the constituents in the community.

And so I would look to the government to ensure that there are standards, to ensure that there is compliance as well as safety; and then create opportunities that will increase adoption and utilization.

In Georgia, we are actually looking forward to the opportunity to participate in some of the high-tech related initiatives because we think that that we will, as a Nation, get more bang for our buck if we do use a centralized system of training or technical assistance for those providers who can't afford to go out and do that on their own.

So if the money is available, I think it does make sense for the State to participate, to help provide training, to help provide technical assistance, as well as to ensure that the incentives that are provided actually meet the needs of those providers in their community.

Mr. WESTMORELAND. Thank you.

We will go another round if you want to.

Chairwoman DAHLKEMPER. I now recognize Mr. Thompson for 5 minutes.

Mr. THOMPSON. Thank you, Madam Chairwoman, ranking member. This is a very important topic in terms of health care.

Actually, a number of the witnesses—I represent that part of Pennsylvania adjoining Mrs. Dahlkemper up in the rural part of Pennsylvania; and having come out of health care—working 28 years in health care, actually—my health system engaged in a somewhat painful process years ago with health information technology as a beta program.

I wouldn't recommend that to anyone, actually; this is where you work out all the bugs. But it certainly has been a good move.

I have some questions. I was interested, representing a very rural area, what has your experience been with interconnectivity? It is one thing to invest in infrastructure within the facilities, within the bricks and mortar, for the practices that you represent or the hospitals or the health care facilities. But networking them for the greatest efficiency in terms of communication, especially in rural America? Any thoughts, reflections on how prepared are we with interconnectivity?

I will open that up to anyone on the panel.

Ms. EDWARDS. Chairwoman Dahlkemper, if you don't mind—and Mr. Thompson—I would like to respond.

The stimulus, the ARRA provisions actually have language in there and opportunities for increasing broadband activities. And in Georgia one of the things that our Governor, Sonny Perdue, has done is require all of the agencies that are eligible for stimulus funding to meet and meet and meet on a weekly basis, to make sure that we drive any dollar towards an end point that can be sustained by the State once these funds are no longer available, and then meet the best interests.

One of those work groups is around broadband adoption, ensuring that if we have a broadband initiative, that it is used to expand the bandwidth for rural providers who want to adopt HIT from the HITECH Act. He has almost required us to say that if you are going to do this, we want to make sure that we get the bandwidth for the communities and maximize that opportunity.

One of the opportunities that all the States should look at is how you intersect and force collaboration between education, health, and technology so that you are not building five or six—we call them T-1 lines—when you only really need one to meet the needs of the people who are out in the rural community, whether it is health or education or safety.

Mr. THOMPSON. Anyone else with a perspective or experience with interconnectivity?

Mr. FETZNER. Yes, from the perspective of home- and community-based care, which is about as dispersed as it gets, interconnectivity to me is the key issue in all of this. What we are really trying to create is a network where every user who joins benefits the whole. If, as long as we are just simply digitizing little silos—a doctor's office here, a hospital here—and they don't talk to each other, we really are not accomplishing all that much.

And so, establishing standards—as Dr. Kressly pointed out, there are some standards that are existing already. Continua Health Alliance has recently published their standards; that is a great first step to creating that interconnectivity. So anything that the Fed-

eral Government can do to push standards quicker to get that groundwork laid will help with the adoption.

Dr. KRESSLY. One of the things I wanted to say, being from rural PA, the standards and implementation are there, but there also have to be resources. Because the small businesses and the rural practices, the primary care physicians, don't have a lot of resources to help write the other piece of the interface.

For example, my local hospital offered to help with health information technology for the primary care people in the region. But they decided that they would pick the vendor that was not friendly for pediatricians and other resources.

And so some people went out and got their own EMR that actually is pediatric friendly. But the hospital won't turn on the spigot to let the information flow both ways even though I have the technology to do it. And there is no way a pediatrician can afford to add that additional cost of interoperability.

So I would say that greasing the wheels between the two interoperable sites needs to come from funding from somewhere else, whether it is at the State level or used at—the interoperability that Dr. Blumenthal was talking about this morning.

It needs to come from somewhere else because it is going to make it much harder for the smaller, independent physician groups when there are big players in the arena who can afford their end and decide they want to push what they want as their agenda, but it freezes out some of the smaller uses of technology which need to be supported.

Believe it or not, in Warren, PA, a colleague of mine just bought an EHR, and he was able to input all the data from the Pennsylvania State registry as part of a pilot project, so all the immunization data he has been entering the last 15 years came back to him in electronic format. But that is a pilot and Pennsylvania State doesn't have the resources to make that a more statewide global initiative.

So we are starting pilot projects but we need resources. The standards are being written. We can't wait for standards to all be finalized to start implementing. Again, the horse is out of the barn and the technology is moving ahead. We need to make sure that the resources put a level playing field for the small, independent practices and people in specialties who are not represented nationally in all the work groups.

Mr. THOMPSON. And I think you hit on a real practical issue.

My most recent experience before coming here was electronic medical records, specifically in a skilled nursing setting, which was great for nursing, but had absolutely no application for the physician part or rehabilitation part or other aspects. I think that is a challenge as we are now spending a lot of money—investing, and I look at it as investing.

But there are not a lot of products out there that will handle the comprehensiveness, the continuum, in all the health care settings.

Chairwoman DAHLKEMPER. We will do another round of questions for 5 minutes each.

Mr. Fetzner, as you talked about the state of HIT adoption, maybe you could talk about the state of HIT adoption and integration in the long-term care industry, an industry that obviously con-

tinues to grow. All of us baby boomers will eventually be at that point. How will the provisions in the stimulus bill improve that adoption?

This goes to the conversation we were just having. The integration and the people that go in and out of those facilities or in and out of those care sectors, if you could address that.

Mr. FETZNER. Well, as part of the state of HIT adoption in home- and community-based care, it is pretty limited. You have providers implementing telehealth and telemonitoring, but again that information is being reported back to that single service provider, and it is not interconnected with the different aspects of the health care delivery system.

With regards to the stimulus bill, one of my concerns in the stimulus bill is what I might consider an overemphasis on EHRs in that entire system. It is an important backbone, but not necessarily sufficient.

So from the stimulus perspective, it would be nice to see a more balanced investment across the entire network of providers where you would lay many different seeds of investment with pilot projects and things across many different settings. I think that would help to create that tipping point of adoption where physicians who never had the information before will now have different information and will begin to realize that is useful to me for X, Y or Z or whatever that might be.

Chairwoman DAHLKEMPER. Thank you.

Dr. Stuckey, how much success has the eye care community had in working with CCHIT to establish criteria for certified HIT systems? And what are the unique challenges that you see your community facing on this front?

Dr. STUCKEY. Well, after giving testimony, I was fortunate enough to have a conversation with Dr. Kressly and her husband; and the amount of positive feedback that I got, we are going to be—we feel fairly assured that we are going to be successful relative to the results coming out of CCHIT.

And the second part of the question was?

Chairwoman DAHLKEMPER. What are the unique challenges that you see the optometric community facing on this front?

Dr. STUCKEY. It is very similar to what was previously said. I mean, basically the industry, being somewhat fragmented as it is, presents itself with the HIT issue—for it to be fragmented also. So as far as the challenges that were spoken to in terms of interoperability and interconnectivity, those are the challenges that we see in the future.

So I would say everybody is really speaking the same language here, and I think if you look at it across the segment of the different health care representatives that we have, I think it is very similar.

Chairwoman DAHLKEMPER. Dr. Kressly you brought up several different points that I found interesting in terms of the immunizations—I think that is what you are referring to when you talk about this physician in Warrington and being able to download that.

Obviously, as a mother of five—and even myself, if I went to the doctor and they said, When is the last time you got a tetanus shot, most of us have no idea, so we get it anyway.

The other point I wanted you to expand a little bit on is the States' ability to define ″meaningful use.″ I am from the northwest corner of Pennsylvania, there is a 45-mile difference between New York State and Ohio in my area, so we have got physicians and patients sometimes going back and forth. So maybe if you could address that a bit.

Dr. KRESSLY. I would be happy to. I think that presents a big problem.

The way—it appears as if the ARRA funding under Medicaid is going to allow States their own State Medicaid programs to define ″meaningful use.″ And I think that poses a problem for, especially, physicians practicing on borders. And the panel was actually speaking at the break; we would like to see government try to make the ″meaningful use″ definition as broad as possible.

The more you hone down and try to make it specific, the more you are going to exclude people from adopting technology. And what we want to do here is actually promote increased adoption, not exclude people or give them reasons not to adopt. And so the broader those ″meaningful use″ definitions are that could cross State lines and apply to different Medicaid programs across State lines, the more easy this will be to implement and, I would expect, more easy for the government to actually be able to certify that people are using things meaningful.

So I would urge everyone to consider that ″meaningful use″ should be broad and easily implemented in broad categories so we can catch as many people and promote as increased adoption as possible, widespread among different users with different needs.

Chairwoman DAHLKEMPER. Thank you. And I would actually ask those in the panel and anyone else in this room who is interested to look at the open comment period here now, and when they have one in the future, and put your input here. You obviously have some great things to say.

I will yield to Mr. Westmoreland. You are really outnumbered; Pennsylvanians all around. Luckily you brought in Dr. Edwards.

Mr. WESTMORELAND. She has a Pennsylvania tie, too. I don't know how that worked out.

Mr. Fetzner, you made a statement saying: When a cardiologist can see a trend analysis for daily vitals of a CHF patient living independently at home, meaningful use will exist. This type of meaningful use does not occur by investing in certified EHRs alone. This occurs when an entire provider network is connected and coordinated around a patient's plan of care. And I understand that.

So you are looking at this ″meaningful use″ term as a living term that is going do evolve; is that true?

Mr. FETZNER. Yes, that is correct. We are going to have a difficult time nailing down one specific meaning, which is why I would completely agree with Dr. Kressly, the broader you make it to be inclusive, the more you are going to stimulate adoption.

Mr. WESTMORELAND. I agree with that. I just don't want to—you know, once we come up with a definition, I think that this is something that you all need to put into this time of input, that this

term, as the system progresses, may change—you know, how it is looked at.

I think that is a linchpin to how successful this is going to be and how many people are going to participate.

Mr. FETZNER. I think the pace of adoption, as it speeds up it is going to be incredibly difficult to put definitions around with regard to regulations and things like that. The more we allow the entrepreneur, the individual, the small business line of sight into what the goal of that regulation is and create a generous and efficient waiver process where they can say, Hey, I am meeting this in a different and alternate method, I think that is going to go a long way to promoting the adoption.

Mr. WESTMORELAND. I think that is a good point. I think Dr. Edwards alluded to that, that the Federal Government needs to get out of the way—I know you didn't say that.

Dr. Edwards, I will ask you one other question about meaningful use. Is it possible for these small group private physicians to meet the HHS health IT information goals without ″meaningful use,″ without that term?

Ms. EDWARDS. Boy. Honestly, yes, Mr. Westmoreland. It is possible for small physician practices, large physician practices to adopt and to utilize technology in a meaningful way without Federal Government having defined ″meaningful.″

I agree with Dr. Kressly. The definition of ″meaningful″ needs to be broad enough to incentivize and encourage the adoption and utilization; however, you need to have some guidance in terms of how you would distribute those funds.

If I ruled the world, I would ensure that the distribution of those funds met the needs of the small business practice, the small physicians, the entities that have the greatest challenge in adopting due to perhaps the age of their practice, their revenue stream or their access to technology, based on their location, being in a rural environment. If we can make sure that we drive the available resources to increase adoption among those who are least likely to adopt, I think we would make the best use of those funds.

″Meaningful″ will mean different things to different people. It is not just adopting it and having it sitting on a shelf; it is actually utilizing it for the benefit of the patient and the consumer.

Mr. WESTMORELAND. Right.

And let me say, you made a point, I think, when the chairlady asked you about age or specialty or whatever. Every time I go to a doctor, I ask them about the IT and the electronic health records.

My wife—and thank the Lord, she doesn't have cancer and she had to go to an oncologist. And one of the reasons that they had not gone, or at least attempted to, is because the system that they looked at did not meet their needs for what it took to input the information.

I went to my doctor and I asked him about it too. It just happened to be a urologist. He made—I don't guess I am violating any HIPAA laws or anything—but he said the same thing.

And so I think this is something that we are going to have to get down and take into consideration when we are looking at ″meaningful use″ to make sure that the Federal Government doesn't have a one-size-fits-all kind of thing and that they have to

look at each of the individual specialties and professions and health care providers; whether it be long-term health care or at home or wherever it is, that they look at this and take this under consideration when they are coming up with this term that is going to be so vital to who is going to be able to have accessibility to the funds.

With that, I yield back.

Chairwoman DAHLKEMPER. I now recognize Mr. Thompson and we have 4 minutes and 45 seconds left.

Mr. THOMPSON. Mr. Jackson, Grove City has overcome some significant hurdles to institute your IT system, but many of your rural neighbors in Pennsylvania have not had the same opportunities or foresight.

The stimulus package included $18 billion of information technology. It is a large dollar amount, but really it is only a drop in the bucket of the realistic need. Included with it were some strings that a 3 percent cut in Medicare payments would occur after 2015 without implementation of a system.

What advice would you give Congress when looking at rural health providers that, frankly, are going to face, I think, more barriers than perhaps other areas in implementing this; and how can we provide further incentives for rural hospitals and doctors?

Mr. JACKSON. Mr. Thompson, the part that I am most concerned about is the collision of the health care redesign with the EMR implementation.

The incentives out there will provide the ability to move some providers off the fence, but ultimately you are looking at an investment that is going to be a recovery not unlike when you install new windows in your home. There is a large investment up front, knowing that over 20 years you will have an incremental savings that will exceed the initial investment.

Somehow we need to get the money into the hands of the rural providers to make that initial investment—not just use it, but be able to acquire the technology. Most of the incentives are in place for use of the technology.

Mr. THOMPSON. You talked about a large investment up front. I would also encourage—my own involvement with information technology, this technology is turning over very rapidly. It used to be 7 years, it is closer to 3 years now. And the folks who design this—it is a good thing, but this initial investment of billions of dollars, it is going to require billions that will have to come out of your operations—maybe every 3 years at a minimum; at the most, maybe 7 years right now.

And I don't put that in the form of a question because we have to go vote. So thank you.

Chairwoman DAHLKEMPER. Thank you, Mr. Thompson.

I want to thank the panel today for your—first of all, for your patience with us as we have to go vote. I thank you for traveling here and for your testimony and for your answers to our questions. I think you brought up a lot of good points.

I will be dropping my Health Information Technology Financing Act of 2009 today, which is a loan guaranty program that will help small group practitioners find the funding they need to implement HIT.

So, with that, I ask unanimous consent that members will have 5 days to submit statements and supporting materials for the record. Without objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 12:25 p.m., the subcommittee was adjourned.]

KATHLEEN DAHLKEMPER, PENNSYLVANIA
CHAIRWOMAN

LYNN A. WESTMORELAND, GEORGIA
RANKING MINORITY MEMBER

Congress of the United States
U.S. House of Representatives
Committee on Small Business
Subcommittee on Regulations and Healthcare
2361 Rayburn House Office Building
Washington, DC 20515-6315

STATEMENT
Of the Honorable Kathy Dahlkemper, Chairwoman
House Committee on Small Business, Subcommittee on Regulations and Healthcare
"Health IT Adoption and the New Challenges Faced by Solo and Small Group Practices"
Wednesday, June 24, 2009

With Congress and the Administration preparing to modernize our health care system, today's hearing is especially timely. In crafting health care reform, it is important to not only find ways to provide coverage to more Americans, but also to identify ways to reduce costs. During a roundtable discussion and previous hearings, this Committee heard how spiraling health care costs are squeezing small businesses.

New technology in the form of Health IT and Electronic Health Records, or EHR, can go a long way towards reducing these costs. Some experts estimate that wide scale adoption of Health IT would lead to annual savings of $77 billion. By streamlining data flow and increasing communication between providers, Health IT reduces errors, increases efficiency and can save patients' lives.

However, implementation of Health IT has not occurred as rapidly as we would hope. Smaller and solo health care providers have a particularly hard time when it comes to adopting Health IT. Fifty-seven percent of physicians who are in practices with more than 50 doctors utilize electronic health records. By contrast, only 13 percent of solo practitioners are putting this new technology to use.

This "Health IT gap" is particularly significant when you consider that most treatment occurs in small practices. Eighty percent of all outpatient visits take place in medical practices with ten or fewer doctors. Given these facts, it is clear we need to find ways to make this technology accessible for small doctors' offices.

Most physicians recognize that Health IT is a critical investment. They know that HIT and EHR will not only save money in the long term, but help them better meet patients' needs. The main problem is that integrating HIT and EHR into a medical practice is so expensive upfront. The starting price tag on an HIT system is $32,000 per doctor. That means the typical medical practice-- with three doctors--pays close to $100,000. That's a big investment for any business, and for many physicians it is enough of a hurdle to stop them from purchasing HIT.

Like any new product, the price of HIT will drop as it becomes more mainstream and more practices purchase it. However, it is unclear when we will reach this tipping point and see prices dip to affordable levels. With the President and Congress moving forward swiftly with health care reform, we cannot wait for the market alone to solve this problem.

The American Recovery and Reinvestment Act took some important steps to spur Health IT adoption. Through Medicare and Medicaid payments, the new law rewards physicians who start using this technology. However, even with these incentives, many small practitioners will find it difficult to make the necessary initial investment. That is why I am proud to be introducing the Small Business Physicians Access to Capital Act of 2009. This bill will establish a new loan program at the Small Business Administration designed specifically for doctors who want to invest in Health IT.

Ultimately, small and solo health care practitioners are small businesses. Similar to small businesses everywhere, one of their biggest challenges is accessing affordable capital. This legislation will help them find that capital. It is my hope that we can explore solutions like these during today's hearing. If we can make Health IT more affordable for physicians, we can make health care more affordable for everyone.

I would like to thank all of today's witnesses in advance for their testimony. I know they are taking time away from their businesses to be here, and I look forward to hearing from them.

Opening Statement of
Ranking Member Lynn Westmoreland
Subcommittee on Healthcare and Regulations
Hearing: "Health IT Adoption and New Challenges Faced by Solo and Small Group Healthcare Practices"
June 24, 2009

Madam Chairwoman, thank you for convening this timely hearing on health information technology and small health care practices. I'd like to extend a special welcome to our witnesses, and especially Dr. Carladenise Edwards, a fellow Georgian, who I will introduce later. As Congress considers health care reform legislation, health information technology will be an important component of that effort. This is a critical issue for the medical profession, and particularly small medical providers. Some studies estimate that 75% of practices in the United States have 5 or fewer physicians.

Health IT is a useful tool for the management of medical information, and its exchange among patients and providers. This technology can help to reduce errors, better manage chronic diseases, decrease paperwork and increase efficiency. Despite these benefits, fewer than 1 out of 10 small medical practices have fully electronic health records. Barriers to small practices adopting health IT, such as cost and the risk of purchasing systems which may become obsolete, remain.

This year's stimulus legislation included ambitious goals for the adoption of health IT. It established Medicare incentives to providers who demonstrate "meaningful use" of health IT, and penalties for those who do not; strengthened the HIPAA privacy rule; and created a new patient right to be notified in the event of a breach. The Department of Health and Human Services will issue regulations according to that law. As we move forward, we hope that small manufacturers of health IT systems and their users, as well as small practice physicians and hospitals, will be included in that dialogue.

