SUBCOMMITTEE HEARING ON THE VALUE OF HEALTH IT TO SOLO AND SMALL MEDICAL PRACTICES

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SUBCOMMITTEE HEARING ON THE VALUE OF HEALTH IT TO SOLO AND SMALL MEDICAL PRACTICES

WEDNESDAY, MARCH 28, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
SUBCOMMITTEE ON REGULATIONS, HEALTH CARE & TRADE
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2360 Rayburn House Office Building, Hon. Charles González [Chairman of the Subcommittee] presiding.

Present: Representatives González, Jefferson, Altmire, Sestak, Westmoreland, and Buchanan.

Also Present: Representative Gingrey.

OPENING STATEMENT OF CHAIRMAN GONZÁLEZ

ChairmanGONZÁLEZ. It is five after, and by D.C. standards we are starting early. So it is my—and I am hoping that other members will be joining us, and we may even have a Member of Congress who has a great interest in HIT who is not a member of this particular Committee, but we are going to welcome him if, as, and when he gets here.

I call this Subcommittee to order now, and, of course, this is the Subcommittee on Regulation, Health Care, and Trade, of the House Committee on Small Business. And the hearing today is entitled "Value of Health Information Technology to Solo and Small Medical Practices."

I will be following the rules established by the chair of the full Committee, Chairwoman Nydia Velázquez, meaning that the chair—myself—and the ranking member, Congressman Westmoreland, will be making opening statements. However, all other members of the Subcommittee are welcome to submit written statements that will be made part of the record at a later date. And I appreciate your participation today.

Today's hearing will offer an opportunity to examine ways we can expand and improve the implementation of health information technology. Health information technology has the potential to advance health care quality, but right now many small health care providers simply cannot afford to offer it.

It is well known that HIT benefits are vast and wide-reaching. Practices which we are fortunate enough to have access to this technology know that it reduces health care costs, improves administrative efficiency, and reduces paperwork. This leads to improved

safety and quality and ultimately increased access to affordable health care.

However, right now there are inadequate incentives for health care providers to adopt many of these technologies. The costs are too high in light of the benefits. As a result, a significant gap exists in health IT adoption between large and small practices.

A study conducted by the Commonwealth Fund revealed that 57 percent of physicians in practices with more than 50 physicians used health information technology, compared with only 13 percent of solo practitioners. More importantly, 80 percent of all outpatient visits take place in medical practices with 10 or fewer doctors, and solo practitioners comprise about two-thirds of all medical practices which provide these services.

Without changes in the way we promote health IT, small physician practices will be left behind the technological curve, and, as a result, patients will fail to benefit from the quality of care electronic health records provide.

Congress needs to do more to help these smaller practices, where the majority of patient care is actually received. This is why I am introducing legislation that will provide financial incentives and other resources to increase the pace of health information technology adoption by smaller practices. These resources will include tax incentives, grants, and subsidized loans, all of which are instrumental to address this particular problem.

I am pleased that the Small Business Committee also recently passed the Small Business Lending Improvements Act of 2007, which will allow small medical providers in underserved areas to access small business administration loans for health IT. One of the most effective ways to do so is to provide financial incentives for such practices to adopt and implement health information technology. This will ensure that smaller practices are encouraged to purchase and implement health information technology while simultaneously protecting them from the financial burden of government regulations and mandates.

It has been estimated that purchasing and installing an electronic health records system can cost more than $32,000 per physician, and maintenance can exceed $1,200 per month. My legislation would help defray some of these high upfront costs. Modern technologies benefits are felt across our country in our daily lives. We have seen and felt its benefits in education and the sciences. Now it is time for our health care system to catch up.

This hearing will focus on the importance of health information technology to small practices, examine the barriers to its implementation, and identify the steps Congress should take to encourage greater adoption by small practices. Small health care providers are struggling and desperately need our help.

Some of the witnesses before us today are pioneers in that they have taken the step and started implementing these technologies. But unless we increase the pace of adoption by smaller practices, there is little possibility that America's health care system will be transformed.

I would like to thank each of our witnesses for taking time out of their busy schedules to discuss this important issue, and, of course, to share their own personal experiences regarding this very

important issue that is coming before Congress and hopefully will be acted upon in the 110th Congress, which we failed to do last Congress.

At this time, it is my pleasure to recognize my colleague and ranking member, Congressman Lynn Westmoreland, for his opening remarks.

OPENING STATEMENT OF MR. WESTMORELAND

Mr.WESTMORELAND. Thank you, Mr. Chairman, and thank you for holding this hearing today, and it is a pleasure to work with you on this Committee. I would also like to thank all of the witnesses that are here today. I know you are solo practitioners maybe, and it is costing you money to be here, so thank you for your participation.

Mr. Chairman, I am glad this Subcommittee's first hearing topic is one of such great importance. I look forward to working with you on strengthening America's small businesses during our time together on this Committee. Today we live in the age of information. We have all become increasingly dependent on having things at our fingertips at a moment's notice.