The National Coordinator for Health IT, in consultation with the HIT Standards Commission, has been drafting standards and the certification for health IT. We are awaiting a definition of "meaningful use," as this definition is critically important. In addition, while I believe health IT has many benefits, and we should encourage its adoption. Small providers are concerned about the interoperability, privacy and security standards, and the fact that the HIT funding has not begun to be distributed. It is important that these concerns be considered.

Finally, I want to add a word about health care reform generally. Small companies are struggling. In a difficult economy, they are doing their best to stay in business. A mandate that employers must offer health insurance will simply add to their already stretched bottom line. I feel strongly that exempting even some small firms will be an invitation to Congress to go back at some future point and include more of them in the

mandate. And I am concerned that a national, government-run health care system could drive private insurers out of the market, reducing competition and raising costs.

Everyone in this room has been a patient, and everyone understands the need for privacy and for respect of medical information. The most important issue for health care reform should remain the doctor-patient relationship. I would hope that health care reform will acknowledge this.

Madam Chairwoman, I appreciate your calling this important hearing. I look forward to hearing the testimony of our distinguished panel.

Testimony Before the
Committee on Small Business
Subcommittee on Regulations and Healthcare

Statement of

David Blumenthal, MD, MPP

National Coordinator,
Office of the National Coordinator for Health IT
U.S. Department of Health and Human Services

June 24, 2009

Chairwoman Dahlkemper, Ranking Member Westmoreland, and Members of the Subcommittee. I am Dr. David Blumenthal, the National Coordinator, Office of the National Coordinator for Health Information Technology (ONC) with the U.S. Department of Health and Human Services (HHS). I am pleased to testify before you on the Administration's health information technology (HIT) activities and specifically how they impact small health care practices.

Introduction

Health information technology, or HIT, allows comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of HIT has the potential to:

- Improve health care quality;
- Prevent medical errors;
- Increase the efficiency of care provision and reduce unnecessary health care costs;
- Increase administrative efficiencies;
- Decrease paperwork;
- Expand access to affordable care; and
- Improve population health.

Interoperable HIT can improve individual patient care as well as bring public health benefits including:

- Early detection of infectious disease outbreaks around the country;
- Improved tracking of chronic disease management;
- Improved safety monitoring of drugs, biologics and medical devices;

- Enhanced evidence of the relative effectiveness of medical interventions; and
- Evaluation of health care based on value enabled by the collection of de-identified price and quality information that can be compared.

The HITECH Act

The American Recovery and Reinvestment Act of 2009 (the Recovery Act) that was signed into law by President Obama on February 17, 2009, included the Health Information Technology for Economic and Clinical Health Act, or HITECH Act. The HITECH Act includes $2 billion in funding to ONC to lay the groundwork for adoption and meaningful use of HIT through infrastructure programs. It also includes an estimated $44.7 billion in incentive payments for Medicare and Medicaid to providers who are meaningful users of certified electronic health record (EHR) technology.

Many physicians in small practices want to adopt HIT, but do not have the ability to invest upwards of $40,000 in the technology systems. By providing physicians and other health care providers with financial assistance for adoption and use of interoperable HIT, we will help reduce this burden. Physicians, including those in solo or small practices, can receive up to $44,000 under Medicare in incentive payment for being meaningful users of certified EHRs. The HITECH Act includes grant programs as well as education and technical assistance opportunities to help providers, especially those in small practices, to overcome barriers to adoption and assist them in using these systems to reduce costs and improve quality for their patients.

Funds will be distributed through Medicare and Medicaid incentive payments to eligible professionals, physicians, and hospitals who are "meaningful EHR users." These incentive payments will help lessen the financial burden for many health care providers to adopt this technology. Meaningful users will become eligible for incentive bonuses in 2011. Beginning in 2015, the Recovery Act authorizes penalties under Medicare for eligible professionals and hospitals that fail to demonstrate meaningful use of certified EHRs.

The qualification criteria for incentives are still in development, and will be defined through regulation and additional guidance materials. However, HHS generally expects that under Medicare, "meaningful EHR users" would demonstrate each of the following:

- Meaningful use of a certified EHR (certification criteria for EHR technology will be established though HHS rulemaking in 2009);
- The electronic exchange of health information to improve the quality of health care; and
- Reporting on clinical quality and other measures using certified EHR technology.

CMS, in close coordination with ONC, intends to publish a proposed rule in late 2009 to propose a definition of meaningful use of certified EHR technology and establish criteria for the incentive programs.

The HIT Policy Committee, which is a federal advisory committee that provides recommendations to the National Coordinator, met on June 16, 2009, to discuss proposed objectives and measures of meaningful use. This discussion focused on a vision for health care that outlined a progression from process measures in 2011 to outcome measures in 2015 for

improved population health. The HIT Policy Committee is currently seeking public comments on the proposed objectives and measures of meaningful use discussed on June 16.

As a part of HHS' effort to ensure that small health care practices have a say in defining meaningful use, ONC and CMS are hosting listening sessions targeted at this community so that HHS is informed of their questions and unique concerns as the HITECH Act is implemented. The decision on the definition of meaningful use is a key step toward transforming our health care system.

In addition to the incentive payments from Medicare and Medicaid, the HITECH Act authorizes grant programs that ONC can implement to help providers and communities adopt and become meaningful users of EHRs. Three of these authorized grant programs include:

- HIT Regional Extension Centers;
- State Grants to Promote Health Information Exchange, or HIE; and
- Developing IT Professionals in Health Care.

Providers in small health care practices that seek to adopt and meaningfully use HIT face a complex variety of tasks. Those tasks include assessing needs, selecting and negotiating with a system vendor or reseller, and implementing workflow changes to improve clinical performance and, ultimately, outcomes. Past experiences have shown that without robust technical assistance, many EHRs that are purchased are never installed or the providers never obtain meaningful use of the systems.

Based on 2008 data from the National Ambulatory Medical Care Survey that is administered by the Centers for Disease Control and Prevention, 21 percent of physicians currently have adopted an EHR, although not necessarily a certified EHR. The adoption rate among small health care practices (5 or fewer physicians) has a significantly lower adoption rate of 13 percent. This discrepancy in the rate of adoption for the Nation and for small practices highlights the need for focused technical assistance for small health care practices.

The HITECH Act authorizes a HIT Extension Program to make assistance and education available to all providers, but with priority given to:

- Individual or small group practices that are primarily focused on primary care;
- Public or not-for-profit hospitals or critical access hospitals;
- Federally qualified health centers; and
- Entities located in rural and other areas that serve uninsured, underinsured, and medically underserved individuals.

HHS published a notice in the Federal Register requesting public comments on a draft description of the HIT Extension Program. HHS received comments from various stakeholders emphasizing the importance of offering technical assistance to solo and small practices in selecting and implementing EHRs.

In addition to providing technical assistance to health care providers, the HITECH Act requires HHS to develop and implement a program to promote the electronic exchange and use of health information among organizations. This program includes planning and implementation grants targeted specifically towards developing capacity for widespread and sustainable health information exchange to enable the meaningful use of EHRs. Growing the capacity of health care providers to share information electronically within communities will begin to unlock the benefits of improved care coordination, greater efficiency of care, and improved population health.

Congress also recognized the importance of having trained professionals in the workforce to provide technical assistance to providers and communities as they implement HIT. The HITECH Act requires HHS to provide assistance to institutions of higher education to establish or expand health informatics education programs, including certification, undergraduate, and masters degree programs, for both health care and IT students, to ensure the rapid and effective utilization and development of health information technologies.

In addition to the grant programs to support nationwide adoption and meaningful use of EHRs, the HITECH Act codifies the Office of the National Coordinator and the responsibilities of the office in establishing the interoperable HIT infrastructure for the Nation. These responsibilities include:

- Incorporating privacy and security protections for the electronic exchange of individually identifiable health information;

- Establishing the HIT Policy Committee and HIT Standards Committee to advise the National Coordinator on a policy framework for the development and adoption of a nationwide health information infrastructure, including standards and certification criteria for the exchange of patient medical information; and
- Adopting relevant HIT standards, implementation specifications, and certification criteria.

Conclusion

HHS is actively working to get programs planned and implemented this year to support hospitals and eligible providers, especially those in small practices, becoming meaningful users of EHRs. While the specific desired outcomes of meaningful use are still being developed, achieving those outcomes will help transform and improve our health care system.

The HITECH Act provisions of the Recovery Act create a historic opportunity to improve the health of Americans and the performance of the nation's health system through an unprecedented investment in HIT. This initiative will be an important part of health reform as health professionals and health care institutions, both public and private, will be enabled to harness the full potential of digital technology to prevent and treat illnesses, improve health, and increase the efficiency of our health care system. This is a remarkable and far-sighted commitment that ONC is honored to lead and support.

Ms. Chairwoman, thank you for the opportunity to appear before you today.

James P. Fetzner

Statement for the Record

House Committee on Small Business

June 24, 2009

Thank you Chairwoman Dahlkemper, Ranking Member Westmoreland, and members of the committee for allowing me the opportunity to testify today regarding healthcare information technology and Title XIII (13) of the "American Recovery and Reinvestment Act of 2009", HIT for Economic and Clinical Health Act. I consider it an honor to be part of the process of moving our health care system into a new and critically important generation of technology and service delivery.

I am James P. Fetzner, Chief Executive Officer of Comfort Care and Resources, a Northwestern Pennsylvania home and community based long term care agency. Currently we serve three counties and hundreds of patients, enabling them to age in place. Our company was started in 1997 by my mother Beverly Fetzner with only a pager, a passion, and a belief that "there is nothing that is done in a nursing facility that can not be done better at home". At that time, and unfortunately still in some places, this philosophy was a radical idea; however, it informed my vision as CEO. As a result, we continue to push the forefront in long term care; working with multiple technology incubators, university centers, state departments, and local agencies. With these partners we will create an integrated and interoperable, HIT enabled, service delivery system that will drastically reduce the cost of long term care.

It is from this perspective as an entrepreneur, not a clinician or practitioner, that I offer my testimony on HIT.

While Title XIII (13) of ARRA makes mention of additional settings, and is intent on facilitating standards, the clear emphasis and investment is focused on the adoption and "meaningful use" of "certified EHR". While this is certainly necessary, it is not sufficient. Meaningful use will not be realized until new high value information is incorporated into work flow and decision making. When a cardiologist can see a trend analysis for daily vitals of a CHF patient living independently at home, meaningful use will exist. This type of meaningful use does not occur by investing in certified EHRs alone. This occurs when an entire provider network is connected and coordinated around that patient's plan of care.

For information to be delivered to and from the front lines of care, in our homes and communities, a seamless ecosystem must emerge. Enterprise Integration will be critical, as information will need to pass through, and be routed to, multiple providers. Providers such as skilled home health, non-medical home care, Area Agency on Aging case management, and others will utilize and contribute to this information before it comes to rest at the Primary Care Physician. Additionally, triggers and alerts will need to be designed for each individual patient to allow anomalies to jump out from the steady stream of data. If we simply digitize the information that currently exists and allow for more efficient and effective transmissions of static data through EHR, the marginal value from HIT will be limited. Significant value will be achieved when new, high value information can be delivered, assimilated, and leveraged for clinical and operational decision making. The most valuable information will be delivered from the front lines of care; from our nurses and nursing assistants. This is more challenging by the day, as the front line of care is becoming dispersed and dis-integrated. Nearly every person's home is a part of the health care system at some point, and the home's role will increase with const-containment measures requiring earlier discharges and less institutionalized care.

It is clear to me that if we look to the future of the health care system, the entry and exit points will no longer be our hospitals and doctors offices, but rather they will be individual homes. Whether that be a patient utilizing the internet to check and update their personal health information, or a client for whom we monitor and deliver

information to their doctors and family, the starting point will be home. Therapy, recovery, and end of life care will continue to shift toward home to match patient's desires in a more cost effective, high quality way.

My recommendations for facilitating the emergence of this interoperable health care delivery system:

1.) Establish policies and standards where appropriate as quickly as possible.
    a.) Until the "rules of the game" are established, innovation will be stifled. Currently the regulatory risk is too high for significant investment to occur. Once entrepreneurs such as myself see that policy and standards are no longer uncertain we will move forward quickly and confidently towards the goal of an integrated health care delivery system.
    b.) Make the regulatory structure smart and flexible.
        i. Regulation by nature favors the established order. Currently there is no established order, and as stated above a regulatory framework can not be delayed; therefore, we must allow for innovation to define and redefine how HIT will be utilized. I would suggest a generous "waiver" process that would allow new approaches to submit for waivers in an efficient manner. Allow for clear line of sight to the goal of the regulation, allowing individuals and firms to make their case for meeting that goal in an alternate method.
2.) Balance investment across the health care delivery system.
    a.) As stated before the certified EHR is necessary but not sufficient. Meaningful use will come from an integrated ecosystem that connects patients with service agencies, with the EHR as one component of that system. Because innovation by nature is unplanned and unpredictable, planting seeds in many different ventures and settings will be the fastest way to create a self-reinforcing network, which will produce a

"tipping point" of development and adoption of HIT, including EHR adoption.

3.) Review and modify payment across all of healthcare delivery.

   a.) Much attention is given to the Fee-For-Service payments, especially for primary care physicians; however, a thorough review of home and community based Medicaid payments to include HIT developments will speed adoption and ensure that those most in need are not left behind.

With advances in technology, we can confidently move forward to redefine the health care system; knowing that the past's insurmountable problems of time and distance will be overcome. No longer will patient's need to adjust their life to fit our healthcare system, but rather our healthcare system will conform to each individual. For long term care, this will mean the long overdue de-institutionalizing of seniors. I am honored to be part of the solution. Thank you for your time and attention.

Testimony of Robert C. Jackson, Jr., MBA, FACHE, before the House of Representatives Small Business Committee Subcommittee on Regulations and Healthcare.

"Health IT Adoption and the New Challenges Faced by Solo and Small Group Healthcare Practices"

Purpose of the Hearing:

The hearing will discuss the challenges solo and small group practices face in adopting health information technology (IT). The Subcommittee will also examine the implementation of policies in the American Recovery and Reinvestment Act of 2009 to promote Health IT adoption.

Testimony:

Distinguished members of the Committee, I am Robert C. Jackson, Jr., M.B.A., FACHE, Chief Executive Officer of Grove City Health System. Grove City Health System is composed of Grove City Medical Center, a 91 bed acute care hospital, Wolf Creek Medical Associates, a multi-specialty physician group, and GCHS Foundation, a foundation that support the mission and efforts of the hospital. We are the nearest healthcare facility to the intersection of Interstate 79 and Interstate 80 in Northwestern Pennsylvania. For a geographic perspective, we are one hour due north of Pittsburgh and one hour and fifteen minutes due south of Erie. The hospital serves a primary service area of approximately 55,000 people in the communities of Grove City, Mercer, and Slippery Rock. About 100 physicians have privileges at our hospital with 35 of them considered Active members of the Medical Staff.

In order to provide a framework to analyze my testimony, I need to explain where Grove City Health System is as far as its journey toward an electronic medical record. In the hospital, all clinical documentation (nursing, physical therapy, social services, etc.) with the exception of the physician's notes and orders are done electronically. We have invested close to $2,000,000 in software, hardware, and training costs to accomplish this.

As part of this ongoing process, we have implemented a Picture Archival and Communications Systems (PACS) in our medical imaging department that captures and stores images digitally making them available to physicians in their office as well as in the hospital. At GCMC every medication does in electronically verified to assure that the right patient is

getting the right does at the right time. All of our internal systems have from finance to nursing are compatible and communicate information transparently back and forth to facilitate the clinical care, coding for services, and billing.

In our physician practice, we are about 90% paperless. Utilizing the MEDENT EMR product has resulted in the six physicians who are employed by Wolf Creek Medical Associates documenting, storing information, and ordering tests for their patients electronically. At GCMC, we also have eight other physicians who use the same product so we have invested in the development of an interface that electronically transmits the laboratory test result to the physician who ordered the test.

Overall, we consider our hospital and medical staff to be early adopters of electronic medical record technology. Strategically, our Board of Trustees and Medical Staff leadership felt that we needed to be ahead of the curve rather than attempting to play catch up.

Our next phase of EMR implementation includes the development of Computerized Physician Order Entry and additional interfaces to facilitate the resulting of other non-laboratory diagnostic tests electronically to the ordering physician.

It has been set forth that the purpose of today's hearing is to discuss the challenges solo and small group practices face in adopting health information technology (IT). The Subcommittee will also examine the implementation of policies in the American Recovery and Reinvestment Act of 2009 to promote Health IT adoption.

To that end, I wish to share with you some of the pros and cons of EMR implementation and use, some of the experiences that our employed and independent physicians had with the implementation of their EMRs, and offer some thoughts on the direction for managing electronic health records.

I would like to acknowledge the Hospital Association of Pennsylvania, CPSI, Susan Hirst of the Sage Group, Family Healthcare Partners, and the Triangle Urology Group for there willingness to provide information for my testimony.

Pros and Cons:

Not everything is made better with automation. However, EMRs offer physician offices the opportunity to streamline office procedures and share information among staff members in an incredibly efficient manner. Use of an EMR brings a higher level of patient safety and regulatory compliance to a practice. For example, with its ability to review a drug through volumes of information to identify any potential pharmaceutical interactions with other medications the patient may be taking or allergies that they may have. This review is done in a blink of an eye giving both the healthcare practitioner and the patient greater confidence in the care they are receiving. The documentation capture with an EMR is more detailed and provides an easily searchable repository of information and patient history at the physician's fingertips. Hospitals and physicians have begun sharing information electronically at the local level but, what is astounding to consider is the potential of the information that can be exchanged and how it could improve the health of our nation. As I mentioned before, at GCMC, we have the means to electronically result laboratory results to physicians who use EMRs in their respective offices and this is only the beginning.

However, this is not to say that it does not have a down size. The introduction of EMRs to the Hospital and physician practice environment adds to the cost of patient care. A private practice physician office is potentially looking at $50,000 for hardware and software, a group practice could easily be spending $200,000, and at the hospital level GCMC has spent about $2,000,000 and counting. That is just to get started. These systems require monthly maintenance and service contracts, which add to the monthly cost of operating the business without adding any revenue. Once you have installed the system, the physician and the physician staff need to be trained on the system and that costs money as well. Again, this is all before they have even seen the first patient. The initial implementation of an EMR could reduce the throughput of a physician practice up to 50% for several months while the physician and staff learns how patient throughput will actually work with the new system versus how they have been trained. Considerations need to be made for those staff that may not be able to or choose not to learn the new system and the impact that could have on practice operations. The use of an EMR also affects the sacred relationship between the physician and the patient. Patients need to feel like they have been heard when they visit with their

physician. The introduction of the EMR in to the patient visit has the potential to take the physicians attention from the patient to assuring that he is capturing all of what he needs in the EMR. This area should not be taken lightly. Any time there is the potential of disrupting the interaction between the physician and the patient the physician must be cognizant of the change and take active steps to compensate for it.

Incentives make sense when you begin to think about what a physician practice would have to give up to be able to say they have an EMR. As a physician practice grows in the number of providers and locations, the use of an EMR increases the efficiency of the practice operations and assures that all providers have access to the patient's information regardless of what location of the practice they visit. As a one or two physician practice, you would think long and hard before making this decision.

An EMR improve information exchange and provide the physician with a greater depth of information, but the introduction of an EMR in to a practice causes significant disruption in terms of patient care and the potentially the financial viability of the practice in the short run.

The Experience in Grove City:

Of the physicians in Grove City that have made the EMR leap, I would say that 90% of them are glad they did it. The hospital owned group, Wolf Creek Medical Associates (6 physicians) and Family Healthcare Partners (an independent family practice and pediatric group with 6 physicians) made the transition at the same time about 3 years ago. If you were to talk to any of the physicians involved, I believe that they would tell you that it was a difficult transition. Both physician groups experienced the decline in productivity and revenue during the install phase and when either group bring in a new physician one of the biggest challenges they face is the initial introduction to the EMR technology.

Family Healthcare Partners is about 98% paperless and Wolf Creek Medical Associates is about 85% paperless. The management of information within both practices is efficient and now completely dependent on the EMR system.

In both of these groups, it required individuals that could see the potential to positively impact patient care through better and more efficient data management and exchange.

All of the challenges described in the previous section occurred in both implementations with physicians from our hospital. These groups were successful because they saw a bigger picture and they were able to mitigate some of the financial risks because of multiple physicians or financial support from a larger organization. However, it does reinforce the reluctance of solo and small physician groups to elect to disrupt their practice financially and operationally when they may already be having a difficult time paying all the bills due to declining reimbursement.

Where is this going?

The physician and hospital that cares for me on a regular basis both have EMRs. The question is how does that help me when I need emergency services when I am visiting Washington DC? Providing incentives through the ARRA is a great step to move those physicians and other healthcare providers that may have been on the fence to begin the adoption process of an EMR. Nevertheless, at the end what has been created? There will be physicians on a myriad of systems and in some cases they will be able to transfer information to and from the hospitals they admit to. As EMR adoption is a central tenant of cost savings in a redesign of the health care system there needs to be a plan for how this will actually improve the health of individuals and not just provide another mechanism to penalize reimbursement of healthcare providers. We need to stay vigilant so that EMR adoption benefits the patients and the physicians and does not simply become a solution in search of a problem. Incentives provided for in the ARRA will increase the use of EMRs, but the EMRs will still be physician specific and stand alone and depending on the resolution of the healthcare redesign discussion the ARRA incentives may become to costly to attain with all of the proposed reduction in payments to healthcare providers.

Conclusions:

The impact of EMR adoption is significant regardless of the size of the healthcare provider. The group that has the greatest risk is the small independent physician practice. EMR adoption can improve the operation

of the office, but while traveling on the journey to a more efficient office practice, it can disrupt the physician/patient relationship, staffing, and the cash flow of a practice. In our experience in Grove City, we saw all of these things happen. Once through the transition period, many of the physicians would not go back to traditional paper records. The incentives in the ARRA will help move providers off the fence in terms of adoption. However with the plan for healthcare redesign happening concurrently we need to be ever cognizant of the unintended consequences of these two important initiative colliding and the focus of EMR adoption becoming only a cost reduction strategy and not improving the quality of care that is provided by our physicians and hospitals.

American Academy of Pediatrics

TESTIMONY OF
SUSAN KRESSLY, MD, FAAP
PRACTICING PEDIATRICIAN
AMERICAN ACADEMY OF PEDIATRICS

before the

COMMITTEE ON SMALL BUSINESS

SUBCOMMITTEE ON REGULATIONS AND HEALTHCARE

UNITED STATES HOUSE OF REPRESENTATIVES

JUNE 24, 2009

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Susan Kressly, MD, FAAP
Testimony before the US House
Committee on Small Business
June 24, 2009

Thank you very much, Chairwoman Dahlkemper and Members of the Committee. Thank you for your leadership and representation of the Third District of Pennsylvania. Many children in northwest Pennsylvania have been helped by the votes you have cast in favor of reauthorization of the Children's Health Insurance Program and the American Recovery and Reinvestment Act. Without these measures, many children would be without Medicaid. The Academy also applauds you for your innovative attempt to find solutions to our health IT funding quandaries.

I am honored to represent the American Academy of Pediatrics before you today. My name is Susan Kressly and I am a practicing pediatrician in Warrington, Pennsylvania. I have a strong interest in health information technology as it relates to pediatrics and I am a member of the Academy's Council on Clinical Information Technology. In addition to serving on the Council's immunization task force, I serve on the Child Health workgroup of the Certification Commission on Health Information Technology. I would like to extend my sincere thanks to this Committee for allowing me this opportunity to represent children, who represent nearly one-third of America's population, but from whom you don't hear, because they cannot vote. I am grateful for the opportunity to give them a voice.

I am also here today to speak for pediatricians. Sixty percent of pediatricians practice in small businesses. We are distinct 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 child health. It pays for 40% of births in the United States, and covers 30 million children. 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 less than 25% of its cost. Most Medicaid dollars are spent on the care of disabled adults and adults in nursing homes.

Pediatricians provide the best care that we can for our patients, and many of us use a variety of tools to improve care. But 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. Surveys by the American Academy of Pediatrics show that payment rates under Medicaid average around 70% of Medicare. In other words, the average pediatrician providing a service for a patient covered by Medicaid receives only about two thirds of the payment received by a provider for the same service for a patient covered by Medicare.

The Academy greatly appreciates the funding included for pediatricians to purchase health IT in the American Recovery and Reinvestment Act or ARRA, and Academy member surveys show that the funding has the potential to reach around two-thirds of pediatricians. However, small pediatric practices, that is, the same small businesses on which this Committee focuses its work, are disadvantaged by the health IT funding infrastructure established by the law because of the low payment rates under Medicaid and also because of the disparities between the ARRA requirements for practices that are paid by Medicaid and those that are paid by Medicare.

First, the funds in ARRA flow differently for Medicaid and Medicare. ARRA requires practices under Medicaid, including pediatric practices, to demonstrate that they meet a specific case mix

threshold for Medicaid to pay incentives. ARRA does not require this for practices receiving Medicare payments. The Academy thinks that pediatricians whose patient panels are made up by 20% Medicaid, CHIP, and uninsured patients should be eligible for HIT funding under the ARRA legislation.

Second, the meaningful use standard in the statute also poses problems. Medicare rules will require "meaningful use" of health IT in order for a practice to qualify for Medicare incentives. A meaningful use standard also applies to Medicaid, but under the statute, it appears that states can create their own rules for what meaningful use means within their own Medicaid programs. As a result, within a brief time, we could have one Medicare definition of meaningful use and fifty-six different definitions of meaningful use in the various state and territorial Medicaid programs. One-third of doctors practice near state lines, meaning that they would need to qualify for HIT payments under ARRA according to two or more state meaningful use rules. Such variances will undermine the purpose of adopting health IT within the Medicaid population, that is, to improve and to measure the quality of health care for all, including children. To improve quality, we must develop data sets that can be compared. A structure that undermines state-to-state uniformity makes that much less likely. Therefore, we urge you to advocate for a repeal of state Medicaid programs' ability to modify the definition of meaningful use from a national standard.

We realize and appreciate that this funding could have flowed only through Medicare, but we also believe children and pediatricians should not have to overcome more barriers than adults and their health care providers to reap the benefits that health IT can provide. The Academy believes that the case mix threshold standard should be repealed so that the Medicaid and Medicare health IT incentive infrastructures are comparable. If that is not possible, the case mix threshold for Medicaid should be lowered as far as possible to provide incentive payments to as many Medicaid providers as possible.

Congress and the Obama Administration have made significant strides in recognizing the need to support pediatric health IT outside of ARRA. Title IV Section 401 of CHIPRA will act as a catalyst for pediatric health information technology by making available $25 million over five years to develop a pediatric electronic health record format and also to measure and improve the quality of pediatric care. We stand ready to work with the Agency for Healthcare Research and Quality to assure that implementation of this legislation will help children.

Many resources have already been applied to forming useful quality measures for adults. Unfortunately, most of those measures do not apply to children. In addition, many quality measures for pediatrics are based on preventing rather than reducing disease, and thus comparisons and analyses that must be performed must be population-based and over long-term before real gains can be demonstrated. Such widespread and long-term benefits include: reductions in morbidity, mortality and quality of life due to improved immunization rates, violence and accident prevention, prevention of mental health disorders, obesity reduction and more. These subtler, longer-to-realize benefits can lead to huge and measurable savings of healthcare dollars for our country, but will take innovative and dedicated leaders to craft

appropriate quality initiatives and measures and it will require technologies and an infrastructure based on individual practices to track data over longer periods of time. Adult quality measures and programs do not and will not provide these measures of child health care quality over the long haul. . We need additional resources to do what is right for our children today and the country tomorrow.

We are all thankful that the Children's Health Insurance Program or CHIP reauthorization became law, and we must be realistic regarding shrinking state Medicaid budgets. Without robust funding assistance, Medicaid providers, including pediatricians, may not be able to adopt health IT as quickly as the national healthcare system needs or as intended by ARRA.

We would also urge you to consider at least two other issues: what we can do now to improve child health, and how we can think outside of the box for the future to improve child health.

There has been much talk about interoperability as HIT becomes more widely adopted. There is already a meaningful use project that exists in pediatrics that is just waiting to have more available resources. I am referring to the State Immunization Information Systems. Standards have been well-defined to create bi-directional, real-time information exchange between various stakeholders using existing technology. There have been many people dedicated to this mission, yet year-after-year states have not been able to upgrade their systems to keep up with the available EHR technology and the cutting edge standards have yet to be implemented in all but a few states. This is a "shovel ready" project that has huge implications for public/private health exchange of information, preventing misuse of healthcare dollars from inappropriate or duplicate immunizations, and that has immediate value to each and every practicing pediatrician.

We urge the Administration to also "think outside the box" while making decisions regarding topics to invest in with ARRA health IT funds. Health IT should be about innovation and we should take this opportunity to harness new ideas to best effect. One option we would urge the Administration to explore is embedding into approved health IT systems much more than Computerized Physician Order Entry or electronic Decision Support. We would suggest that systems link to databases of pediatric knowledge so that physicians can practice the best quality medicine, but also so that the families of patients can become better educated during their healthcare encounters. In the pediatric realm, this would involve links to leading sources of pediatric information that could be customizable for pediatric conditions. Ideas like these would help leapfrog patient care and educate family members about how to stay healthy and decrease over-utilization of unnecessary health services.

In conclusion, as the Small Business Committee continues its debates and discussion around implementing incentives for the adoption of health information technology systems under the ARRA, please keep in mind the special needs of the children and pediatric practices. Pediatric practices often operate under tighter margins, are not directly supported by the Medicare system, and have more burdensome restrictions on receiving ARRA incentives than do providers who receive Medicare payments. To provide the best health care for children and to help pediatricians

leverage the best that health information technology has to offer to support that care, we need partners and incentives that will allow us to reach that goal.

Thank you very much for the opportunity to testify before you today.

STATEMENT
of the
American Optometric Association
to the
Committee on Small Business
Subcommittee on Regulations, Healthcare and Trade
United States House of Representatives

RE: Health IT Adoption and the New Challenges Faced by Solo and Small Group Healthcare Practices

June 24, 2009

The American Optometric Association (AOA) appreciates the opportunity to provide comments regarding "Health IT Adoption and the New Challenges Faced by Solo and Small Group Healthcare Practices" to the U.S. House of Representatives, Committee on Small Business, Subcommittee on Regulations, Healthcare and Trade.

We commend you, Chairwoman Dahlkemper, Ranking Member Westmoreland, and members of the Subcommittee, for the leadership and vision you have shown in recognizing the fundamental need to promote widespread adoption and use of health information technology (HIT). Your ongoing efforts will help improve health care quality, prevent unnecessary medical errors, reduce overall health care costs, increase administrative efficiencies and expand access to affordable care for a greater number of Americans.

We are grateful for the strong efforts of this Committee and Congress to spur adoption of HIT. In particular, we applaud the inclusion of HIT incentives within H.R. 1, the *American Recovery and Reinvestment Act of 2009* (ARRA), which provides financial incentives to help health care providers purchase and implement HIT systems. As a result, doctors of optometry and other Medicare physicians who implement and report meaningful use of electronic health records (EHRs) will be eligible for incentives beginning in 2011.

Beyond incentives, a key element to widespread adoption and use is the development of uniform HIT standards. To this end, ARRA formally established the role and functions of the Office of the National Coordinator for Health Information Technology (ONCHIT), which is to promote the development of a nationwide interoperable HIT infrastructure. ARRA also created the HIT Policy and Standards Committees, which are comprised of public and private stakeholders and charged with providing recommendations on the HIT policy framework, standards, implementation specifications and certification for EHR.

Today, the AOA urges the Committee and Congress to work with the Department of Health and Human Services (HHS), America's doctors of optometry and a broad range of health care providers to address

existing barriers to increased adoption and use of HIT while working to guarantee those systems are interoperable, secure and functional.

Specifically, the AOA asks Congress to urge the ONCHIT and the HIT Policy Committee to promote the rapid development and deployment of a certification for eye care EHRs and appropriate certifications for other medical specialties to ensure that eye care providers as well as a wide range of other health care providers are able to take advantage of the ARRA incentives and get to work on building an interoperable nationwide HIT network.

In addition to certification concerns, the AOA is troubled that some providers are not currently eligible for HIT adoption incentives and may be left behind as an HIT network develops. While ARRA provides incentives to Medicare physicians, the legislation does not include strategies to spur HIT adoption among a large and diverse group of providers which comprise a significant part of our health care delivery system. We are also concerned that these clinicians that are now ineligible for HIT incentives may be vulnerable to future Medicare cuts that hinge upon HIT utilization. Ultimately, this would reduce patient choice and overall access to care.

The AOA today urges the Committee and leaders in Congress to consider alternate strategies to provide HIT adoption incentives to a greater range of health care providers to ensure that all elements of America's health care delivery system are included as the development of a nationwide HIT network advances.

Working together, we are confident that Congress, HHS, the AOA and other health care provider organizations can help put this nation on track toward developing a much needed nationwide HIT network. In doing so, we can help America achieve long-lasting and equitable health care reform while delivering on the long-held promise of ensuring greater access to needed health care services, including comprehensive eye and vision care, that are high quality and increasingly affordable for patients and the American taxpayer.

The Central Role of HIT

HIT is generally defined as: "the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing and use of health care information, data, and knowledge for communication and decision making," including applications such as telemedicine and use of the Internet. Encompassing a huge range of products and systems, HIT allows for the comprehensive management of health information through secure exchanges between health care consumers and providers. It is one of the key elements in an overall effort to virtually reshape the entire culture of American health care.

According to the Institute of Medicine, the EHR is the central component of HIT and supports the ordering of prescriptions and tests, aids in clinical decision making, and facilitates development of a longitudinal record such as viewing, ordering, messaging, documenting, care management, analysis, and reporting. It serves to expand care providers' ability to organize patient data, reduce paperwork, replace lengthy records processes, help deliver more coordinated care through making information sharing easier among patients' team of health care providers, and can also prevent errors in the delivery of patient care.

When used effectively, EHRs enable providers to deliver care more efficiently. For example, EHRs may eliminate or substantially reduce the need to physically pull patient charts from office files or patients' visits and could prompt providers to prescribe generic drugs instead of more costly alternatives. A September 2005 report by the RAND Corporation estimated that $77 billion annually would be saved if

90 percent of physicians adopted HIT. The report also estimated another $4 billion in savings from reductions in prescription errors.

According to HHS, the use of HIT will ultimately facilitate the collection of cost and quality data that will support a new system of "value-oriented care". The data collected will allow health care purchasers to compare the price and quality of care and encourage the utilization of the most cost-effective care. The use of EHRs can also improve the quality of care by reminding providers about such things as appropriate preventive care, identifying harmful drug interactions or possible allergic reactions or even help providers manage patients with complex chronic conditions.

Greater use of this technology could even lead to future scientific breakthroughs with the computer-age ability to exchange and manage data to provide personalized health care. Soon, patients may also be able to access their own health records, a possible step toward greater patient compliance with health care regiments and an increased interest in healthy lifestyles.

While a number of integrated delivery systems have already implemented EHRs across their organizations, such as Geisinger Health System and the Department of Veterans Affairs, very few solo providers and small group health care practices have adopted HIT despite the potential to increase efficiency and improve quality. While Optometry has proven to be on the forefront of HIT adoption for small business health care providers, a number of obstacles to widespread adoption and use remain among solo and small group practices.

Barriers to Widespread HIT Adoption

The *American Recovery and Reinvestment Act of 2009* (ARRA) provides substantial financial incentives that will help physicians purchase and implement HIT systems. The provisions within ARRA provide $19 billion over a specified five-year period for physicians in Medicare. Beginning in 2011, Medicare physicians who implement and report meaningful use of EHR will be eligible for an initial incentive payment up to $18,000. While ARRA includes a provision that will reduce Medicare payments for physicians who do not use EHR systems to take effect in 2015, there are exceptions for significant hardship cases.

ARRA provides incentives through the Medicare Part B program to encourage physicians to adopt and use qualifying EHR in a meaningful way. ARRA explicitly states that for a physician to be a "meaningful user" of HIT and be eligible for the financial incentives, the EHR that he or she uses must be certified. However, to date the only federally recognized certification body is the Certification Commission for Healthcare Information Technology (CCHIT). While AOA concerns outlined below focus mostly on eye care, we believe that our situation will not be unique as other medical specialties with specialized EHR systems seek to develop certification through CCHIT.

The eye care community was notified that eye care was one of the Commissions's planned expansion areas for 2010 and beyond. The Commission placed eye care on the roadmap using the following timeline: 2009 for research; 2010 for development; and, 2011 for launch. Working together with the American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgery (ASCRS), the AOA expressed appreciation that eye care was included on the draft roadmap, but believed it was essential for the eye care specialty to have an accelerated timeline for launch and asked the Commission to be flexible when developing final timelines for a number of reasons.

First and foremost, AOA and its partners argued that ARRA put in place financial incentives and penalties based on the adoption and "meaningful use" of certified HIT systems that will have a profound impact on our members and their ability to adopt HIT and become meaningful users. Because of a lack of

resources and capacity, the Commission later announced that eye care would remain on the CCHIT expansion roadmap under the originally proposed timeline. This month, we were delighted to learn that CCHIT is open to eye care EHR certification launch in 2010.

The eye care community understood the constraints on CCHIT, but feels the accelerate timeline would coincide deadlines imposed in the ARRA, and that our members will be able to take advantage of this opportunity make the HIT improvements that will increase patient safety and expand on their growing participation in quality programs such as PQRI and data registries if certification is made available in 2010. This is crucial for our members to implement and use certified EHRs and meet ARRA requirements.

Another major reason we sought flexibility and acceleration of the timeline was the readiness and preparedness of the eye care professional organizations and the eye care EHR vendor community. The eye care provider and professional community have organized in response to demand from our collective members for high-quality, HIT solutions that are appropriately designed for eye care; as well as demands by public and private payers seeking to control costs and improve the care provided to respective beneficiaries.

It became apparent that the limiting factor for CCHIT to add specialty areas of certification was resources. Today, the AOA would strongly recommend that ONCHIT endorse and support the expansion of specialty areas of CCHIT certification to ensure ARRA incentives serve their intended purpose of spurring widespread adoption of HIT. In addition, the AOA would warn that as policymakers and certifying organizations move to define "meaningful use" we want to also caution against a "one-size-fits-all" approach. Just as different types of providers need different types of EHRs, the meaningful use of EHRs can vary. The bottom line should be improved results for patients.

Recommendations:

-- Encourage the rapid CCHIT development and deployment of certification for eye care and other EHRs

-- Urge support from ONCHIT to help fast track CCHIT certification for eye care and other EHR systems

-- Recognize that eye care EHRs should cater to the needs of both ODs and MDs who provide eye care

-- Recognize that "meaningful use" of EHRs may vary depending on the practice of the provider

In an effort to help address existing barriers to increased adoption and use of HIT, the AOA asks Congress to urge ONCHIT and the HIT Policy Committee to promote the rapid development and deployment of a certification for eye care EHRs and appropriate certifications for other medical specialties to ensure that eye care providers as well as a wide range of other health care providers are able to take advantage of the ARRA incentives and get to work on building a interoperable nationwide HIT network.