It is now difficult to remember a time without Internet search engines, e-mail devices fastened to our hips, or GPS navigation systems in our cars. However, this wave of technology has not yet been fully implemented in one of the world's most important industries, and that is the health care industry.

While the science of medicine makes dramatic advancements almost daily, the method of managing patients' medical records has lagged far behind. And this is why I am so glad to be here today to discuss this issue. I think everyone involved recognizes the tremendous value health information technology provides. Collecting patients' information in a more efficient, productive manner helps prevent medical error and reduces paperwork.

Minimizing these two factors improves the overall health care system while also lowering cost. I applaud President Bush for his recognition of these benefits and for his call for the widespread adoption of the electronic medical records, the EMRs, within the next 10 years.

Unfortunately, while these values are understood by all, the financial costs of implementing health IT are felt by most, and for some it can be the barrier against establishing IT in their own practices. This is especially the case for smaller health care practices like the ones throughout my district in Georgia. And even after addressing the financial burden, in most cases a small practice must still confront the complex state and federal laws that entangle all businesses.

There are many proposals focused on addressing these problems, most of which use a mixture of financial incentives and policy changes. Although there is no quick fix for a national implementation of health IT, there is a considerable desire for it. And I am glad that the Chairman has introduced a bill, and also Congressman Gingrey has one, both that address this issue.

For that reason, I believe that it is important that we take as many ideas into consideration as possible in order to make the best decision for our health care providers and our health care system.

This Congress faces a great challenge as it tries to lower the overall cost of health care, and I am hopeful that the work of this Subcommittee will do its part in answering this challenge.

I welcome this distinguished panel, and thank you all for your willingness to testify in front of us today. And, Mr. Chairman, I would like to request that all members have five days to revise and—legislative days to revise and extend their remarks.

ChairmanGONZÁLEZ. Without objection.

Mr.WESTMORELAND. Thank you.

ChairmanGONZÁLEZ. I had indicated earlier that the remaining members of the Committee will be able to—or the Subcommittee will be able to submit their written statements for the record.

To the witnesses, let me explain the little mechanism there on the lights. Obviously, green means go. When it is yellow, that means you have one minute left. When it is red, time has expired. As you have already been instructed, you have submitted written statements that obviously would exceed five minutes, but we are asking you to please summarize your written testimony in those particular five minutes, and then we will proceed with questions.

At this time, though, I believe there may be an occasion for Congressman Phil Gingrey from the great State of Georgia to be joining us at a later time, and I would be asking at this time for unanimous consent to allow a non-member of the Subcommittee and the larger full Committee to sit here at the dais and participate with members of the Committee.

So without any objection, it is so ruled. And when he gets here, if you will just direct him to have a seat up here. Thank you very much.

It is my pleasure to be introducing the witnesses at this time. I will be deferring the introduction of two of the witnesses to my colleagues, but I will start off with Dr. Lynne M. Kirk is President of the American College of Physicians, the nation's largest medical specialty society. The American College of Physicians represents more than 120,000 physicians in general and internal medicine and related subspecialties.

Dr. Kirk is also the Associate Dean of Graduate Medical Education and Associate Chief of the Division of General and Internal Medicine at the University of Texas Southwestern Medical Center. Welcome, Dr. Kirk.

Dr. Mark Leavitt is Chair of the Certification Commission for Health Care Information Technology, and we will learn more about that particular commission during the testimony. The mission is to accelerate the adoption of a robust inter-operable health information technology. The organization now actively certifies electronic health record systems and recently received official recognition from HHS as a certification authority.

Dr. Leavitt is a Clinical Assistant Professor at the Oregon Health and Science University and is a fellow of the Health Care Information and Management System Society.

Dr. Margaret Kelley—and welcome Dr. Kelley because she is a constituent—is a partner in Southeast OB-GYN Associates, located in San Antonio, Texas, and serves as the Chief of Surgery and Chief of Staff for Southeast Baptist Hospital. Dr. Kelley will be testifying on behalf of the American College of Obstetricians and Gyn-

ecologists, which has over 49,000 members and is the nation's leading group of professionals providing health care for women.

At this time, I am going to recognize Congressman Jason Altmire for the introduction of Dr. David Shober.

Mr.ALTMIRE. Thank you, Mr. Chairman.

Dr. Shober is from my district. He is a partner in Lawrence County Family Medicine Practice, located in New Castle, Pennsylvania. He and his partner own and manage their business. They installed an electronic health record in 2004. Their practice consists of two physicians, one physician assistant, and a nurse practitioner. They have two offices that operate simultaneously, a small one in a township and the other one in a rural setting.

They provide in-patient medical care at one hospital and four nursing homes. In addition, Dr. Shober serves as President of the medical staff at Jameson Memorial Hospital. Previously, he served as Vice President and Chairman of the Department of Medicine. This is a 200-bed community hospital serving a population of 90,000 people.

Dr. Shober is testifying on behalf of the Health Information and Management System Society, HIMSS. That is a membership organization focused on health care information technology representing more than 20,000 individual members and 300 corporate members.

ChairmanGONZÁLEZ. Thank you very much. And I would like to point out, in looking over the bios of members—and we don't do that until actually we have hearings and such—it is my understanding that Congressman Altmire has a master's in health administration. Is that correct?

Mr.ALTMIRE. That is right.

ChairmanGONZÁLEZ. So we are looking for a little bit of leadership here.

[Laughter.]

At this time, I would like to recognize the ranking member, Congressman Westmoreland, for the introduction of our next witness.

Mr.WESTMORELAND. Thank you, Mr. Chairman. It is my pleasure to introduce my constituent, Kevin Napier, M.D., who is an Internist with Internal Medicine of Griffin, in Griffin, Georgia. Dr. Napier has honorably served his community and his nation since graduating from the Medical College of Georgia. He spent five years practicing at numerous U.S. Navy medical clinics before entering civilian medicine.

Dr. Napier has been a general partner with Internal Medicine of Griffin since 2001, where they made the transition to health IT in 2005. Former Chief of Staff of the Spalding Regional Medical Center, currently Dr. Napier serves on the Board of Directors of the Spalding Regional Medical Center.

I want to thank Dr. Napier for being here to share his perspective as a small medical practitioner, and I look forward to hearing the testimony he has.

ChairmanGONZÁLEZ. Thank you very much, and we will proceed with the testimony and the first witness, Dr. Kirk.

STATEMENT OF LYNNE M. KIRK, M.D., FACP, PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS

Dr.KIRK. Thank you, Chairman González and Ranking Member Westmoreland. As a general internist at the University of Texas Southwestern Medical Center in Dallas for the past 26 years, I have had the privilege of providing health care to thousands of Texans while training the next generation of American physicians.

The American College of Physicians is the largest specialty society in the U.S., representing 120,000 internal medicine physicians and medical students. More Medicare patients count on internists for their medical care than any other physician specialty. Of our members involved in patient care after training, approximately 20 percent are in solo practice, and 50 percent are in practices of five or fewer physicians. This is the group of physicians that is least likely to have the necessary capital on hand to invest in technology.

We greatly appreciate your attention to the barriers small health care practices face in adopting HIT. ACP strongly believes the goal of widespread adoption and use of HIT to improve quality of care will only be successful if we first recognize the complex issues of financing, redesign of practice workflow, and the need for ongoing technical support and training.

We believe it is absolutely essential for Congress to begin to offer targeted financial assistance programs to fund HIT in small medical practices. These practices need financial assistance for the initial startup costs of acquiring the technology, but also recognition of the ongoing costs as well.

Numerous studies and policy experts have confirmed that full adoption and utilization of HIT can revolutionize health care delivery by improving quality and reducing health care costs. Despite these positive claims about HIT, few physician practices are able to afford the substantial initial capital or afford the costs associated with training for and maintaining the technology. This obstacle is especially acute for physicians practicing in small office settings where three-fourths of all Medicare recipients receive their outpatient care.

Acquisition costs can average as much as $44,000 per physician. The average annual ongoing costs can be about $8,500 per physician. The business case does not exist to make this kind of capital investment. Another related barrier is that savings from HIT will largely go unrecognized for the physicians making these investments. Public and private payers, not the physicians, will realize the savings from physician investment in acquiring the necessary HIT.

Therefore, ACP strongly believes that physicians' contributions must be recognized through implementation of reimbursement policies that allow sharing of the system-wide savings of HIT. First, the college recommends Congress build into the Medicare physician payment system an add-on code for office visits and other services provided with support of HIT. The amount of the add-on should relate to the complexity of the HIT adopted by the practice.

Secondly, Congress should allocate the necessary funding for small practices to make the initial HIT investment. We believe that grants, loans, tax credits, or a combination of the three, coupled with the Medicare add-on, are sufficient to put the necessary HIT

systems into the hands of small practices. That is why we are particularly supportive of the bipartisan bill H.R. 747, the National Health Information Incentive Act, sponsored by Subcommittee Chairman Charles González, because it specifically targeted those small practices—the practices that are in need of the most financial assistance.

We also believe that the offering of SBA loans, which is what this Committee has jurisdiction over, is an appropriate mechanism to accomplish this goal. HIT alone will not lead toward full recognition of the potential benefits that include improved quality and better outcomes.

We believe that the use of HIT should be directly linked to the concept of organizing care around primary and principal care in a model called the patient-centered medical home. This model is based on the premise that the best quality of care is provided not in episodic illness-oriented care, but through patient-centered care that emphasizes prevention and coordination.

In summary, the college strongly believes Congress should provide the necessary funding to offset the initial costs in obtaining HIT and should recognize the ongoing costs in utilizing this technology. It is the combination of one-time and ongoing financial incentives put forward by Chairman González that we believe will substantially speak HIT adoption and the use of technology to foster improvements in quality of care.

Only when Congress begins to recognize the contributions of physicians will we begin to achieve savings through the adoption of HIT. Therefore, we believe funding initiatives should allow for individual physicians to share in the system-wide savings attributable to HIT.