The AOA looks forward to working with the Committee and Congress to ensure the development of a nationwide HIT network that is interoperable, secure, functional and includes a broad range of health care providers. The AOA firmly believes that by developing an interoperable, integrated and inclusive HIT network we can together help America achieve long-lasting and equitable health care reform while delivering on the long-held promise of ensuring greater access to needed health care services, including comprehensive eye and vision care, that are high quality and increasingly affordable for patients and the American taxpayer.

House Committee on Small Business
Subcommittee on Regulations and Healthcare

"Impact of Health Information Technology Legislation on Small Businesses and the Role of Government"

June 24, 2009

Statement by
Carladenise Armbrister Edwards, Ms.Ed, Ph.D.
Georgia Department of Community Health

Good morning Chairwoman Dahlkemper, Ranking Member Westmoreland, and Members of the Committee. Thank you for inviting me to testify before you today on a topic that I am very passionate about – Health Information Technology. My name is Carladenise Armbrister Edwards, Ph.D. and I presently serve as the Chief of Staff for Georgia's Department of Community Health (www.dch.ga.gov), the state agency responsible for the administration of the Medicaid and Children's Health Insurance Programs (CHIP), the State Health Benefit Plan, the State Offices of Health Improvement and Rural Health, the Certificate of Need program, and the State Office of Health Information Technology and Transparency. Effective July 1st, our Agency will assume responsibility for Healthcare Facility Regulation and Licensure, as well as Public Health and Emergency Preparedness. As the Chief of Staff, I am responsible for ensuring that the Agency operates in the most efficient and effective manner while providing our health care beneficiaries, be it the 1.5 million Medicaid members or the 700,000 state employees have access to the highest quality health care delivered in the most cost effective manner.

Prior to serving in my present position with the great State of Georgia, I owned a small health care consulting business in the great State of Florida called The BAE

Company (www.thebaecompany.com). Our company was founded to improve the health and well-being of the community. My father, Lt. Col. Anthony Armbrister, USMC Retired and I built our business to help other small businesses with strategic planning and business development, implementation of health information technology, and change management and system re-design. Therefore, I come to this committee with experience in your three areas of interest: health information technology implementation, small business ownership, and health care administration.

It is my understanding that this committee is interested in learning more about:

(1) how health information technology will impact small businesses, particularly health care practitioners effected by the Health IT provisions in the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5;

(2) the government's role in promoting the adoption of Electronic Medical Records through the use of financial incentives and penalties as outlined in the Recovery Act; and

(3) Finally, what role does Health IT play in Health Care Reform and will it positively or adversely affect small business owners.

Health Information Technology (HIT)

First, I will attempt to address the issues related to the impact of HIT on health care providers and the benefits and drawbacks of the Recovery Act from the perspective of a large government employer that contracts with health care providers for the Medicaid and State Employee health plans. As you can imagine, the state has a vested interest, *a $12 billion interest*, in ensuring that health care services are provided in the most cost effective and efficient manner possible. We want to make sure our employees have access to quality health care, so that we can have a strong, productive work force

and we want to make sure our beneficiaries have access to quality health care at the lowest possible cost to the State; therefore, we are strong proponents of Health IT. As stated in the June 16, 2009 draft definition of Meaningful Use posted by the Office of the National Coordinator's Health IT Policy Committee:

> "the ultimate vision [for our health care delivery system] is one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities"[1] which we know drives up the cost of health care.

Health Information Technology, specifically the *meaningful use* of electronic health records, is a primary mechanism for achieving the ultimate vision. Through the meaningful use of HIT, health care providers can access their patient's medical history, medication lists, allergies, prevent contraindications, coordinate treatment protocols, and expedite care in urgent and non-urgent situations. Patients will be able to access their health information when and where they need it making health care more transparent resulting in patient empowerment, increased accountability for quality and cost, and improved patient safety. So from our perspective HIT is a *good thing.*

The Department of Community Health (DCH) is actively participating in the advancement of Health Information Technology and Transparency in several ways, including:

[1] "Meaningful Use: A Definition". Recommendations from the Meaningful Use Workgroup to the Health IT Policy Committee. June 16, 2009.

(1) First, the establishment of a health transparency website that provides health care consumers with information that allows them to identify providers by location, cost, and quality indicators; to evaluate health plans according to the services they offer; and to learn about health conditions and related treatments. We built this website with funds provided by the Centers for Medicare and Medicaid Services (CMS) to empower consumers with objective, unbiased health information (www.georgiahealtinfo.gov). Georgia would like to see more money available from the federal government to support this tool and others that are designed to educate consumers with information that ultimately will help us reduce unnecessary health care expenses.

(2) Second, the Department has given grants to local communities, large and small health care providers, and community health centers (FQHCs, RHCs, and CAHs) to implement interoperable electronic health record systems that allow the sharing of health information among disparate providers in a community to improve care coordination. The state was able to give out $1 million in grant funds the first year of the program and $750,000 the second year. Due to state budget deficits, this program is at risk of being discontinued; despite the financial benefit the state could achieve upon full implementation of an interoperable health information exchange that can reduce duplication, improve patient safety, and increase access to care through the use of telemedicine and electronic prescribing. The Recovery Act has set aside funds *(approximately $300 million)* for regional health information exchange. Georgia is positioning itself to compete for these funds, so that we can continue providing our small

physician practices with grants to adopt HIT and to work with community partners to create regional health information exchanges.

(3)Third, Georgia's Medicaid program is creating ***Georgia Healthe Connect***, a Web-based application that will allow Medicaid Providers access to an interoperable electronic health record in a private, secure, virtual environment which allows them to avoid the challenges associated with purchasing, hosting, and maintaining the hardware and software necessary to sustain a traditional EHR in their practice. Our goal is to eliminate the financial barrier that prevents adoption among small physician practices that treat our most vulnerable citizens through the Medicaid and Children's Health Insurance Programs.

(4) Lastly, but not finally, DCH is working collaboratively with our academic institutions, managed care companies, health care associations, public health districts, public and private provider community, Quality Improvement Organization, and fellow government agencies to sustain Georgia's Electronic Health Record Partnership which was created in 2008 when Georgia was designated one of the 12 CMS EHR demonstration sites. DCH is very well poised to serve as one of the Regional Extension Centers authorized by the Health Information Technology for Economic and Clinical Health Act (HITECH); to disseminate loans to small physician practices and grants to Medicaid providers authorized by HITECH; and to provide training and technical assistance to ensure compliance with the new Health Insurance Portability and

Accountability Act (HIPAA) provisions which increase accountability for maintaining private and secure health information systems.

DCH believes that the concerted effort put forth by our State's government to implement a strategy for increasing the adoption and utilization of Health IT will only serve to improve the quality of care and reduce the cost of health care that is a consequence of inefficiency, over utilization, and limited access to the right information in the right place at the right time. If it is done well, the Recovery Act can provide states the resources required to maintain and expand their efforts to ensure health care providers, no matter how small their practice, have access to Health IT and that they are able to benefit from group purchasing; extension services aimed at ensuring successful implementation through training, system integration services, and work flow re-design; as well as financial incentives for adoption and meaningful use.

Potential Drawbacks to Government Involvement in HIT

I have spoken about the opportunities our Agency has identified from the Recovery Act, and I have tried to outline the work that is taking place in Georgia and how the Recovery Act could potentially support the work we are doing to advance Health IT. Again, I am speaking from the fundamental premise that Health IT is a "good thing" and is necessary if we are going to transform our health care system into one that is much more efficient and accessible. *I do not need to tell anyone on this committee how frustrating it is to arrive at your doctor's office for a follow-up visit (after losing valuable time at work trying to call into the office to schedule the appointment when you wish you could have done it via e-mail or on the Internet) and your medical records from the*

specialist, hospital, or lab are not there! If the only thing we accomplish with Health IT is forcing providers to electronically schedule appointments and send lab results then that would be a huge win to everyone, especially the small business owner who can not afford the loss in productivity when their employees have to make two trips to the doctor when one trip would have sufficed had the physician been able to access the information.

The drawbacks to assuming Health IT is the panacea and to the state or the federal government investing in Health IT are few, but they do exist. Primarily, the drawback is the potential for failure. Frederick Douglas once said that "Power does not concede without demand"[2]. If health care consumers do not demand a change, then providers are still going to be reluctant to implement a change and the resources used to invest in that change will be for nothing. Not only do we need to change how health information is captured, filed, exchanged, and protected, but we have to change the value of that information to the individual consumer, the health care provider, and the health officials responsible for monitoring the population's health and well-being. Technology transformed the individuals ability to manage their own financial portfolio and for businesses to manage their cash flow. Through technology entrepreneurs have been able to build businesses and expand their businesses into global markets. Technology provides access to data and information that can be used for strategic decision making in business and for clinical decision making in health care.

The role of the government should be to knock down the barriers that prevent the use of technology in health care while allowing consumer demand and competition to design, develop, and sustain the products and services that best meet the consumers' needs. This approach will create opportunities in the private sector and result in the best

[2] The Fredrick Douglass Papers. 1857. *"Without Struggle/No Freedom Quote."*

products with the best value. If the funds from the HITECH Act are used to reduce the financial barriers that prevent small businesses from adopting technology, to educate consumers about the value and the importance of health IT, and to help maintain efficient and accessible health care programs for the millions of Americans who depend on government funded health care, then the public will be well served by the Recovery Act and the government would have served its purpose.

Meaning of Health Care Reform and Health IT to the Small Business Owner

I conclude my testimony with a few words on what Health Care Reform and Health IT means to the small business owner. As I stated in my introduction, my father and I started a health care consulting firm in Miami, Florida in 2005. The type of business is only relevant in that I have seen firsthand how the successful implementation of Health Information Technology has improved my clients' productivity, service delivery, patient and staff satisfaction, and ability to meet quality and safety goals established by their funding sources and/or accrediting bodies. More importantly, my role as a small business owner has given me a greater appreciation for the work you all are doing here in Washington, D.C. The bold steps you are taking to transform the health care system to one that is more accessible to small business owners and their employees are heroic given the resistance to change and the current status of the economy. We can have the best health care system in the world, but if I can not afford to access it then what use is it? As a small business owner, we want to be able to provide competitive benefits, to maintain a healthy workforce, and to make a little profit, but the present structure prohibits that in most instances.

What health care reform means to me as a small business owner is the opportunity to participate in a health care system that equalizes access to health care coverage similar to my access to car or homeowners insurance.

What health IT means to me is the opportunity to have access to my health information and my families health information so that I can manage my "health care portfolio" the way I manage my financial portfolio – easy access to my prescription history, view reports on my cholesterol or blood pressure or weight in a meaningful way, and have confidence that my physician has the information needed to keep me safe, healthy, and productive.

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Thank you for the opportunity you have given me to share a snapshot of the work we are doing in Georgia under the leadership of Governor Sonny Perdue and DCH Commissioner Rhonda Medows, and for allowing me to share my thoughts on how we can best put the $19 billion investment of ARRA funds to use for the benefit of private health care providers and small businesses across the country.

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June 26, 2009

Testimony by AHDI/MTIA CEO Peter Preziosi, PhD, CAE, Regarding Health Information Technology Adoption

Dear Honorable Members of the House Subcommittee on Regulations and Healthcare:

On behalf of the Association for Healthcare Documentation Integrity (AHDI) and the Medical Transcription Industry Association (MTIA), which represent a $15 billion sector comprised of approximately 1,700 companies-mostly small businesses with revenues under $5 million-employing an estimated 300,000 healthcare documentation professionals, I submit the following testimony concerning:

1. **The crucial services provided by medical transcription service operators (MTSOs) in clinical documentation by ensuring the accuracy and completeness of patient health records and how that role is essential to successful EHR adoption and:**

2. **The unique challenges small medical transcription businesses will have in supporting physician practices resulting from the impact of the Health Information Technology for Economic and Clinical Health Act's (HITECH Act) new HIPAA standards.**

Please consider this testimony as you investigate and discuss the challenges solo and small group practices face in adopting health information technology (IT) and the implementation policies in the American Recovery and Reinvestment Act of 2009 to promote Health IT adoption. In addition, please include this testimony in the official report for the hearing you held on Wednesday, June 24 concerning these topics.

The Crucial Role MTSOs Play in Quality Clinical Documentation and Successful EHR Adoption

Since physicians have a high level of familiarity and comfort with the dictation/transcription process and narrative reports, it is important to ensure that certified EHRs can accept interfaced data from the dictation/transcription process. At least 1.2 billion clinical documents are produced in the United States each year. Dictated and transcribed documents make up nearly 60 percent of all clinical notes. These documents contain the majority of physician-attested information and are used as the primary source of information for reimbursement and proof of service. Dictation has historically been and continues to be the documentation method of choice for physicians. Small businesses employ tens of thousands of healthcare documentation professionals in "green," home-based jobs that support physicians in solo and small group practices across the country in producing healthcare records from the dictation process to ensure accurate capture of patient history, as well as the care encounter. Embracing the dictation/transcription process as a common method of getting information into the health record will increase physicians' willingness and ability to transition to electronic health records (EHRs).

We must ensure quality by employing the skills, knowledge, and experience of healthcare documentation professionals to review patient health records. The quality of patient reports is essential to reducing errors in healthcare delivery and preserving the integrity of health information, especially as information is increasingly exchanged across healthcare enterprises, potentially worsening errors at an exponential rate and thereby putting patients at greater risk. While healthcare documentation

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has evolved due to the introduction of new technologies such as electronic EHR systems and speech recognition, the need for skilled, knowledgeable, and experienced healthcare documentation professionals remains strong. An "extra set of eyes" is still needed to ensure the accuracy and completeness of patient health records. By capturing and correcting errors that otherwise would exist in records and be transmitted across providers and enterprises, healthcare documentation professionals greatly improve the quality of narrative reports, structured data, and documents. Many EHR systems require the physician to enter data, increasing their burden on providing direct care to patients. Using healthcare documentation professionals in partnership with physicians to document care and to ensure the quality of these records will likely save money because it deploys more cost effective healthcare documentation professionals to capture data rather than expensive clinicians.

Even with the aid of federal financial incentives, solo and small group physician practices will face significant financial challenges in adopting and implementing an EHR system if burdens to care increase and the use of EHR systems is cumbersome, resulting in increased cost at the solo and small group practice level. **Requiring certified EHRs to accept interfaced data from the dictation/transcription process is a simple, yet proven and highly effective, step the federal government can take to ensure that new health IT improves quality of care in a way that physicians will welcome and embrace.** For more information about how our organizations and professionals stand ready to support greater and more successful EHR adoption, please refer to the four following documents we included for your consideration:

1. A white paper discussing in detail how medical transcription can help accelerate EHR adoption;
2. A handout outlining the value and benefits of medical transcription for EHR adoption;
3. An abstract of a study revealing the crucial role that healthcare documentation professionals play in correcting dictation errors and ensuring the accuracy of patient health records; and
4. A handout on the need to include "practical use" within the definition of "meaningful use."

New HIPAA Requirements Will Burden Technology Strapped Small MTSOs.

Small MTSOs face substantial challenges in meeting the new HIPAA standards laid forth in the HITECH Act. Under the Act, MTSOs, although still technically considered business associates, will now be held accountable at a covered entity level rather than a business associate level for HIPAA privacy and security rules and will be subject to civil and/or criminal penalties for violations of the new requirements. The Act requires MTSOs to implement policies that establish administrative safeguards (such as security policies and training), physical safeguards (such as locks and building security systems), and technical safeguards (such as computer encryption, log-in IDs, and auto-log off). **The medical transcription sector has long embraced privacy and security standards to protect patient health information; however, implementing the new standards could become a serious financial burden for small MTSOs needing to purchase additional auditing, encryption, and document tracking technology tools to comply with the new rules, which could threaten the jobs of the people they employ.**

While there are a few large, publicly traded MTSOs, the overwhelming majority of MTSOs are small businesses. These small businesses have found it increasingly difficult to survive amidst accelerated consolidation, decreasing profit margins, mounting overseas competition, and growing government regulation. As described in the first section of this testimony, small MTSOs contribute greatly to

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improving quality of care and patient safety by ensuring that patient health records are accurate and complete. They also employ tens of thousands of healthcare documentation professionals, many of whom work in small towns and rural areas hit hard by the economic recession.

Our associations will work with the federal government on education, training, and outreach to the clinical documentation sector to ensure compliance with the regulatory requirements. **Small MTSOs are well-positioned to continue to provide quality clinical documentation in the age of EHRs; however, to secure a future for small MTSOs, the jobs they provide, and the crucial role they play in health care, the federal government must recognize and help address the challenges faced by them. The success of that effort will require collaboration, technical assistance, and financial support, including funding to retool and equip the workforce with the skills and knowledge necessary to harness the full potential of new and emerging technologies.** We look forward to working with the government on that important effort.

We hope you find this information helpful. Please do not hesitate to contact me if you have any questions or would like additional information. Thank you for your time and consideration of my testimony.

Sincerely,

Peter Preziosi, PhD, CAE
Chief Executive Officer
Association for Healthcare Documentation Integrity/
Medical Transcription Industry Association

MEDICAL TRANSCRIPTION:
PROVEN ACCELERATOR OF EHR ADOPTION

The recently enacted Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009 represents an important first step towards achieving the vision of a nationwide, fully interoperable electronic health record (EHR) system. However, the gap between that vision and current reality remains wide. Many healthcare providers still use paper records. Other providers have tried to implement EHR systems, but unfortunately, many such projects have failed. "Industry experts agree that failure rates of electronic medical record (EMR) implementations range from 50 to 80 percent."[1] Clearly, the challenges of EHR adoption and implementation remain great.

The medical transcription/clinical documentation sector is well positioned to serve as a faster bridge and solution to enabling greater EHR adoption. The medical transcription sector can support the HITECH Act in the following three ways:

1. **Use Existing and Proven Technology Platforms to Facilitate the Transition to Electronic Records:** Healthcare enterprises facing fiscal and/or worksite challenges in implementing large-scale, fully integrated EHR/EMR platforms can increase adoption by using existing electronic document exchange solutions found in medical transcription service platforms. Standardized healthcare documentation exchange practices will bolster the nationwide electronic exchange for health information in a secure, private, and accurate manner.

2. **Develop and Support Quality and Security Standards Leading to Greater Document Compliance and Improved EHR Adoption:** When capturing patient encounter information accurately, uniformly, and securely across healthcare enterprises, there is greater likelihood of ensuring quality and compliance of the record for safe patient outcomes and legitimate reimbursements.

3. **Continue to Create a 21st Century Workforce to Enable EHR Roll-out**: Grow and develop the medical transcription workforce by creating new opportunities for these entry-level, technology-enabled intelligent workers. The tacit knowledge and experience of the medical transcriptionist should be redeployed to support existing workflow practices, assist in migrating the healthcare system from a paper-based record to a fully interoperable electronic system and serve in risk management and document compliance roles to ensure the integrity and security of electronic document management systems.

[1] A Common Sense Approach to EMRs. AdvancedMD, July 11, 2006, https://www.advancedmd.com/pressroom/white_papers/commonsense_to_emrs.pdf.