The college commends Chairman González and the members of the Subcommittee for holding this important hearing. We are pleased that the Committee is examining the barriers small practices face adopting HIT. The benefits of full-scale adoption of interoperable HIT will be significant, leading to a higher standard of quality in the U.S. health care system.

Unfortunately, without adequate financial incentives, small practices and their patients will be left behind this technological curve.

Thank you.

[The prepared statement of Dr. Kirk may be found in the Appendix on page 37.]

ChairmanGONZÁLEZ. Thank you very much, Dr. Kirk.

Dr. Leavitt?

STATEMENT OF MARK LEAVITT, M.D., Ph.D., CHAIRMAN, CERTIFICATION COMMISSION FOR HEALTH INFORMATION TECHNOLOGY

Dr.LEAVITT. Thank you. Chairman González, Ranking Member Westmoreland, and distinguished members of the Subcommittee, thank you for inviting me today. My name is Mark Leavitt, and I am Chair of CCHIT, an independent non-profit organization with the mission of accelerating the adoption of health IT.

The topic of health IT in small practices is near and dear to me. I started solo practice 25 years ago, and I realized that paper-based record-keeping would be not only inefficient for me but dangerous

for my patients. So I created one of the first electronic medical records for myself 25 years ago.

A quarter of a century later my colleagues—fewer than 1 in 10—have the benefit of this technology today. I assume that is why I am here, and that is why we are talking about it.

I think that others will speak to the issue of the benefits of health IT as well as the costs, but there are really two major barriers that I think we need to focus on. One is clearly cost, and the other is risk. And we are going to hear about the cost of health IT, the figure of $15- to $50,000 per physician is a good one, or $32,000 per physician.

And, by the way, it is highest per physician the smaller the practice, because they cannot amortize the fixed costs. The ROI, the return on investment, is slow or absent. There is no additional reimbursement when a provider adopts electronic health record technology.

Now, besides the costs, physicians face significant risks when they move to electronic records. Many have made mistakes selecting and implementing these systems. Sometimes it can even threaten the financial viability of their practices, and also we are all familiar with the risks to patient privacy when computer systems are not adequately secured.

Finally, the question: how can the government help accelerate the adoption of health IT in these small practices? Well, starting with the President's appointment of a national coordinator for health IT in 2004, and followed by the establishment of strategic advisory panels by the Secretary of HHS, a number of federal initiatives have already been launched.

Now, the organization which I chair represents one of those initiatives. CCHIT was awarded a three-year contract with the first year devoted to accelerating the adoption of health IT in physician office practices. We think that certifying these electronic health record products can help practices in four ways.

First, reducing the risk when they select and purchase an electronic health record. Second, making sure that these systems will be interoperable. In plain English, it means they will plug in and connect and exchange information—receiving data from a lab, sending a prescription electronically, or forwarding a record when they refer a patient.

Third, we hope that certification can enhance the availability of financial incentives or regulatory relief. And finally, and very critical, by making sure that when we move from a paper to a digital health care information world, privacy is enhanced rather than reduced. And I believe that is possible.

Our efforts are showing signs of success. In just nine months, we have certified 57 products targeted to ambulatory care to physician practices, so they have a wide selection of products to choose from. By the way, over 70 percent of these products come from companies that are themselves small businesses, and the majority of them serve small practices—one, two, three, up to five doctors.

Also, we are seeing payers now keying some financial incentives. In Hawaii, Blue Cross Blue Shield of Hawaii is offering $50 million in incentives for physicians who buy certified electronic health records. We are also seeing health information networks relying on

certification. In New York, a Medicaid project to share prescription history with doctors is relying on certification to ensure that the systems are sufficiently secure.

For this success to continue, it is critically important that adequate funding be continued for the Office of the National Coordinator and for these key enabling projects. Your legislation should build on this momentum. I believe the most effective policy stimulus involves physician payment incentives, first for IT adoption and later for using the IT to measure and improve quality.

The Medicare Physician Voluntary Reporting Program, PVRP, offers a 1.5 percent bonus for reporting certain quality measures. It is a step in the right direction, but it is too small in magnitude by a factor of five to ten to have a financial impact on these practices considering electronic records.

Summing up, health IT promises all of us enormous quality and cost-saving benefits, but small offices are struggling to adopt it. The strategic federal initiative launched in 2004, including certification of health IT products, is showing positive results. I encourage you to offer legislation that builds on this momentum, and help us achieve electronic medical records by 2014.

Thank you for inviting me today, and I look forward to your questions.

[The prepared statement of Dr. Leavitt follows:]

[The prepared statement of Dr. Leavitt may be found in the Appendix on page 46.]

ChairmanGONZÁLEZ. Thank you, Dr. Leavitt.

Dr. Kelley?

STATEMENT OF MARGARET KELLEY, M.D., SOUTHEAST OB-GYN ASSOCIATES, ON BEHALF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr.KELLEY. Chairman González, Ranking Member Westmoreland, and all of the members of the Subcommittee, thank you for inviting me to share my experiences in adopting information technology in my OB-GYN practice. I am speaking today from my experiences as well as on behalf of the American College of Obstetricians and Gynecologists.

My father, Dr. Harmon Kelley, and I operate a two-physician practice, Southeast OG-GYN Associates, in San Antonio, Texas. We have about 14,000 patient visits a year and deliver about 300 babies annually. In 2004, we made the decision to convert our antiquated records system to an electronic medical record or an EMR. We wanted a more efficient and productive office.

Also, given the litigious environment in obstetrics and gynecology, my father and I wanted to make sure we were able to document everything that we do in our practice. An EMR would allow us to keep a much more comprehensive and legible record than our paper-based system did.

The initial cost of upgrading to an EMR was approximately $100,000, $50,000 per physician. My father and I had to carefully weigh the pros and cons of purchasing such an expensive system, and ultimately decided that it was an investment that we had to make, so that we could better meet the needs of our patients.

Our staff of 10 took two full weeks away from patient care to train on the new system with trainers provided by the EMR vendor, but the formal training was just the beginning. Virtually every aspect of our practice had to be modified. Where we used to simply just jot down a note on a patient chart, we now had to learn to navigate the new system and type our notes into an electronic form.

Because of our learning curve, each patient visit took longer, reducing the number of patients we could see in a given day. This caused patients to wait longer to schedule appointments, and because we were seeing fewer patients, our practice revenue dropped as well. Ours was a frustrating transition for staff, physicians, and patients alike.

In fact, it took our practice approximately two years to be able to accommodate as many patients as we did before we invested in our EMR. The investment of $100,000 up front, and a diminished number of patients that we could see, made the initial months of implementation very lean indeed.

Three years later our staff and our patients are finally able to appreciate the full potential of health information technology in our practice. Our old way of doing things seems completely archaic in retrospect, and I could never go back.

One of the biggest benefits is 24-hour access to all patients' charts. If I am at the hospital in the middle of the night laboring a patient, and I need her prenatal record, I can view it and print it through any computer that has Internet access. I can view the patient's record, including her plan of treatment, medications, when I am at home on call. And I also can catch up on reviewing lab results and telephone calls without coming into the office on the weekend.

There are also obvious patient benefits. Our EMR allows us to view a patient record's drug allergies, check for drug interactions, and so medications are prescribed more safely. It links to the ACOG guidelines to facilitate the practice of evidence-based medicine. We also add the patient's picture to our medical record. It helps us remember the patients, but it also reduces medical errors.

We received a positive response from our patients. They like seeing doctors using modern technology, and it gives them peace of mind because they know our commitment to their health and safety is behind the change. The most obvious barrier in the adoption of information technology in small practice is the initial cost, usually about $50,000 per physician. This investment is somewhat of a gamble.

The technology changes rapidly, and systems often do not communicate with each other well. Many physicians are fearful that this year's investment will be outdated or obsolete in a few short years.

Some people mistakenly believe physicians will easily recoup their investment, because the technology will make them more efficient and able to see more patients. The irony is that health information technology makes many offices significantly less efficient for months, or even years after upgrading to an EMR. And even when the practice adjusts to the new system, it doesn't necessarily translate into more patients or more revenues.

We want to use the technology to make our office visit minutes more meaningful, not to strip additional minutes off of an office visit that is already too short. Medicare and private sector health insurers are complicit in keeping us in a paper-based system. Private insurances and Medicare constantly expect us to deliver more care for less money.

For one of my insurers, global fee for prenatal care is only $1,200, which includes the delivery, the care, and 60 days' postpartum care. Medicare is slated to cut physician payment by 10 percent in 2008, and 40 percent over the next eight years. As the rates continue to be cut from all angles, it can be difficult for many practices to justify an investment in health information technology.

I am a firm believer in the enormous potential of health information technology, but leadership from the Federal Government spearheaded by this Subcommittee is necessary to make it possible for small and rural physicians.

Thank you for holding this important hearing and striving to help small practices provide the best care to their patients.

[The prepared statement of Dr. Kelley may be found in the Appendix on page 53.]

ChairmanGONZÁLEZ. Thank you very much, Dr. Kelley.

Dr. Shober?

STATEMENT OF DAVID R. SHOBER, D.O., PRESIDENT, MEDICAL STAFF, JAMESON HOSPITAL, LAWRENCE COUNTY FAMILY MEDICINE, PC, ON BEHALF OF THE HEALTH INFORMATION MANAGEMENT SYSTEM SOCIETY

Dr.SHOBER. Chairman González, Congressmen, Congresswomen, it is a pleasure to have this opportunity to meet with you today.

We were motivated to purchase an electronic health record for a number of reasons—we wanted the instantaneous connectivity between both offices, we wanted access to our files from outside locations, insurance and medical legal requirements driving a need for more thorough documentation, need a more efficient record-keeping system. We wanted to be able to reduce documentation errors, standardize our record to a level not possible with a handwritten chart. We wanted to be able to electronically audit our performance.

Unfortunately, as you will see, the road to using the electronic health record system is a difficult one. We purchased our system three years ago. The cost was considerable. Our initial investment was $200,000. Our annual costs are $50- to $60,000. While we have been able to recoup some savings, the record is still an expenditure for us.