Medical Transcription as a Faster Bridge to EHR Adoption

- ***The Promises and Challenges of EHR Adoption***: EHRs promise to lower costs resulting from inefficiency and inappropriate and/or redundant care while improving the coordination of care and exchange of information among healthcare enterprises. However, despite these promises and efforts to date, adoption rates among physicians still remain relatively low, with costs cited as a major deterrent.[2] Other adoption concerns include complex organizational and system work flow issues and the increased documentation burdens on the part of physicians when they are asked to use direct text entry. Several studies have shown that practice productivity can decrease by at least 10 percent for several months following EHR implementation. In some non-oncology studies, the average drop in revenue from that loss of productivity was approximately $7,500 per physician."[3]

- ***Using Existing, Proven Technologies to Go Paperless:*** While the healthcare industry slowly migrates to broader acceptance and adoption of EHR technologies, the capture, collection, and documentation of health information continues to evolve as well. In fact, electronic document management tools are available now through medical transcription companies without having to implement a full EHR system. This opens up the possibility of providing lower cost solutions to physician practices and healthcare enterprises that cannot afford the higher costs of EHR/EMR platforms in the interim. Electronic document systems have the capability today to eliminate paper charts and improve productivity and efficiency without the multi-year timeframe or high cost of a comprehensive EHR system. Using readily-available technology to create a simplified approach to going paperless has been key to success.[4]

Electronic document systems have the capability today to eliminate paper charts and improve productivity and efficiency without the multi-year timeframe or high cost of a comprehensive EHR system.

- ***Dictation-Transcription: Doctors' Preferred Method of Documentation:*** Physicians have long embraced the dictation-transcription process for documenting patient care encounters. At least 1.2 billion clinical documents are produced in the United States each year.[5] Dictated and transcribed documents make up nearly 60 percent of all clinical notes. These documents contain the majority of physician-attested information and are used as the primary source of information for reimbursement and proof of service. Dictation has historically been and continues to be the documentation method of choice for physicians because it produces complex, specific narrative that ensures accurate capture of patient history as well as the care encounter. In addition, it corresponds intuitively to the physician's usual method of working, it is flexible, data is presented in a predictable order, and it requires the same or less time than other current reporting methods. Further, discrete data contained within these narrative reports can be tagged using XML coding for export to EHR databases. A study by Columbia University concluded that such

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[2] "Electronic Health Records in Ambulatory Care - A National Survey of Physicians." New England Journal of Medicine, July 3, 2008.

[3] Oncology Outlook: The Costs and Benefits of Health IT in Cancer Care, Jivesh Sharma, MD, August 21, 2008.

[4] "Going Paperless Without EHR?" EMR Advice, February 2, 2007.

[5] National health statistics reports no. 5, 2006 National Hospital Discharge Survey; no. 3, National Ambulatory Medical Care Survey-2006 summary; no. 4, National Hospital Ambulatory Medical Care Survey-2006 outpatient department summary; no. 7, National Hospital Ambulatory Medical Care Survey-2006 emergency department summary; no. 12, Ambulatory Surgery in the United States; Hyattsville, MD: National Center for Health Statistics. 2008.

structured narratives represent "a new vision of electronic health records as collections of rich, interrelated narratives rather than lists of isolated facts" which "serve as a more accurate reflection of a patient's health and a more effective source of knowledge for clinical decision making."[6]

- ***MTs Ensure the Accuracy of Data Entered into Electronic Systems:*** One of the primary functions that medical transcriptionists serve is that of a second set of "eyes and ears" to ensure the accuracy of clinical documentation. Medical transcriptionists routinely flag from 10 to 20 percent of dictations for problem analysis. Potential errors such as wrong drug names or dosages, "left-side, right-side" discrepancies, and inconsistent findings (e.g., drug listed under both medications and allergies) are flagged for physicians to review. Because of this editing step, transcribed notes approach 100 percent accuracy when completed. By contrast, electronic data entry by physicians and other caregivers is prone to error. A study of direct text entry into an EMR found that "60 percent of patients reviewed had one or more input-related errors averaging 7.8 errors per patient," "copying another clinician's note and making changes had the highest rate of error," and "overall, MDs make more errors than other clinicians, even after controlling for the number of notes."[7] Medical transcriptionists play a key role in ensuring that accurate information is entered into electronic medical records and help prevent the perpetuation of errors.

While electronic data entry by clinicians may solve many of the problems associated with paper records, it also creates new problems and new risks to patient safety.

- ***The Importance of Integrating People with Technology***: New and emerging technologies can greatly enhance documentation processes but their successful implementation hinges on how they are used and integrated into practice. In a report released by the National Center for Research Resources, electronic clinical documentation systems enhance the value of EHRs by providing electronic capture of clinical notes, patient assessments, and clinical reports.[8] Implementation of template-based data capture systems will further streamline the process and create greater efficiency in documentation for some patient encounters. However, the documentation of most encounters will not be readily facilitated by template solutions. To force complex data into a restricted template could greatly compromise both the scope and quality of the patient encounter record and has the potential for greater fraud and abuse in the system. Speech recognition products are other useful tools for the documentation cycle, especially as a solution paired with a documentation specialist who monitors the quality and placement of the information.

To force complex data into a restricted template could greatly compromise both the scope of quality of the patient encounter record and has the potential for greater fraud and abuse in the system.

Johnson SB, Bakken S, Dine D, Hyun S, Mendoca E, Morrison F, Bright T, Van Vleck T, Wrenn J, Stetson P. An Electronic Health Record Based on Structured Narrative. J Am Med Inform Assoc. 2008;15:54–64.

Wier CR, Hurdle JF, Felgar MA, Hoffman JM, Roth B, Nebeker JR. Direct Text Entry in Electronic Progress Notes: An Evaluation of Input Errors. Methods Inf Med 2003; 42:61-7.

Electronic Health Records Overview, MITRE Center for Enterprise Modernization, National Institutes of Health, National Center for Research Resources, April 2006.

- ***Working with EHR Vendors for Successful EHR Adoption:*** Data capture and documentation technologies will continue to evolve as the healthcare system moves toward electronic exchange of health information. EHR systems will need to provide and support protocols that will work interoperably and in conjunction with the virtual medical documentation industry given that a large percentage of healthcare facilities (whether acute-care, ambulatory care, or private practice) long ago transitioned their documentation services off-site, using either an at-home workforce or an outsourced service provider. Most EMR systems do not currently have a way to export voice dictation that is embedded into the EMR software. This greatly limits the outsourcing ability of the practice and restricts transcription or speech-recognition editing to an on-site scenario only. Therefore the clinical documentation sector must work in closer collaboration with EHR/EMR vendors to improve integration of clinical documentation functions as EHR platforms roll out for adoption.

Quality and Security Standards Lead to Greater Document Compliance and Improved EHR Adoption

- ***Creating Document Standards to Improve Patient Care:*** Consistent, complete, and accurate documentation are critical to patient safety and coordination of care. Document standards, particularly in the areas of nomenclature, formatting, quality assessment, privacy, and security, ensure document integrity. The medical transcription sector has begun promulgating these standards. As the industry transitions toward broader adoption of electronic health records, the sector continues to champion the quality and security of documentation and health information.

- ***The Best of Both Worlds: Integrating Narrative Documents with EHR Technology:*** The Health Story Project,[9] an industry alliance initiated by the Association for Healthcare Documentation Integrity (AHDI), the Medical Transcription Industry Association (MTIA), M*Modal Technologies, Alschuler Associates, LLC, and the American Health Information Management Association (AHIMA), formed to develop and promote implementation guides for common types of narrative notes. The implementation guides are templates for the HL7 Clinical Document Architecture (CDA), balloted by HL7, with whom Health Story has an associate charter relationship. This project bridges the gap between narrative documents produced through dictation and the structured, computable records necessary to feed the EHR by using common metadata and data templates developed for the CDA. Transcription documents can be imported directly into the EHR along with EHR summaries such as the Continuity of Care Document (CCD), another implementation of templated CDA.

  The CDA-based EHR data and dictated notes can be aggregated in document registries and document management systems for exchange, reporting, and longitudinal analysis. Over the past two years, the Health Story Project developed four technical implementation guides as draft standards for trial use using. These report types include the Consultation Note, History & Physical, Operative Note, and Diagnostic Imaging Reports, the latter developed in conjunction with DICOM. Adoption of these standardized electronic documents will unlock the valuable data from narrative documents, facilitate the unrestricted flow of this narrative-source data into the EHR, and expedite the development of interoperable clinical document registries for use within healthcare enterprises and health information exchanges. There remain important document types to be defined as well as work to support their implementation. The healthcare industry

[9] The Health Story Project, www.healthstory.com.

must adopt these standards for narrative document types to reap the full benefits of electronic documents.

- ***Working to Uphold the Privacy and Security of Patient Health Information:*** The HITECH Act has more stringent privacy and security provisions. Under the Act, both medical transcription service organizations (MTSOs) and independent medical transcriptionists (MTs), although still technically considered business associates, will now be held accountable at a covered entity level rather than a business associate level for HIPAA privacy and security rules. The Act requires MTSOs and independent MTs to implement policies that establish administrative safeguards (such as security policies and training), physical safeguards (such as locks and building security systems), and technical safeguards (such as computer encryption, log-in IDs, and auto-log off). In addition, business associates will be subject to direct penalties for violations of the security provisions.[10] AHDI and MTIA will work with the federal government on education, training, and outreach to the clinical documentation sector to ensure compliance with the regulatory requirements.

  The Act also expands federal security breach law to mirror protections that many states have passed in recent years. It requires business associates to notify covered entities of any unauthorized access, acquisition, or disclosure of their "unsecured PHI" that compromises not only the patient's privacy and security, but also the integrity of the information.[11] Considering the impact of these changes on MTSOs and independent MTs, AHDI and MTIA will work toward establishment of uniform security encryption standards for the exchange of protected health information between MTSOs, independent MTs, and the provider community. In addition, AHDI and MTIA will move toward mandatory certification of documentation specialists handling PHI to validate their full understanding of privacy and security policies.

A 21st Century Workforce to Enable EHR Roll-out

- ***Ensuring Quality of Care, Patient Safety, and Proper Reimbursement***: The current health IT workforce grew out of a fragmented and manual paper-generated system. As health information demands increase within an automated, electronic environment, the medical transcription workforce will become more integrated, and current roles will transform into new ones. No matter how advanced the technology and standard vocabularies become, clinical providers and documentation specialists entering data into electronic record keeping systems must be precise, specific, and accurate. Medical transcriptionists serve on the front line of risk management by creating accurate, reliable, and complete transcribed documents that help prevent medical errors, improve patient safety, and facilitate the coding and billing process for insurance programs. Without these knowledgeable professionals serving in this essential risk management role, there is greater potential for increased medical error rates as well as documentation fraud and abuse.

Medical transcriptionists serve on the front line of risk management by creating accurate, reliable, and complete transcribed documents that help prevent medical errors, improve patient safety, and facilitate the coding and billing process for insurance programs.

[10] HITECH ACT Sections 13401 & 13404.

[11] HITECH ACT Section 13402.

- ***A Skilled and Knowledgeable Workforce That Embraces Emerging Technologies:*** Today's medical transcriptionist, or documentation specialist, represents a growing sector of the U.S. workforce typified by a technology-enabled, knowledge worker employed from home. This environmentally-friendly worker is a computer-savvy, skilled technician who produces the healthcare documents that provide the foundation for the revenue cycle, the front line for patient safety and risk management, and the facilitation of continuity of care. Documents produced by medical transcriptionists eventually become part of patients' permanent files. Many MTs or documentation specialists are embracing new data capture and documentation technologies such as speech recognition to improve the documentation process.

- ***A Growing Industry and Profession That Boost Job Creation*:** New job creation is an essential component of the HITECH Act. According to the U.S. Bureau of Labor Statistics, employment of medical transcriptionists is projected to grow 14 percent from 2006 to 2016, faster than average for all occupations.[12] Demand for medical transcription services will grow as the result of an aging population and individuals living longer with chronic diseases. These populations receive proportionately greater numbers of medical tests, treatments, and procedures that require documentation. The medical transcription workforce will be instrumental in assisting with the transition to EHRs and play a vital role in ensuring documentation integrity within the fully interoperable electronic health environment of the future.

- ***Innovative Initiatives to Prepare the Workforce of the Future*:** To help meet the demand for greater documentation services in healthcare, AHDI and MTIA have worked with the U.S. Department of Defense (DOD) and Department of Labor (DOL) in creating an initiative called *Mission Medical Transcription: a Career that Moves with You*. This career outreach program targets military spouses interested in a portable career in an ever changing and expanding health IT arena. Portable credentials and an environmentally friendly home-based career is perfectly suited to the mobile lifestyle of military families and those seeking re-enlistment. Since Mission Medical Transcription was launched in April 2007, over 800 military spouses enrolled in AHDI approved schools and many have taken advantage of the Career Advancement Accounts offered by DOD and DOL.

- ***Medical Transcription: A Career for the 21st Century*:** A high level of demand for transcription services will be sustained by the continued need for electronic documentation that can be shared easily among providers, third-party payers, regulators, consumers, and health information systems. Growing numbers of medical transcriptionists will be needed to amend patient records, edit documents from speech recognition systems, and identify discrepancies in medical reports. As the healthcare system transitions to greater EHR adoption, documentation specialists are ideally suited to assist with this transition and can be easily retooled and trained to take on new roles in an electronic health environment.

The Association for Healthcare Documentation Integrity (AHDI), formerly AAMT, has been the professional organization representing medical transcriptionists since 1978. AHDI sets standards of practice and education for medical transcriptionists, administers a certification program, has established a code of ethics, and advocates on behalf of the profession. For more information, visit www.ahdionline.org.

The Medical Transcription Industry Association (MTIA) is the world's largest trade association serving medical transcription service operators. Its mission is to create an environment in which medical transcription companies can prosper, grow, and deliver the highest level of healthcare documentation services. For more information, visit www.mtia.com.

For more information, please contact Gregory H. Doggett, JD, Government and Policy Affairs, AHDI/MTIA at (209) 247-7610 or gdoggett@ahdionline.org.

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[12] United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, 2008-09 Edition.

The Value and Benefits of Medical Transcription for EHR Adoption

Value Proposition	**Medical transcription service organizations (MTSOs) and medical transcriptionists (MTs) are valuable resources to health care providers and the use of electronic health records (EHRs) in four key areas:** I. **Efficiency**: We enable **dictation**, which is the most efficient way for physicians to document patient care.[1] II. **Clarity**: We produce **narrative notes** that tell a patient's full story and enhance clinical decision making.[2] III. **Usability**: We enable **meaningful use** of EHRs in two key areas: interoperability and quality measures.[3] IV. **Accuracy**: We find and correct documentation errors made by physicians, providing **98%+ accuracy** of clinical information.
Benefits	**We help break down barriers to EHR adoption commonly experienced by physicians and other caregivers. Our services:** • Make efficient use of physician time (We keep doctors from becoming data entry clerks.) • Preserve face-to-face interactions between physician and patient (Physicians can focus on the patient, not the computer screen.) • Ensure the quality and validity of clinical data going into an EHR (Physicians are not very accurate in dictating or entering patient data.) • Promote information sharing among caregivers in a secure environment (Every day we route readable patient notes among physicians and hospitals.)

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[1] With a few exceptions such as Ob/Gyn and Ophthalmology, which are form-based.
[2] Hartzband P, Groopman J. Off the Record — Avoiding the Pitfalls of Going Electronic. New England Journal of Medicine 358;16:1656-58.
[3] The three most commonly cited elements of "meaningful use of an EMR" in the HITECH ACT are (1) electronic prescribing, (2) interoperability, and (3) reporting on quality measures.

ABSTRACT

Improving the Accuracy of Narrative Patient Notes

The Role of Documentation Specialists in Supporting Physician Use of EMRs

Robin Daigh, MBA, Tamara Brown, George Catuogno, Jay Cannon, Sherry Doggett, Gerry Kelly, Peter Preziosi, PhD.

Background
The HITECH Act invests $20 billion to fund development of a nationwide health information technology infrastructure and encourage the electronic use and exchange of health information. The Act includes financial incentives to assist hospitals and physicians in transitioning from paper-based charts to electronic medical records (EMRs). Over 1.2 billion patient encounters[1] are documented by physicians each year. The majority of these notes are dictated by physicians and then transcribed or edited by medical documentation specialists (a.k.a. medical transcriptionists). Many EMRs seek to replace this popular documentation method with direct physician entry of patient information.

Objective
This study was conducted to examine the role of medical documentation specialists in improving the accuracy of patient notes. We examined how often dictation errors are found by documentation specialists while transcribing and editing dictation files, and identified the most common types of errors.

Methods
Sixty two medical documentation specialists recruited from seven different organizations throughout the US participated in a one day study on May 21, 2009. They processed 2,051 physician dictations, of which 39% were hospital inpatient notes such as history and physicals, consults, discharge summaries and radiology reports, and 61% were outpatient notes such as new patient exams, progress notes and consults. Sixty percent of dictations were transcribed directly from voice files while 40% were processed through speech recognition software and then edited. Errors were defined according to standard industry definitions.[2] Critical errors are those which could compromise patient safety or continuity of care. Major errors are those which could compromise the integrity of a note without risk to patient care. Study participants were instructed to tally each occurrence of a critical or major error and to determine whether the error was due to physician misstatement ("dictation error") or to a mistranslation by speech recognition software ("speech recognition error"). Minor errors such as punctuation and grammar errors were not included in the study.

Results
Dictation errors: Medical documentation specialists identified 689 dictation errors in 2,051 dictations, an average of 0.33 errors per dictation. Critical errors accounted for one-third and major errors for two-thirds of all dictation errors. The most common critical errors were wrong patient, wrong drug name or dosage, and left/right discrepancy; the most common major error was use of made up words or acronyms.

Speech recognition errors: The 823 dictations initially processed through speech recognition software contained 1,215 speech recognition errors before editing, or an average of 1.48 errors per dictation. Critical errors accounted for 43% and major errors for 57% of all speech recognition errors. The most common critical errors were wrong patient, wrong drug name or dosage, and wrong lab value; the most common major errors were use of made up words or acronyms and gender mismatch.

Discussion
This study demonstrates that the accuracy of medical records is improved when medical documentation specialists verify information dictated by physicians. Documentation specialists edit reports as part of their job, correcting obvious errors and flagging others for physician clarification. Dictation is the preferred method of documentation for most physicians because it aids clinical decision making,[3] makes efficient use of physician time, and produces narrative notes ideal for sharing with other clinicians.[4] This study showed that error rates were 22% for dictation and 52% for dictation with speech recognition translation before transcription and editing. Direct data entry by clinicians (typing into EMR templates and free text fields) has been shown to have high error rates as well. Weir et al. found 84% of all notes had at least one documentation error, with an average of 7.8 errors per inpatient chart, and concluded physicians made more errors than other clinicians even after controlling for number of notes.[5] By contrast, final reports produced by documentation specialists have been shown to consistently achieve accuracy rates higher than 99%.[6]

Conclusion
Electronic medical records have the potential to improve health care delivery by enabling patient information to be easily shared and accessed by physicians. However, physician entry of patient information without editing, whether dictated or typed, can result in errors that compromise the usefulness of EMR notes. Medical documentation specialists enable physicians to concentrate on clinical activities, by assisting with documentation tasks in the same way nurses assist with patient care. They serve as a second set of "eyes and ears" for physicians, and help to ensure the accuracy of clinical information in both paper charts and electronic medical records.