We realized a number of benefits and challenges with our implementation of the electronic record. The initial challenge was deciding which system to purchase. Our next challenge was to develop an electronic connection between our two offices. With no Internet access to our rural office, we installed a dedicated T1 line, which is a high-volume telephone data line, at an additional cost of over $200 a month.

The implementation of our records system required considerable staff and physician education and training. It has created a finan-

cial challenge for a small business. We were required to commit a considerable amount of time, both inside and outside of the office, and this was quite difficult in a busy practice.

While we have eliminated the cost of creating a paper record, we still have the cost of scanning and shredding all of the unnecessary paper that continues to arrive at our office. We also found ourselves dependent upon a reliable electrical system. We needed to install generators at the offices in order to keep our system running with outages.

The system has allowed us to create a more complete note. The development of templates for standard portions of exams creates further efficiency. I am, however, concerned that the use of templates has been scrutinized by the insurance chart reviewers and attacked in the courtroom or deposition. I believe that for us to move forward templates must be accepted as an adequate method of record-keeping.

Another challenge is that we have not been able to integrate some of the standard federal forms into the EHR, examples being the FMLA, DOTCDL. Normally, companies create or purchase their own versions of these forms, and hand signatures are required. For the electronic record process to move forward, legislation will need to standardize the forms and permit electronic signature.

Medical record copying now being easier for us to accomplish, we have found ourselves still limited by the fact that other entities are not capable of accepting the electronic transfer of information. At present, we are the only practice within a 30-mile radius that has an electronic record. When it comes time to move a record, we need to copy it on paper and then mail it or give it to the patient, adding further inefficiency.

Currently, we hand write, print, or fax prescriptions. We are not able to e-prescribe to all pharmacies or the VA. This inconsistency creates additional work and inefficiency. Some insurance carriers and mail order pharmacies even demand that we cut and paste on our old prescription pads.

I believe all pharmacies should be required to accept e-prescriptions. One of our major barriers is our ability to communicate with other electronic health record media. In order for us to communicate with these difference license programs, an interface between systems must be built. As a small business, I can't afford to pay for multiple interfaces.

Federal regulations should require that health IT software have the capability to interface with other licensed programs, to allow free market pricing and break down costly communication barriers. In order for us to maintain and operate our system, we have had to dedicate a full-time employee as a computer specialist.

From a payer standpoint, electronic health records with universal connectivity could eliminate the unnecessary repetition of testing, which often occurs when test results are not available in a timely manner. Not only will it save money, but it will certainly improve the quality of patient care.

In small communities like mine, the physician and the hospital are dependent upon each other to deliver quality care. Jameson Hospital, our local facility, is struggling with the acquisition on in-

formation technology, trying to perform a balancing act as they provide necessary hospital services, try to bring their staff along with information technology.

I see the only initial way to provide an incentive for adoption of health information technology is to provide financial assistance. As you can see, the burden for electronic record acquisition is significant. The ongoing cost is fixed. I believe the physicians and hospitals should be given financial assistance to cover their acquisition costs, as well as reimbursement to help cover the ongoing cost of this program.

In spite of the significant cost, time, and effort required to implement a system, I am optimistic that with universal adoption of electronic health record efficiencies for payers, physicians, and health care providers will materialize. Most importantly, my experience demonstrates that the EHR system will help improve the quality of patient care.

Thank you.

[The prepared statement of Dr. Shober may be found in the Appendix on page 58.]

ChairmanGONZÁLEZ. Thank you very much, Dr. Shober.

And before we proceed with the next testimony, I wanted to welcome our colleague, Congressman Phil Gingrey, from the great State of Georgia. Welcome, and thank you for your participation today.

Mr.GINGREY. Thank you.

ChairmanGONZÁLEZ. And next witness, Dr. Napier.

STATEMENT OF KEVIN NAPIER, M.D., INTERNAL MEDICINE OF GRIFFIN

Dr.NAPIER. Chairman González, Ranking Member Westmoreland, and members of the Committee, thank you for the opportunity to testify before you today regarding my experience in information technology and health care.

My name is Kevin Napier, M.D., and I practice internal medicine in Griffin, Georgia.

Information technology is a subject of great importance to members of the medical community and government, as well as the general public. Internal Medicine of Griffin has nine physicians and admits patients to Spalding Regional Medical Center, which is a facility with 180 beds.

We made the transition to electronic health records in February 2005. Prior to that point, the health records were in traditional folders where loose paper was placed in the order in which it was generated, which generally included office notes, laboratory reports, radiology reports, physician correspondence, insurance correspondence, as well as Medicare correspondence.

This led to frequent episodes of the inability to locate items needed for care, and occasionally not being able to locate the chart at all on the day of the visit. Internal Medicine of Griffin evaluated systems for two years prior to our selection of a vendor. After that decision was made, it was nearly another year prior to implementation of that system due to hardware installation and training needed for physicians and staff.