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[1] National health statistics reports; no.'s 3,4,5,7,12. Hyattsville, MD: National Center for Health Statistics. 2008.
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[4] Johnson SB, Bakken S, Dine D, et al. An An Electronic Health Record Based on Structured Narrative.
[5] Weir CR, Hurdle JF, Felgar MA, Hoffman JM, Roth B, Nebeker JR. Direct Text Entry in Electronic Progress Notes. Methods Inf Med 2003; 42:61-7.
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Direct Text Entry in Electronic Progress Notes

An Evaluation of Input Errors

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Summary

Objectives: It is not uncommon that the introduction of a new technology fixes old problems while introducing new ones. The Veterans Administration recently implemented a comprehensive electronic medical record system (CPRS) to support provider order entry. Progress notes are entered directly by clinicians, primarily through keyboard input. Due to concerns that there may be significant, invisible disruptions to information flow, this study was conducted to formally examine the incidence and characteristics of input errors in the electronic patient record.

Methods: Sixty patient charts were randomly selected from all 2,301 inpatient admissions during a 5-month period. A panel of clinicians with informatics backgrounds developed the review criteria. After establishing inter-rater reliability, two raters independently reviewed 1,891 notes for copying, copying errors, inconsistent text, inappropriate object insertion and signature issues.

Results: Overall, 60% of patients reviewed had one or more input-related errors averaging 7.8 errors per patient. About 20% of notes showed evidence of copying, with an average of 1.01 error per copied note. Copying another clinician's note and making changes had the highest risk of error. Templating resulted in large amounts of blank spaces. Overall, MDs make more errors than other clinicians even after controlling for the number of notes.

Conclusions: Moving towards a more progressive model for the electronic medical record, where actions are recorded only once, history and physical information is encoded for use later, and note generation is organized around problems, would greatly minimize the potential for error.

Keywords

Medical records systems, computerized; quality control; decision support techniques; communication; evaluation studies

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Introduction

Medical Communication as a Risk Factor

Accurate and clearly-written communication in the medical record is essential to preventing patient injury and in promoting accurate billing and clinical decision making. The recent Institute of Medicine (U.S.) report "To Err is Human" estimated that as many as 98,000 people die each year in the United States because of medical errors (1). Illegible, incomplete, and inaccessible provider narratives can be a significant source of error and frustration. Direct provider entry into a computerized patient record system is viewed by many as the solution to communication problems (2-5). Electronic notes have been found to be more complete, to contain more relevant patient factors, and to document more appropriate clinical decisions than paper records (6). In particular, the inclusion of physician narratives in the electronic medical record makes electronic records superior to paper records by increasing access, team collaboration, and coordination (7).

Although electronic note entry may solve or obviate many of the problems associated with paper records, it will also create new problems and new risks to patient safety. Electronic note entry occurs in a variety of forms, including typing, dictation, forms-based scanning, and voice recognition. Each of these modalities is associated with specific types of errors. Traditionally, the surveillance systems of quality management, quality assurance, and risk management assess errors in paper records through chart review. These systems focus on the presence (or absence) of specific content that supports billing, informed consent, adequate oversight, and quality of care. With the advent of direct text entry into electronic notes, new types of surveillance mechanisms need to be developed to monitor the new types of errors. Traditional quality assurance activities may not be sufficient in an environment where notes are entered directly by providers. The objective of this study is to examine the incidence of input errors related to direct text entry for progress notes in a provider-entry environment in order to inform efforts of preventing and reducing such errors.

Direct Text Entry

Direct text entry (typing) of notes is perhaps the least favorite method of notes generation by providers. In order to make the method palatable to busy clinicians, typing-assist functions are often added, such as copying and pasting functions, templates, and automatic object insertion (e.g., clinical values are brought in from other parts of the electronic chart). The resultant ease with which text material can be handled raises the likelihood of a new class of errors, errors that would not be seen in a paper chart.

Although a goal of electronic records is increased availability, accurate communication may diminish for several reasons. First, the usual method of skimming notes and medical material works well with paper but is difficult to mimic in an electronic format. Second, notes might be copied from previous notes (by the same author or by an-

other author), resulting in diminished reader confidence in the both the validity and centrality of the content if the duplication is obvious. When the same content appears day after day on a patient, readers begin to doubt the utility of the material. Third, information, such as laboratory results or vitals that are automatically inserted as text may look the same as typed text, causing authors to not attend to its timeliness or even realize it is there (8). When this occurs too often, readers begin to doubt the accuracy of note content. To reduce these kinds of errors in information flow, it is essential to identify the degree to which new typing-assist functionality is used *appropriately*. New surveillance schemes can then be established for the electronic record, with subsequent alteration of the note generation system if required (9).

The errors of interest in our study were those related to direct text entry, in other words *documentation* errors related to input. Specifically we examined: 1) the incidence of copying, template use, and imbedded-object use, and 2) the relationships between these functions and misinformation in the chart. This paper does *not* address whether the material in the note matches the clinical reality of the patient. For example, a note that indicated "Potassium is normal" when serum potassium was, in fact, highly elevated was not an error we studied. However, if the text fragment "Potassium is normal" was copied into a note containing other text indicating an abnormal potassium level, then a copying error would be noted. Although mode-of-entry has been shown to affect clinical error rate (10), mode-of-entry is not a focus of this study. Here we present the results of a systematic assessment of the documentation error incidence in a randomly selected sample of charts.

The VA Information Processing Environment

The Department of Veterans Health Administration (VHA) released its Computerized Patient Record System (CPRS) nationally in 1998. Implementation was organized through workgroups across 22 national regions. The CPRS is a fully-integrated electronic medical record that supports direct provider order entry, notifications/alerts, laboratory data, radiology reporting, medication status, appointment scheduling, problem list, consultations, intelligent clinical reminders, and all forms of text material (including progress notes, health summaries, and procedural reports). It uses a distributed architecture, with a legacy database (MUMPS) backend supporting an object-oriented front-end (Delphi).

CPRS allows notes or portions of notes to be freely copied and pasted. It also allows for the imbedding of placeholders ("objects") that are filled-in automatically by the computer with data stored elsewhere in the electronic record (e.g., lab values, current medications, the problem list, vital signs, some patient demographics, some reports, and some kinds of free text). A user can create templates, precompiled boilerplates that can contain both text and imbedded objects. CPRS does not support the capture of data from the free text for later use in decision support.

Early experience with CPRS suggested that there might be problems with the very typing-assist functions designed to encourage provider acceptance of direct note entry. For example, some users reported that notes were often exact replicas of each other. We were concerned that there might be significant, invisible disruptions to accurate information flow. Thus this study was conducted to formally examine the incidence of documentation errors related to copying, as well as other documentation errors associated with the use of objects and templates.

Methods

Site

The site of this study is a 110-bed, tertiary-care, Veterans Administration medical center located in a large urban setting. The site is associated with a medical school and serves as a training location for residents and students across all disciplines. Attending physicians and residents supervise the notes of interns and students. Notes written by students require co-signatures. At this center, providers were mandated to use electronic order and progress note entry. Physician-generated narratives include history and physicals, consults, discharge summaries, and daily progress notes. Other clinical staff enter electronic notes as well, including nurses, physical therapists, occupational therapists, respiratory therapists, and clinical pharmacists. Notes from all of these disciplines were included in the study. In CPRS addenda can be written and attached to a specific progress note. Addenda are useful when attending physicians want to indicate that they have read and agree with the note of a resident or when a group note is being constructed. Nearly all physician notes are typed directly by the physician. Dictation and subsequent uploading is supported, but those clinical areas (e.g., the emergency room) using dictation are few.

Subjects

Sixty patients were selected randomly from all 2,301 inpatient admissions in the 4-month period ranging from August through December of 2000. Patients who stayed less than a day were excluded from the study. Housestaff (interns and residents) turn over completely every July and then rotate at varied schedules throughout the year. During the study period, the housestaff were fairly stable. All services and clinical roles were included, with the exception of the operating and recovery rooms (notes from these areas are not stored in CPRS). Altogether the 60 patients had a total of 2,316 narrative notes and addenda, for an average of 39 narratives per patient. This study examined only the regular notes (n = 1,891), excluding addenda. The average length of stay per patient was 8.6 days.

Evaluation Criteria

The evaluation criteria were initially developed by a group of clinicians familiar with CPRS who also have a strong background in medical informatics. The group consisted of two physicians (one with formal in-

formatics training), two PharmDs, and a Ph.D social psychologist with a background in nursing. The focus of the criteria was to evaluate the impact of typing-assist functionality on documentation errors. Two non-clinical research assistants established the final evaluation criteria using an iterative pilot process. The process included independent assessment of a small set of records, group discussion of assessment disagreements, and criteria revision. Although the research assistants were not clinicians they were familiar with medical language. This process was repeated until the criteria became stable. The list of criteria is described in Table 1. Once the criteria were established, 20 notes were reviewed independently and the degree of interrater reliability was assessed. Cohen's kappa was computed across each category and was very high, ranging from 0.80 to 1.00 (Table 1). The kappa metric controls for chance agreement and is a useful measure of interrater consistency (11).

Table 1 Evaluation categories for note assessment

Category	Description	Kappa
Copying	If a note was copied from any previous notes, the exact text from each was highlighted. Copying was classified as to whether it was from a note written by the author or a note written by another. Across both categories, the degree of copying was ranked into one of 3 levels of alterations: *Copied Note in Full, Copied Note With Small Changes*, or *Copied Note With Substantial Changes*.	1.0
Copying Error (within any copied note)	A copying error was defined as an error that clearly resulted from copying, including, but not limited to errors in reference to timed material (e.g., "today the patient walked for the first time" repeated for 3 days, or "the patient is afebrile" while the vital signs clearly showed a fever). Clinical errors, such as failing to monitor potassium when a patient was on Lasix were NOT part of the assessment.	0.84
Wrong Patient	The name of the patient in the text does not match the name on the heading.	1.0
Patient Name	The patient's name was not documented directly in the text. (Y/N)	1.0
Patient Age	The patient's age is incorrectly documented in notes.	1.0
Inconsistent Text	Text within a note that clearly contradicts the meaning of another part of the note, e.g., "X-Ray results were normal" with "X-ray showed significant pulmonary infiltrates."	0.80
Outdated Vital Signs	Vital signs that are captured as an object are greater than 24 hours old.	1.0
Authorship Problems	The person who signed the note either copied another signature or was not the author of the note.	1.0

Note: Kappa results indicate the degree of agreement between the two raters independently assessing 20 notes.

Note Assessment

All notes were printed and the reviewers read each note at least three times. Initially, the note was examined for evidence of copying from a previous note. A second pass was made if similarity of phrasing, content, or form was found to be at least 50% identical. The original text and the secondary text were highlighted and the degree of change was evaluated. *Copied Note in Full* required that the copied note consist of the exact content of the original note. *Copied with Small Changes* required that the note consist of basically the same content as the original with only a small numbers of changes and no important additions, or consist of the same text with a change in formatting. Small changes might include changes in dates or text like: patient is "very alert" versus "moderately alert." A note was categorized as *Copied Note with Substantial Changes* when the copied note consisted of the same basic content as the original note but with a large number of new data items added that were important to the understanding of the patient's current status, progress, or medical course. An example of this type of note is one that includes clearly copied data in the areas of vitals, labs, and subjective impressions but that also includes new text describing sensory, vascular, and wound assessments. On the third pass the note was examined for inconsistent text, incoherent text, outdated objects, or errors in signatures.

The case-review method makes it relatively easy to spot text copied from one point to another within one chart because the phrasing and structure of sentences would be identical. Because the study used only a small fraction of the patients admitted during the study period, it was not possible to assess copying *across* patients. Using manual review, it is not possible to scan hundreds of other charts looking for text similar to a given note. Automated methods may someday be of use in future studies.

Errors fell into two broad categories: copying and non-copying. *Copying errors* were inconsistencies of text or timing that arose *because* of the act of copying. Inconsistent text was information in the text that contradicted other parts of the same note. For example, a note could read in one section that "the lungs were clear" but then say that the "lung sounds showed significant rales" in another section of the same note. Inaccurate timing would result when the content of a copied note contained time sensitive data that was not adjusted after the copy was made. For example, the following narrative was copied from a note each day over for four days:

Table 2 Incidence of copying by note origin and amount of change (% of copied notes, n = 372)

	No Change	Small Change	Large Changes
Own Note	6 (1.61%)	32 (8.60%)	219 (58.87%)
Other's Note	1 (0.27%)	7 (1.88%)	107 (28.76%)
TOTAL (of 372)	7 (1.88%)	39 (10.48%)	326 (87.63%)

"Pt. had episode of recurrent ataxia yesterday, MRI/MRA was done this afternoon and was negative." Will keep pt. over weekend for observation.

Because the author did not edit the time-sensitive information after copying the note for the new day, the information is erroneous. Two copying errors would have been counted for each of the last three days.

Non-copying errors were documentation errors not clearly associated with copying. These included inserting an outdated patient-data object (e.g., labs from a previous admissions), not correcting signature problems, entering erroneous patient details (e.g., name, age), and failing to mention the patient by name in the note. The first two are especially relevant informatics issues. In CPRS, historical patient data can be automatically inserted into a note by an imbedded object, for example vital signs that are automatically pulled into the patient's admission note template by an imbedded "vitals" object. If the admission vital signs have not been already entered into CPRS by the time the note is created, the values inserted could be months old. Although the date comes with the object when it is inserted, it is often overlooked by the note's author. Signature problems occurred because maintaining the data that support electronic signatures is a challenge. Providers are linked to a encrypted code (i.e., their electronic "signature"). When a provider completes a note, the computer prompts for this signature code. Based on the code entered, provider details like name and role (e.g., student, intern, resident, attending) are stamped on the note. Creating and keeping up-to-date the database of names and roles is a daunting task for a teaching hospital.

Results

The percentage of all notes with at least one documentation error was 84%. The average number of documentation problems per patient was 7.8 (not including signature errors). The source of the errors is described below.

Copying

Overall, 19.7% (372/1891) of notes showed some form of copying, either from the same author or another author. Across 60 patients, 43 had at least one copied note (72% of patients, 8.7 copied notes on average). Table 2 shows the degree of changes made when notes were copied. Inspection of the table indicates that the most prevalent pattern of copying was an author copying his/her own previous note and making substantial changes. This pattern is expected, as the same provider is seeing the patient repeatedly, but the number per patient seems high. The large number of notes copied from another author is more problematic as the timeliness and conclusions of the copied text may not be fully understood by the copier. Since only intra-chart copy errors were examined, these numbers are conservative.

Copying Errors

Within the 372 copied notes, there were 374 documentation errors, averaging 1.01 error per copied note. The overall error incidence was the same for copied and non-copied notes, but within the group of copied notes the amount of change and the source of the copied the material influences the probability of an error, as shown in Table 3. Note that the incidence of errors varied across both the source of copying and the amount of change. A Kruskal-Wallis test comparing the median number of errors between notes where no changes were made, small changes were made and large changes were made was significant ($X^2_{(df=2)} = 9.56$; $p < .008$). Inspection of the mean rankings between groups indicates that making no changes or small changes resulted in the largest number of errors (Mean Rank = 209.89, 217.94 and 182.24) for "No Change", "Small Change" and "Large Change" respectively.

Table 4 shows that the incidence of copying varied across clinical role. Overall, MDs wrote 35% of all the notes, yet they were responsible for 50% of the copied notes. Nurses wrote about 27% of all notes, but were responsible for only 21% of the copied notes. Therapists wrote the next largest group of notes, about 17% of all notes written, generating 8% of all copied notes. The pattern of copying errors also varied across roles. The MDs made overall 89% of the total number of copying errors (131/148) as compared with the nurses who made less than 1% (2/148).

Table 3 Mean number of errors per note across note origin and amount of change. Number of notes per cell is in the parenthesis

	No Change	Small Change	Large Changes
Own Note	3.17 (n=6)	0.47 (n=32)	0.19 (n=219)
Other's Note	0.0005 (n=1)	1.14 (n=7)	0.60 (n=107)

Non-copying Errors

Across all 1,891 notes, there were a total of 2,481 non-copying errors or 1.3 documentation errors/note. These documentation errors arose from a variety of sources and each is listed below.

Wrong Patient. Of all 1,891 narrative notes, only 5 were clearly on the *wrong patient*. This number is a conservative estimate, since the name of the patient was usually not included in the text by the author (CPRS stamps the name on the note after signing but the wrong patient could have been selected at the outset). The judgment of the raters was based on clear, unequivocal evidence that the note belonged to another patient (e.g., completely different problems).

Inconsistent text may have important clinical consequences as the text may state opposite conclusions about selected signs and symptoms. Overall, there were few non-copied notes that displayed inconsistent text (n=29). *Incomplete text* was less of a problem and refers to dangling sentences or garbled sentence structure. In both areas, physicians were the most frequent contributors as they authored 80% of all notes with inconsistent text and 61% of notes with incomplete text, as Table 5 illustrates.

Outdated imbedded objects are pulled in from another part of the chart and the last recorded item is pasted in the note. Twenty-seven notes had *vital signs* that were older than 24 hours of the time of writing. The average age of the old vitals was 29.5 days with a range of 2 to 530. This long period suggests that the vitals were being pulled from an outpatient visit. This would happen if the admission nurse failed to enter the vital signs before the admission note was written. Nurses were responsible for about 37% of the notes with outdated vitals; physicians were responsible for the remaining 63%.

Signature Identification. Across all of the notes, many electronic signatures (53%) failed to appropriately reflect the credentials and/or title of the author. These problems ranged from not having the title or credentials of the author to not having either items for the co-signer(s).

Table 4 Incidence of copying notes with and without errors across clinical role

ROLE	Number of Notes (n=1891)	Number of Copied Notes (n=372)	Number of Copying Errors (n=148)	Mean Number of copying errors per note (n=372)	Mean Number of non-copy errors per note (n=2481)
Physicians	685 (36%)	187 (50%)	131 (89%)	1.9	0.85
Nurses	545 (29%)	79 (21%)	2 (1%)	0.03	1.82
Therapists	321 (17%)	31 (8.33%)	0 (0%)	0.03	1.67
Medical Students	102 (5%)	42 (11%)	7 (5%)	0.17	0.62
Social Workers	73 (4%)	0 (0%)	0 (0%)	(0)	1.45
Pharmacists	49 (3%)	31 (8.33%)	7 (5%)	0.23	1.39
Other	116 (6%)	2 (1%)	1 (0%)	0.5	1.18

Templates. Many of the paper templates (i.e., fill-in the blank forms) that were in use prior to the introduction of CPRS were imported "as is." On screen, these forms can be very long, up to 5 pages in length. Overall, there were 408 notes based on templates (22% of the total). Table 6 displays the percent of total templated notes by each clinical role. Nurses were by far the greatest users of the templates, creating 60% of the total templated notes.

To determine the degree to which templates were incomplete, reviewers counted the number of possible fill-in items on the template, the number of items actually filled in, and the number not filled in. The relative likelihood (displayed by the role of the note author) of items being filled in is displayed in Table 6. Across roles there was little difference in the proportion of items left blank, and all were quite large indicating that the CPRS format for templates was equally problematic for everyone. Having to search screen after screen of empty fields in a templated note impedes information transfer.

Table 5 Percent of notes with inconsistent text by type of provider (% of notes involved)

ROLE	Inconsistent Text (n=29)	Incomplete Text (n=28)
Physicians	23/29 (79%)	17/28 (61%)
Nurses	3/29 (10%)	2/28 (7%)
Therapists	0/29 (0%)	2/28 (7%)
Medical Students	0/29 (0%)	3/28 (11%)
Social Workers	2/29 (7%)	1/28 (3%)
Pharmacists	1/29 (4%)	2/28 (7%)
Other	0/29 (0%)	1/28 (4 %)

Table 6 Proportion of templated notes used by different clinical roles (% of notes involved)

ROLE	Percent of Templated Notes by Role (n=408)	"Fill-In" Items per Note, by Role	Percent Items Left blank, by Role
Physicians	66 (16%)	1609 items in 66 notes, avg. = 24	209/1609 (13%)
Nurses	246 (60%)	16,683 items in 246 notes, avg. = 68	3632/16683 (22%)
Therapists	6 (1 %)	234 items in 6 notes, avg.= 39	29/234 (12%)
Medical Students	0 (0%)	0 notes	NA
Social Workers	18 (5%)	300 items in18 notes, avg. = 17	36/300 (12%)
Pharmacists	5 (1%)	263 items in 5 notes, avg. = 53	21/263 (8%)
Other	67 (17%)	3, 061 items in 67 notes, avg. = 46	556/3,061 (18%)

Discussion

This study demonstrates that direct entry (typing of electronic documentation) by clinicians can result in significant documentation or data entry error. Overall, 60% of patients had one or more data entry errors in their records, and the average number of data entry errors per patient was 7.8. The vast majority of patients had at least one copied note. Although copying of notes was quite prevalent, copying itself did not increase the probability of a documentation error, unless copying was done with no changes. The type of errors focused on in this study was admittedly narrow, but the purpose of the study was to determine how the new typing-assist functionality affected the accuracy of documentation. Data entry errors of this type are to be distinguished from errors that result from recording the wrong clinical information or from inaccurate assessment of the patient.

The utility of imbedded objects, templated text, and copying and pasting capacity greatly enhances acceptance of direct typing entry by providers. However, this enhanced capacity brings with it new challenges for patient safety. These typing-assist functions challenge four normative expectations regarding information flow in medical settings. The first expectation is that the information typically provided in a progress note is what is minimally necessary to record. Writing by hand encourages succinctness. With the capacity to copy large amounts of data, progress note length can be as long as 8-10 pages and include a great deal of data found elsewhere. The result is that the readers searching for information have to change the way they search. As it stands, much information may simply not be read. The second normative assumption is that progress notes correctly reflect the decision-making process of the provider. Notes that contain a great deal of clinical information extracted from other areas of the chart by copying or templates may obfuscate the thoughts of the reader. As two well-known authors in informatics wrote recently regarding the clinical record:"[it] strives to remain as true-to-life as possible, by capturing not only syntactic meaning but also semantic interpretability (12)." To address both the "necessary-minimum" concept and the "decision-making continuity" concept, we recommend setting limits on the sizes of templates, reviewing templates currently in use for length and utility (item by item), deleting blank items in templates, and a creating a structured way of copying and pasting that would discourage unedited copies.

The third normative expectation is that progress note data are temporally relevant and accurate. In the paper record we are accustomed to records where information is recorded as needed, each datum following the previous as a function of time. A reader knows that the second note was written prior to the first and the information contained in the second note is later than the first. Although electronic notes are time-stamped in CPRS (it is known when they were signed), the reader may not actually know when the note was written. If they contain copied information readers cannot be sure that the timing of the information coincides with the timing of the note. Finally, because readers can filter notes by author and title before selecting a note to read, it may be less likely that the notes are read in chronological order. We recommend altering index sorting and filtering software in way that encourages chronological review (or warns when chronological order is violated).

Finally, medical records are usually reviewed using a "skimming" and "skipping" process in order to synthesize large segments of information. If the record design is familiar, well laid out, and the reader an expert in the field, the reader is able to correctly infer substantial information rapidly and with little in-depth reading (13,14). CPRS allows the view of the medical record to become inconsistent and disjointed, so a reader's ability to review the patient's history using a "skimming" paradigm is limited. We recommend rethinking the electronic presentation of the chart content in ways that reflect problem-oriented thought processes.

Future work in this area will need to pay closer attention to process issues and the interaction of clinical care with the process of documentation (15). Generally, people perform better with fewer errors if all the data needed to support a decision or task can be viewed on one page together and data entry is a seamless component of workflow (16). Having a computer anticipate which data are relevant and which should be recorded would require a very advanced decision support tool, one that could infer importance of content and level of expertise of the reader. While this is a grand challenge for informatics, CPRS could do far more in integrating the various components of a medical record with the task of the user.

Instead of pursuing strategies to facilitate the construction of written progress notes, a more progressive model of the medical record should be developed that is not dependent on the metaphor of paper progress notes. One can imagine several ways to minimize the error potential of word processing features: smarter templates (e.g., automatic pasting of results and orders into pertinent templates, with updates that are both time and context sensitive); encoded history and physical data (e.g., eliminating re-typing and pasting by using the original instantiation); and a problem-oriented data display and documentation process.

Conclusion

Electronic free text notes promise to improve the quality of patient care because data access is enhanced, text is readable, and notes are often more comprehensive. However, typing-assist short cuts result in disruptions of the normative flow of information and introduce a high incidence of documentation errors in the medical record. In our study of a fairly typical CPRS implementation (an electronic medical record system in use by one the world's largest health care networks) each patient had on average of 7.8 documentation entry errors per admission. Copying, inconsistent text, automatic object insertion and electronic signature problems were the major source of these problems. Several enhancements could reduce these kinds of errors, including minimizing template use and size; reviewing templates for utility; introducing structured copying and pasting, and re-engineering problem-oriented data display.

Acknowledgment
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Federal Affairs Department

June 26, 2009

David Blumenthal, MD
Office of the National Coordinator for Health Information Technology
200 Independence Ave, SW
Suite 729D
Washington, DC 20201

Re: HIT Policy Committee Meaningful Use Comments

Dear Dr. Blumenthal,

The American Academy of Ophthalmology (Academy) appreciates the opportunity to submit comments to the Office of the National Coordinator's (ONC) HIT Policy Committee on the current metric and definition of "meaningful use". The Academy is the world's largest association of eye physicians and surgeons—Eye M.D.s—with more than 18,000 members in the U.S. The Academy believes the definition for "meaningful use" needs to be broad, achievable and encompassing of all physicians' regardless of their specialty. Without realistic opportunity for participation across the medical specialties, wide-spread adoption of electronic health records (EHR) by 2014 will be extremely difficult. Moreover, complex requirements with increasing levels of functionality every two years create obstacles and roadblocks to adoption, reducing the likelihood of achieving the vision of the HITECH Act. Most importantly, any physician who is excluded from the definition of a "meaningful user" should also be exempt from future penalties imposed by ARRA.

The requirements for "meaningful use" and EHR certification must be streamlined. Given the current uncertainty that many providers face in selecting an EHR system, varying levels of requirements/certification only increase the hesitation physicians feel regarding health information technology (HIT). For example, how will providers know that their product will remain qualified for future years? Will they have to purchase a new system if their present system fails to meet the next set of "meaningful use" or certification requirements? **After 2013, "meaningful use" should be tailored to be more specialty specific because there is a variance in practice patterns across specialties and certain functionalities and capabilities may be necessary for some specialties to have and others not.** An ophthalmology "meaningful user" is different from an oncology "meaningful user."

An intermediate certification process for 2011 should be established for providers that do not have software products certified in their specialty to help address the issue of specialty EHR system certification. By 2013, it will be understood that their software needs to be certified to meet the certification requirement.

The Academy agrees that improving quality, safety, and efficiency are extremely important goals for HIT. **If quality measures are mandatory for a provider to demonstrate "meaningful use," however, the measures should include all that**

are part of the CMS' Physician Quality Reporting Initiative (PQRI) because such measures have already been thoughtfully vetted, encompass a wide range of physicians , and physicians are already reporting on them. The current example of quality measures presented by the HIT Policy workgroup apply by and large to only primary care/internal medicine. An ophthalmologist would automatically be excluded from demonstrating "meaningful use" and qualifying for the HIT incentives if the current list is not expanded to include the eye care measures that our members have been reporting on for more than two years now. Ophthalmology has been a champion in technology adoption and the development, adoption and implementation of HIT standards. We were also leaders in developing and promoting the use and reporting of quality measures and, as written, guidelines would exclude ophthalmologists from eligibility for incentives that help defray the cost of adopting HIT. **At a minimum, there needs to be an alternative means of demonstrating quality of patient care for physicians that do not have quality measures applicable to them.** Currently, several ophthalmic subspecialists do not have applicable PQRI measures, as is the case for other surgical specialties. Ultimately, the "meaningful use" measures should be more and not less inclusive than the PQRI measures.

In addition, **the Meaningful Use workgroup needs to clarify the percentage goal of reporting on quality measures.** The EHR demonstration project is not a good example of HIT adoption or the incorporation of quality measures into EHRs because it was only open to primary care. The program and the resulting quality measures were specifically tailored to primary care physicians, which is only one sector of the provider and Medicare population. At this time, there are only a handful of HIT-enabled quality measures, but the AMA Physician Consortium for Performance Improvement (PCPI) Collaborative is working on making current and future quality measures HIT-enabled. **The Academy urges the Meaningful Use workgroup to work with the PCPI Collaborative on HIT-compatible quality measures.**

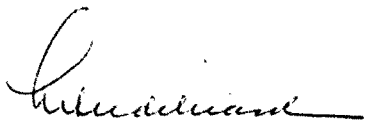
The Academy is concerned with the Population and Public Health measures and objectives. In 2011, the metric discusses the ability to exchange health information with external clinical entities, specifically labs, care summary and medication list. **What is the exact technical specification to allow this exchange and will it be mandated on both sides for exchange to occur?** Currently, most labs do not send their results electronically nor are we aware of labs having this capability. For small specialties, the overhead cost of setting up electronic exchange with the laboratories is high compared to the return (e.g., less frequent use of laboratories than other specialties). 2011 objectives also includes submitting electronic data to immunization registries, reportable lab results to public health agencies, and electronic syndrome surveillance data to public health agencies according to applicable law and practice. **Are there standard technical specifications that allow this exchange? Will these standards be adopted at national or local level?** If it is local or not streamlined across the country, the vendor will need to know how to exchange the information based on the location of the practice, which could lead to confusion and costly implementation. **The Academy is also not familiar with the definition of "electronic syndrome surveillance," so we ask for clarification if this is going to be a mandatory functionality and requirement for demonstrating "meaningful use". Practices that adopt EHRs with the above functionalities should not be deemed a non-compliant "meaningful user" if they cannot perform this type of exchange of information with labs, registries and public health agencies because these external entities are not set up to exchange this type of information electronically.**

The 2011 metric discusses the role of patients and family interaction with their physician and HIT. The Academy is concerned that the proposal of providing patients with electronic access or electronic copy of their health records/personal health record is not feasible. The Academy is not aware of current adopted systems in eye care of having this capability and whether practices are capable of implementing this because of the extra training and security measures they will have to take. **We urge you to delay the mandate of personal health records having to be linked to EHRs.**

Interoperability should first focus internal to the practice before external interoperability is required (eg. link to your devices before linking to a lab). This will allow physicians the ability to streamline the devices and technologies in their practice and ease workflow which has the potential to increase productivity and quality. It will also allow for the technology to automatically upload into a patient's electronic health record, which can potentially reduce errors.

The Academy appreciates the opportunity to comment on the Committee's proposal and looks forward to providing ongoing input to the Committee to ensure that the EHR meaningful use objectives and measures are reasonable and achievable. Should you have any questions about these comments, please contact Koryn Rubin at krubin@aaodc.org or 202-737-6662.

Sincerely,



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AAO Federal Affairs Secretary

Lloyd Hildebrand, MD
Chair, Committee on Medical Information Technology

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June 29, 2009

Submitted Statement

United States House of Representatives Small Business Committee

Subcommittee on Regulations and Healthcare

Meaningful Use Matrix

Dear Chairman Dahlkemper, Ranking Member Westmoreland and members of the Subcommittee on Regulations and Healthcare:

Thank you for the opportunity to provide our statement on the preliminary definition of "Meaningful Use" as presented to the HIT Policy Committee on June 16, 2009.

On behalf of the 41 members of the Rural Hospital Coalition, Inc., a trade association of Louisiana rural hospitals, I write to express our concern regarding the proposed definition of meaningful use. In its current form, we oppose the definition. Overall, we applaud the efforts of the HIT Policy Committee to achieve its vision of "one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities." However, we believe that because most rural hospitals will be unable to meet the requirements of the definition and subsequently be ineligible for incentive payments and subject to future payment penalties, the proposed definition of meaningful use cannot lead to a realized vision for all patients and providers.

We echo the assessment of the proposed definition by the Rural Wisconsin Health Cooperative and the Rural HIT Coalition. Additionally, we urge you to consider two phasing structures for meaningful use, based on either the location and classification of the hospital (rural or urban, CAH or PPS) or the adoption level of the provider. Our primary concern is that the current matrix is too advanced for rural hospitals. Even if each provider could immediately secure a vendor, we do not believe that implementation of the required technology according to the incentive timeline is feasible, based on the current average rural hospital adoption level. Rural hospitals, arguably the most vulnerable health care providers, will effectively be excluded from the incentive system, and ultimately, the hospitals and rural residents will suffer the consequences as they are left behind on the path to achieving the HIT Policy Committee's vision.

We are also concerned about hospitals located in areas with some internet access, but insufficient broadband capability. A network and electronic health record system are only as good as the provider's local internet connection. Insufficient capability only compounds the hurdles faced by many rural providers, and we ask that you consider this particular obstacle as your revise the definition of "meaningful use".

Thank you for your consideration of our statement.

Sincerely,

/s/

Linda K. Welch
Executive Director

Louisiana Rural Health Information Exchange
Rural Hospital Coalition

June 29, 2009

Submitted Statement

United States House of Representatives Small Business Committee

Subcommittee on Regulations and Healthcare

Meaningful Use Matrix

Dear Chairman Dahlkemper, Ranking Member Westmoreland and members of the Subcommittee on Regulations and Healthcare:

Thank you for the opportunity to provide our statement on the preliminary definition of "Meaningful Use" as presented to the HIT Policy Committee on June 16, 2009.

The Louisiana Rural Health Information Exchange ("LARHIX") is a statewide health information exchange network established and maintained by the Rural Hospital Coalition, Inc., the Louisiana Department of Health & Hospitals, and the Louisiana State University Health Sciences Center – Shreveport ("LSUHSC-S"), that supports health information technology initiatives in rural areas of Louisiana. The LARHIX network operates using the internet and enables health care professionals to access medical records from any provider database that is connected to and participates in the network. LARHIX promotes the adoption and utilization of electronic health records among providers in order to make the records accessible to other providers, patients, and authorized persons via the network integration engine, in addition to connecting rural physicians to LSUHSC-S specialists.

On behalf of LARHIX, I write to express our concern regarding the proposed definition of meaningful use. In its current form, we oppose the definition. Overall, we applaud the efforts of the HIT Policy Committee to achieve its vision of "one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities." However, we believe that because most rural hospitals will be unable to meet the requirements of the definition and subsequently be ineligible for incentive payments and subject to future payment penalties, the proposed definition of meaningful use cannot lead to a realized vision for all patients and providers.

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Thank you for your consideration of our statement.

Sincerely,

/s/

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NATIONAL RURAL HEALTH ASSOCIATION

June 29, 2009

Submitted Testimony

United States House of Representatives Small Business Committee

Subcommittee on Regulations and Healthcare

June 24, 2009 Hearing:

"Health IT Adoption and the New Challenges Faced by Solo and Small Group Healthcare Practices"

Dear Chairman Dahlkemper, Ranking Member Westmoreland, and members of the Subcommittee on Regulations and Healthcare:

The National Rural Health Association (NRHA) is pleased to have the opportunity to submit testimony for this hearing to discuss information technology challenges faced by small health providers.

Specifically, we are interested in commenting on the definition of "Meaningful Use" of electronic health records as requested by Dr. David Blumenthal, National Coordinator, Office of the National Coordinator for Health Information Technology HIT Policy, Department of Health and Human Services, on June 16th.

The NRHA is a national nonprofit membership organization with more than 19,000 members that provides leadership on rural health issues. The Association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

Introduction

NRHA is supportive of the HIT Policy Committee's ultimate vision, "in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities." Indeed, we strongly believe that HIT, if implemented with the significant upfront planning, workflow assessment, and change management that are required for success, will be a critical tool to help all providers achieve this vision over time.

As currently structured, however, the meaningful use draft definition threatens to undermine the ability of small and rural providers—those that are most in need of assistance (including rural acute care hospitals, critical

access hospitals (CAH), rural health clinics (RHC), and other rural healthcare entities)—to participate in the promised healthcare transformation.

We strongly urge you to consider the following factors:

- The 2011 meaningful use draft requirements roughly correspond to reaching stage 4 of the 7 stage Healthcare Information Management Systems Society (HIMSS) Electronic Medical Record (EMR) Adoption model.[1]

- CAH's and rural acute care hospitals average 1.2 on HIMSS EMR Adoption Scale, whereas general medical-surgical hospitals average 2.5.

- A "reasonable" time required for any hospital to implement from stage 1 to stage 4 (considering what is required for appropriate vendor selection, workflow assessment, education, and implementation) is 3-5 years.

- Many CAH's and rural acute care hospitals will be required to essentially start from scratch after determining that their existing vendors will not position them to become meaningful users, and this will add to the "reasonable" time required.

- Many CAH's and rural acute care hospitals will need to address critical network infrastructure and HIT staff expertise challenges that will also add to the "reasonable" time required.

- Rural clinics have an analogous HIT adoption disparity and related challenges

If the above factors are granted, then average CAH's and rural acute care hospitals that begin their implementation process now will not be able to achieve the 2011 requirements until 2013 or later and as a result will receive no reimbursement.[2]

They will next be faced with the daunting challenge of reaching roughly stage 5.5 on the HIMSS adoption scale in literally no time and with no incentive dollars to assist the process.

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[1] The HIMSS EMR Adoption model is the healthcare industry's recognized source of hospital EMR adoption survey statistics. Each of the seven HIMSS hospital adoption stages, which represent a logical progression from basic foundational systems to a completely automated environment with advanced decision support, corresponds to various implementation milestones and challenges. The NRHA is not commenting on whether the HIMSS EMR model should be adopted as a federal standard. Rather, we are using the survey data reported in association with the model to demonstrate the EMR adoption disparity between the average rural hospital and the average general medical surgical hospital. Whatever meaningful use scale is eventually adopted, the disparity identified by the HIMSS EMR adoption statistics will remain in place and will need to be addressed.

[2] Anthony Trenkle, director of the Center for Medicare and Medicaid Service's (CMS) office of e-Health Standards and Services, said the requirements will not be "tiered" based on when the provider adopts an EHR after 2011. Instead, whatever meaningful use standards are applicable for the year the provider applies for an EHR subsidy are the standards that provider must meet, regardless of whether it is the provider's first year of EHR implementation.

The draft definition claims to achieve a balance between on the one hand: (1) currently available EHR capabilities, (2) the time needed to implement, and (3) the implementation challenges associated with small practices (and presumably small hospitals); and on the other hand: (1) the urgent need for health reform, and (2) the desire to substantively improve health outcomes.

Our analysis indicates that the draft definition only achieves this balance for providers that have already made significant strides in their EHR adoption efforts. If the Meaningful Use Matrix is aggressive yet achievable for hospitals that average 2.5 on the HIMSS adoption scale, we question the practicality of this also being achievable for a hospital that averages 1.2 or 0. Given that achievability is one of the tenants of the HIT Policy Committee, **we implore the Committee to reconsider a course of action that will result in the vast majority of the providers most in need of assistance being effectively excluded from receiving ARRA HIT incentive funds**.