It was recommended to us by our vendor that, due to the complexities of the system, we should consider reducing our schedules for a short period of time to allow the practice to adjust. The final cost including training was nearly $400,000. Six of the physicians in my group are primary care physicians, and we quickly learned that we were going to be financially impacted during this transition period.

We financed the cost of this IT implementation and began paying $1,000 per month per doctor, and we will continue to do that for the next three years. After considering the yearly threat of payment reductions from the Centers of Medicare and Medicaid Services, CMS, it is easy to see why more practices do not quickly transition to EHR.

In the first year after implementation, we did see a reduction in both the number of patients treated as well as a reduction in our incomes. However, as we start our third year on the system, I am pleased to report that we have become more proficient, and we now see more patients than ever.

The benefits for our patients and physicians now include immediately available and legible office notes, laboratory data automatically entered into the system by the laboratory company, digital EKGs, and remote access to the entire record. We believe that this has improved the quality of our care, both for hospital-based as well as hospitalized patients.

Recently, the hospital we utilize announced that its emergency department was also implementing an electronic record, and they selected the same vendor that we utilize. This further promises to improve information flow and quality.

Our story is not unlike most practices that have made this transition. I recently had the opportunity to meet with several solo practitioners in southern Georgia, some of which also utilized EHR. The number one barrier to full implementation reported by these physicians was cost. Another area of concern includes the lack of a uniform standard between EMR vendors.

If a solo practitioner were to join another group, he could not integrate his old patient files into the new practice without a costly conversion process. Physicians also worry that the increased productivity offered by the system does not balance the additional cost.

Due to the nature of health care, certain specialties feel that EHR is not easily adaptable to their style of practice. However, despite these reservations, I feel that the benefits of IT in health care outweigh these risks. There are several options for fostering implementation in IT and health care. These include offering tax credits rather than deductions for IT implementation, and offering technology bonuses for practices treating Medicare beneficiaries that utilize IT.

The creation of a common standard for EHR companies would further enhance the portability of the public's health records. It is my belief that physicians want to adopt information technology into their practices, but simply allowing market forces to steer that change is not enough. Health care providers are feeling pressure more than ever, and assistance with this transition is greatly needed.

Thank you for the opportunity to testify.

[The prepared statement of Dr. Napier may be found in the Appendix on page 73.]

ChairmanGONZÁLEZ. Thank you very much, Dr. Napier.

I have been informed that we were going to have a series of votes, but they have been postponed. So we might have an opportunity to go uninterrupted this morning, which would be very nice.

One of the benefits of chair is I get to go first. That is kind of—which I enjoy quite a bit.

[Laughter.]

Dr. Leavitt, we have some prepared questions. And, generally, I go all over the place, but I am going to stick to this particular script, because I think there is some important information that we need to gather today. A critical step toward a national health information technology network will be some way to evaluate the systems themselves, and to ensure that they will not quickly become obsolete.

You have already heard the concerns expressed by the practitioners in different parts of our country. Small practices often do not have the financial resources, expertise, or time to perform extensive evaluations of the quality, the price, the support, ease of use, and impact on productivity of information technology systems.

Now, are you aware of any organizations, independent of your own, that is engaged in the practical evaluation of health information technology products sold by vendors today that might assist the physicians as they go through that process that has already been described by Drs. Kelley and Shober and Napier?

Dr.LEAVITT. This is a very good question. And as you know, we focus on part of that, which is the compatibility of the systems and the functionality. But we don't publish prices, and we don't do surveys of end users.

To my knowledge, there is no organization doing that with a public mission. It is being done commercially by consultants, but, unfortunately, that generally just adds to the cost of buying the system. In fact, sometimes part of the cost of buying the system is retaining a consultant to help you pick one.

So in terms of a way to efficiently help the physicians in a way that doesn't increase their costs, I am not aware of any initiative other than the certification initiative.

ChairmanGONZÁLEZ. So if I was a physician, and I was looking for some guidance, there is no really recognized organization that doesn't have a product or service to be marketing that I would be able to turn to.

Dr.LEAVITT. That is correct. Your professional associations, most of them—the American College of Physicians, the American College of Obstetricians and Gynecologists, the Family Physician Organizations—they are actually helping. But it is probably not appropriate for them to actually start selecting vendors and saying this commercial company is one that you should use, so I think they tend to steer away. They simply help educate their members. So what you are asking for doesn't exist as a—in the marketplace today that I know of.

ChairmanGONZÁLEZ. Thank you very much.

Questions for Dr. Kelley—small practices that are part of an integrated care system are more likely to adopt health information

technology than those that are not, help networks provide financial support, technical assistance, and legal protection. In your opinion, why are more small practices not part of an integrated care system? I know that you and your dad—and you know other practitioners, and they may be part of a greater group—if you understand my question, or I can try to clarify it.

Dr.KELLEY. Are you asking why—I guess if you could clarify, you are asking why small practices, individual practices, aren't in a larger network to help—

ChairmanGONZÁLEZ. Correct. Is it possible to—in other words, it is just you and your father. But is it possible to expand that with other of your colleagues to maybe minimize that cost?