Another critical factor to consider is the patient safety impact of setting phase requirements that will lead to rushed implementations. Any review of Agency for Healthcare Research and Quality (AHRQ) or other patient safety organization HIT research will find a stress on the importance of early planning, workflow assessment, and change management as part of successful HIT implementation. If reasonable time is not given for healthy implementation processes, providers are likely to experience increased medication errors, decreased patient satisfaction and safety, reduced efficiency, and a high percentage of implementation failures. All of these likely effects, which are obviously counterproductive to the goals of the American Recovery and Reinvestment Act (ARRA) and the Policy Committee, will disproportionately impact rural and underserved providers.

Two areas of particular concern are the 2011 requirement for Computerized Physician Order Entry (CPOE) and patient portals, both of which are advanced applications that are traditionally (and for good reason) implemented as capstone applications after dozens of other applications (such as the ancillary systems that feed the data repository, physician EMR portals, and e-Medicate Administration Records or MAR's) are implemented. To rush these in as part of the 2011 phase, even if achievable, which we dispute, would likely lead to a high risk of implementation failure, as well as an increase in the errors the legislation is designed to prevent.

Even as we stress the significant flaws of the draft Meaningful Use Matrix, **we want to make clear that we believe the ARRA HIT incentives, if properly structured, have the potential to profoundly increase rural provider HIT adoption and care quality**. We also believe that rural providers should be required to stretch to receive their incentives, just as more advanced EHR providers will be required to stretch. But to avoid the consequences outlined above, we believe the rural provider stretch must be developed from the baseline of current rural provider average HIT adoption levels, rather than the significantly higher average adoption levels of large hospitals and systems.

We believe that a tremendous amount is at stake here for rural providers. **If the draft Meaningful Use Matrix is approved as written, early-stage adopters will be effectively excluded from incentives, and/or will be incentivized into implementing too quickly to achieve the goals of the Committee**. This will likely create a future provider landscape of HIT haves and have-nots with numerous negative impacts for most rural and underserved communities. If, instead, the Committee creates a second meaningful use phasing structure for early-stage adopters, then we will see a future in which all providers have made significant strides along the HIT adoption continuum. Early-stage providers that are currently largely paper-based will have implemented scores

of systems to improve the safety and efficiency of their care, and will in 2015 stand positioned to participate in the healthcare reform HIT vision articulated by the Committee.

Recommendations:

1. In order to achieve the goals and the ultimate vision articulated in the Committee's report, we believe it will be necessary to create two distinctive phasing structures for meaningful use: one phasing structure for providers with mid-stage adoption levels, and another phasing structure for providers with early-stage adoption levels. The current draft Meaningful Use Matrix may be appropriate for the mid-stage adopters, but is clearly too advanced for early-stage adopters. Our preliminary estimate of appropriate meaningful use phasing for early-stage hospital adopters corresponds to the following HIMSS adoption level stages: reach roughly 2.0 in 2011; 3.0 in 2013; and then 4.0 in 2015. We believe this staging for early-stage adopters is as much of a stretch as the draft MU requirements are for mid-stage adopters. However, more work needs to be done to set appropriate meaningful use phases, both for inpatient (hospital) and outpatient (clinic) requirements, which will stretch the early-stage provider group.

2. Therefore, we recommend that a workgroup be convened to develop an early-stage adopter phasing model consistent with the goals of the Committee. This workgroup should include rural health, rural HIT, and patient safety representatives who are familiar with current rural HIT adoption levels and challenges. The workgroup should be tasked with developing a second early-stage adopter meaningful use matrix that is achievable, is consistent with the goals of the Committee, and which stretches early-stage providers.

3. We also recommend that time should be allotted for the development and presentation of an impact analysis of the likely effects of approving the draft Meaningful Use Matrix as written. We have generally identified likely impacts in this commentary. But given what is at stake, we believe that additional time should be granted to provide a more thorough, validated assessment of the impacts, specifically on rural providers and the sixty-two million Americans they serve.

Thank you for your consideration of our concerns. We look forward to hearing from you on this matter, and we hope that we can work together to best realize the promise of HIT to improve the health of rural America.

Sincerely,

Beth Landon

Beth Landon

President

National Rural Health Association

06/17/09

Rural Wisconsin Health Cooperative (RWHC) comments regarding the preliminary definition of "Meaningful Use" as presented to the HIT Policy Committee on June 16, 2009.

[RWHC is a cooperative of 35 rural hospitals (including 28 Critical Access Hospitals) that promotes regional collaboration for health and health care services on behalf of rural communities.]

As an organization with significant experience in rural electronic health record (EHR) implementation, we believe that the meaningful use definition, as drafted, will make it impossible for the average small rural hospital, including critical access hospitals (CAHs), to meet the meaningful use standard.

The result will be that the vast majority of an entire sector of providers will be excluded from receiving ARRA HIT incentive funds and, consequently, will lack the tools required to engage the challenges of healthcare reform.

In the HIT Policy Committee Meaningful Use Workgroup Presentation, the three part phasing (2011, 2013, 2015) of meaningful EHR use is characterized as a balance between on the one hand: (1) currently available EHR capabilities, (2) the time needed to implement, and (3) the implementation challenges associated with small practices (and presumably small hospitals?); and on the other hand: (1) the urgent need for health reform, and (2) the desire to substantively improve health outcomes.

According to the HIT Policy Committee presentation, the proposed Meaningful Use Matrix achieves this balance by providing escalating capabilities that will meet the need of reform and yet be feasible and achievable for providers to attain.

We disagree with this assessment. Please consider the following factors:

- The 2011 meaningful use draft requirements roughly correspond to reaching stage 4 of the 7 stage HIMSS EMR Adoption model.
- CAHs and rural hospitals average 1.2 on HIMSS EMR Adoption Scale, whereas general medical surgical hospitals average 2.5
- A "reasonable" time required for any hospital to implement from stage 1 to stage 4 (considering what is required for appropriate vendor selection, workflow assessment, education, and implementation) is 3-5 years.
- Many CAHs and rural hospitals will be required to essentially start from scratch after determining that their existing vendors will not position them to become meaningful users; and this will add to the "reasonable" time required.

Contact: Louis Wenzlow, RWHC Director of Health Information Technology, lwenzlow@rwhc.com

06/17/09

- Many CAHs and rural hospitals will need to address critical network infrastructure and HIT staff expertise challenges that will also add to the "reasonable" time required.

If the above factors are granted, then average CAHs and rural hospitals that begin their implementation process now will not be able to achieve the 2011 requirements until 2013 or later and as a result will receive no reimbursement.[1] They will next be faced with the daunting challenge of reaching roughly stage 5.5 on the HIMSS adoption scale in literally no time and with little to no incentive dollars to assist the process.

One question is at the core of our concerns: If the Meaningful Use Matrix is aggressive yet achievable for hospitals that average 2.5 on the HIMSS adoption scale, how can it also be achievable for a hospital that averages 1.2 or 0? Given that achievability is one of the tenants of the HIT Policy Committee, we believe that the Committee needs to adjust the definition for hospitals currently lower on the scale.

We believe it would be reasonable to move CAHs and small rural hospitals to above stage 2 in 2011; then above stage 3 in 2013; and then to roughly stage 4 in 2015. While it is outside the scope of the word allotment to go into the requirements point by point, we would like to call attention to our own meaningful use recommendations, which identify an attainable (yet still aggressive) rural-focused phase-in of meaningful use: http://www.rwhc.com/Meaningful.pdf.

Relating to the Meaningful Use Matrix requirements for 2011, two areas of particular concern are the requirement for CPOE and patient portals, both of which are advanced applications that are traditionally (and for good reason) implemented as capstone applications after dozens of other applications (such as the ancillary systems that feed the data repository, physician EMR portals, and e-MARs) are implemented. To rush these in as part of the 2011 phase, even if achievable, which we dispute, would likely lead to a high risk of implementation failure, as well as an increase in the errors the legislation is designed to prevent.

The ARRA HIT incentives, if properly structured, have the potential to profoundly increase all provider HIT adoption and care quality. But by setting the bar at a place within reach of the average large facility yet out of reach of the average small facility, HHS will effectively exclude the providers that serve predominantly rural areas. This will have a severely negative impact on rural providers, as well as on the rural communities and the 62 million rural residents that rely on them for healthcare. Please reconsider this course of action.

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[1] Anthony Trenkle, director of the CMS' office of e-Health Standards and Services, said the requirements will not be "tiered" based on when the provider adopts an EHR after 2011. Instead, whatever meaningful use standards are applicable for the year the provider applies for an EHR subsidy are the standards that provider must meet, regardless of whether it is the provider's first year of EHR implementation.

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Statement of

Terry Neese

Distinguished Fellow
National Center for Policy Analysis Family Policy Center

And

John C. Goodman

President & CEO
Kellye Wright Fellow
National Center for Policy Analysis

on

Health Information Technology: What's the cost to small businesses?

Small Business Subcommittee on Regulations and Healthcare
United States House of Representatives
June 24, 2009

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Madam Chairwoman and members of the Subcommittee, thank you for the opportunity to join in the debate as you consider different options for adopting health information technology (HIT) and the implementation of policies in the American Recovery and Reinvestment Act of 2009 (ARRA). We represent the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

http://www.john-goodman-blog.com/wp-content/uploads/Comments and Images/Health_IT.jpgA new study[1] in the *Archives of Internal Medicine* finds that hospitals using health information technology experience fewer complications and lower mortality. The technology studied included electronic medical records, decision-support tools, physician order entry and automated medical notes. However, the real question is whether the investment in HIT is cost effective and whether the adaption of the policy should be mandated by government fiat.

We believe the answer to the latter is emphatically no and that the calculations of the former should be left up to individual providers and the market place. In fact, after working on a study of the cost effectiveness of HIT, Peter Orszag, former director of the CBO, said in 2008, "Significant financial benefits [from HIT adoption] will never flow to individual doctors and hospitals."[2] Similarly, the CBO found that, "By itself, the adoption of more HIT is generally not sufficient to produce significant cost savings."[3] Surely, HIT can provide benefits to providers and patients, but those decisions should be driven by caregivers and patients, not government dictate. Access to quality and affordable health care will improve by giving decision rights to patients and their doctors. Health care dictated from Washington will have numerous unintended consequences and will not help Americans find quality and affordable care.

Why is it that any given auto mechanic uses a computer to track auto repairs, order parts, and diagnose problems but America's health care providers can't use a similar system in the exam room? The answer is very likely two-fold. The first being value and the second is that the guy at the local garage doesn't receive his payments from Washington. The case is clear that there is value is moving toward electronic medical records just as there is value in keeping electronic records of someone's automobile. The answer on why HIT is lacking must then lie with the differences in how doctors and mechanics are paid.

Health care providers get paid based on coding provided by Medicare and Medicaid. Since there is no code for HIT, doctors have no incentive to adopt technologies that can benefit them and their patients. Instead of spending more money without solving the problem like we did with the ARRA, it is time to revisit how doctors are paid. Under our current system, patients are almost completely removed from the payment process. Be it a government program or a third-party payer, such as employer sponsored health insurance, patients are not responsible for payment.

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[1] Archives of Internal Medicine, "Clinical Information Technologies and Inpatient Incomes: A Multiple Hospital Study," Accessed at http://archinte.ama-assn.org/cgi/content/abstract/169/2/108, January 26, 2009.

[2] Peter Orszag, Congressional Briefing, June 2008, taken from Rich Daly, "HIT Systems May Be Costly Initially but Have Advantages in Long Run," *Psychiatric News*, 2008.

[3] Evidence on the Costs and Benefits of Health Information Technology," Congressional Budget Office, May 2008, p. 11, at http://www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf (March 18, 2009).

What incentive would a mechanic have to keep costs low on a tire rotation if someone else picked up the tab? He certainly wouldn't be accountable to the car owner and since the car owner wasn't stuck with the bill they probably wouldn't really care how much the final bill was either. If we are able to change the incentives and return decision making ability to the patient, doctors will be able to realize the value of adopting HIT systems because patients will see the benefits of fewer errors, ease of use and, ultimately, better care. Until we realize this and move forward with a system based on the ability of patients to drive decisions, we are going to be stuck with a system based on perverse incentives that continues to explode costs, limit access, stifle innovation and limit quality of care.

For too long, the answers to America's health care shortcomings from Washington have been, "throw more money at the problem. That will fix it." Far more likely is that the $20 billion included in the ARRA will be inefficiently spent on systems that don't effectively solve the problem. We will be sending hard earned tax dollars after yet another inefficient and wasteful government program. Even within the federal government itself, previous attempts to upgrade technology have fallen flat. Dollar after dollar has been sent to the IRS, FBI, and the air traffic control system to modernize and upgrade IT but we have seen little benefit and too much waste. And these are all relatively simple enterprises involving single federal agencies. Health IT is vastly more complex and must include hundreds of thousands of private organizations that have invested in legacy systems that work reasonably well and are as varied as there are providers.

The United Kingdom has been trying to adopt a similar information technology upgrade for its National Health Service (NHS) since 2002. This plan was far less ambitious than the U.S. version, involving merely 30,000 physicians and 300 hospitals, all of whom are already employed by the NHS. Originally estimated at 2.3 billion pounds, the cost is already at 12.7 billion pounds ($18.4 billion), or about as much as is provided in the stimulus package for the entire United States. A recent report to Parliament admitted the program is four to five years late and may never be implemented as envisioned. The project has lost two of the four vendors who were working on it, and some of the elements that have been installed are not meeting expectations.[4]

The NCPA is a strong advocate of the health care system adopting HIT as rapidly as possible, but this cannot be done from a command-and-control system in Washington. Individual providers must be allowed the flexibility to adopt whatever technology is best able to deliver value to their patients. Even ignoring that "meaningful use" is not defined in the ARRA proposal, the government should not be in the business of picking winners and losers. What works at the Mayo Clinic might not work in the Parkland Hospital system in Dallas and neither would be a sure thing at a rural hospital such as the Western Plain Medical Complex in Dodge City, Kansas.

The work of the HIT Policy Committee, the Centers for Medicare & Medicaid Services (CMS), and the Office of the National Coordinator for Health Information Technology (ONC) to help set the rules for the ARRA is, on some level, admirable. Ultimately, it will probably amount to good work after bad. No matter the level of flexibility legislators and bureaucrats in Washington

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[4] Greg Scandlen, "Taking Another Look at Health Information Technology," Accessed at http://www.john-goodman-blog.com/taking-another-look-at-health-information-technology/, March 2, 2009.

try to build into a system, they are unable to match the flexibility of thousands of individual providers. A few hundred people in Washington cannot possibly match the collective intelligence of America's patients, doctors, nurses, and countless other medical professionals.

The ARRA provisions achieved wide bipartisan support in Congress and in the health care industry, based on the hope that the investment will help improve efficiency, cut costs, and result in better care. However, the reality is likely to be far different. Small businesses, including medical providers, do their best when they have the flexibility to meet the demands of a local market. It is beyond conceit that Washington, once again, believes they can meet the demands of those local markets with new regulations and more money. Real value and quality care can be provided at lower cost when decisions are made by those in the exam room. As long as patients are bystanders to the care, all types of care and technological adaptation will suffer.

Madam Chairwoman and members of the committee, thank you once again for the opportunity to contribute to this very important conversation. I look forward to working with each of you as Congress revisits this and other issues related to health care. It appears the health care reform train is leaving the station and I would stress the importance of market forces and patient control as the best way to lower cost, improve quality, and increase access to health care in this country.

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Written Testimony for the House Committee on Small Business, Subcommittee on Regulations and Healthcare Hearing on Health IT Adoption and the New Challenges Faced by Solo and Small Group Healthcare Practices

Statement of
PDX, Inc.

June 24, 2009

Madam Chairwoman, Members of the Committee:

On behalf of PDX, Inc., we are pleased to submit the following written statement on the Subcommittee's important hearing on the issue of health IT adoption and the new challenges faced by solo and small group healthcare practices.

Established in 1985, PDX is a growing Ft. Worth, Texas-based pharmacy software and services company that is very interested in the health IT regulations that will be promulgated as a result of the Health Information Technology for Economic and Clinical Health Act provisions contained in the American Recovery and Reinvestment Act of 2009 (ARRA). PDX pharmacy software technology was designed to assist pharmacies in addressing the requirements of high volume prescription filling and the demands of third party processing. The PDX Pharmacy System ensures that the third party requirements of pharmacy chain clients are in place alongside the essential clinical tasks.

Nearly 10,000 pharmacies use PDX software to fill, bill, and track prescriptions, including sixty pharmacy chains, supermarkets, and mass merchants, and more than approximately 1,000 independent pharmacies in the United States. To date, there are more than 700 million prescriptions in our centralized, interoperable pharmacy database.

ARRA lays the groundwork for the widespread adoption of electronic health records (EHRs). PDX firmly believes that greater efficiencies and savings in the delivery of healthcare must come from the adoption of such health IT.

However, we are concerned that any specification of health IT requirements or standards, such as those to be promulgated pursuant to ARRA's EHR incentive provisions, which require Federal agencies, providers, and health plans to utilize health IT systems once the systems become available, should not be so overly prescriptive as to adversely affect the ability of small businesses, such as independent pharmacies and software development companies, from competing in the marketplace and undo the substantial groundwork already established to enable thousands of pharmacies to process the records of millions of Americans.

ARRA regulations defining "meaningful use" of EHRs, the standards for interoperability, the minimum requirements for a certified product *and* who will certify the products are of critical importance as pharmacies plan for EHR implementation.

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However, the diversity of pharmacy businesses does not lend itself to a "one size fits all" approach. On the contrary, smaller pharmacies could be disproportionately affected by regulations that favor proprietary systems developed by large pharmacy chains because of lack of portability and interoperability of patient records outside the chain.

Complete portability and interoperability of all patients' prescription records could be realized by normalizing the data from all pharmacies including prescriptions paid for in cash or by third parties, including Medicare. This normalized data should then be made available at the patient's request to any pharmacy in the US. This technology will provide patients the ability to transfer their prescription record anywhere and allow physicians, hospitals, pharmacies, and other authorized healthcare providers to view their patient's prescription history to prevent medical errors and harmful drug interactions.

The technology for such a centralized prescription database already exists. PDX's Electronic Pharmacy Record ("EPR") presently provides these efficiencies and savings to be realized while at the same time incorporating portability and interoperability objectives. PDX, along with its sister affiliate Rx.com Partners, L.P., have developed a nationwide Electronic Pharmacy Record updated in real-time that offers complete portability and interoperability of normalized prescription data, resulting in a complete prescription profile that includes prescription records from a variety of pharmacies and healthcare providers. The PDX/Rx.com Electronic Pharmacy Record database currently includes all prescriptions from over 4,000 pharmacies across the U.S., representing over 70 million patients and almost one billion prescriptions. Over 1,000 additional pharmacies will add their data to this repository in 2009, bringing the patient count to over 100 million, or approximately one-third the population of the U.S.

Any legislation addressing health IT standards or contemplating a national health information technology infrastructure should take into account the existing solid groundwork already established by PDX and Rx.com in developing a real-time updated, centralized, normalized and interoperable Electronic Pharmacy Record repository for clinical access by physicians, patients, hospitals, and pharmacies, whether small, independent or part of a large chain.

Thank you, members of the Subcommittee, for the opportunity to submit this statement on behalf of PDX. As these important regulations are being drafted, we stand ready to be an advocate for small business and a resource for the Subcommittee.

Sincerely,

Michael Ingram
Executive Vice President,
Chief Financial Officer and
General Counsel

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