Dr.KELLEY. I think that it really doesn't minimize the cost. It actually expands the cost. And I think that also it is just such—this is not widespread now, and there is such great hesitancy that it is not a real driving force right now for smaller practices to integrate, just for implementing information technology in the practices.

ChairmanGONZÁLEZ. The biggest barriers that you pointed out, first of all, was going to be the cost, just the cost to your and your father exceeding—was it $100,000?

Dr.KELLEY. $100,000.

ChairmanGONZÁLEZ. And yet you did that, and then you—I think the testimony or your experience was actually the same experience that the other physicians had, and that is that there is the learning curve, which means you have less time to tend to the physicians, you have a drop in the patient caseload, and obviously that translates to less income and such. That was your experience?

Dr.KELLEY. Correct.

ChairmanGONZÁLEZ. And having experienced that, I think the most telling sentence that you had was you still would not go back to the old system.

Dr.KELLEY. Correct.

ChairmanGONZÁLEZ. So it was worth the investment.

Dr.KELLEY. Yes, sir. It was quite worth the system. The practice three years later runs much more smoothly. You have everything in one resource. You don't have missing—as other physicians said, you don't have missing lab reports, you don't have missing charts.

Another point that I really, really love about the system is documentation of telephone calls with physicians and patients. Typically, you just don't—on call at night, you don't have documentation of that conversation with patients, and it becomes a bigger problem in larger groups where a physician is covering three or four other doctors. You just have no documentation of a conversation between a physician and patient, and all of those conversations can be documented within the patient's chart.

And also, laboratory follow-up. You have the laboratory—you have the results, you have the plan of care, and you have a checking point to make sure that the care was—the plan of care was carried out. And so you have checks and balances that you now have better control over and documentation of, and that improves safety for patients.

ChairmanGONZÁLEZ. I appreciate it.

My time is up, and at this time I will recognize the Ranking Member, Congressman Westmoreland.

Mr.WESTMORELAND. Thank you, Mr. Chairman.

Dr. Leavitt, you mentioned that your organization did not certify how the end user I guess, how this affects the end user. Don't you think that is an important part? And I guess the other part of the question is: do you look at the integration factor for all of these systems as how they would integrate with each other, or if they had that capability?

Dr.LEAVITT. Very good questions. So the first question is the user experience. We definitely have physicians and other users of these systems asking CCHIT if we could measure the usability of the systems and rate them. And it is right now a concept, but you have to be able to do this objectively. And sometimes what works for one physician doesn't work for another.

So usability of a system is not something that everyone agrees on how to measure. But we hope to be able to move into that. We do it in a crude way now, in that the systems are inspected. There are actually expert jurors, and one has to be a practicing physician. And they observe the system, and it has to go through a scripted demonstration. If it runs over a certain time limit, the system would not be certified. So that is a rough measure of usability.

Now, your second question, what are we doing about making sure that the systems integrate? That is actually one of our major roles is making sure that the systems are interoperable, and this year we are requiring that the systems can send prescriptions and refill prescriptions electronically, so you can't be certified if your system doesn't do that.

We also require that they can receive laboratory results. And I was talking to Dr. Shober before the session, and the laboratories are telling him, "We can't hook up to your system unless you pay us, because we have to customize it." That has to stop. It needs to be plug and play.

You buy the system, it connects securely, just as if anyone has used—so many systems on the web, whether those are personal finance applications that connect to your bank or your credit card and download the information securely, the physician system should be able to download the labs securely, transfer patient records securely, and we are pushing toward that. It will take several years, but we raise our criteria every year.

Mr.WESTMORELAND. Well, I think that is going to have to be a goal, because I can see where some small practitioners, when you start talking about investing $100- or $200,000, and it may not even be compatible or be able to be upgraded or—you know, that is a big investment to make, not having any security, especially just for a short term.

Dr. Napier, in your testimony, you said you implemented this information about two years ago. And just to give Mr. Leavitt some help, is there anything you would have done differently in looking at—in how you did it? Is there anything that you might suggest to some other practices, if they were going to do this today, different than what you did?

Dr.NAPIER. Well, as I testified, we spent about two years evaluating systems before we finally moved forward with a vendor, because of these issues that have already been listed out by the other experts here today. We really felt like we went with the best ven-

dor that we had available to us, and in looking back we would still choose the same vendor that we did.

However, I think that we would have spent more time—and as I mentioned, we spent a year before full implementation of the system after purchasing it. And two months of that was in customization of templates. A lot has been talked about templates here today, and we spent two months customizing templates.

And in retrospect, we should have spent about four months customizing templates, because once you go live with the system it is very difficult to put the additional time into going back and doing more customizing. And so we would have spent more time on the front end with customization.

Having said that, I think part of the certification process, it would be nice if we had specialty-specific certifications for various programs that are available, because many companies they are trying to sell as many products as they can. And many of them do not fit for certain specialties, and they are not going to tell you that up front. And it would be nice if we had an independent way of knowing which ones are appropriate for which type of practice and in which specialty.

Mr.WESTMORELAND. Just to follow up on that, you practice internal medicine.

Dr.NAPIER. That is correct.

Mr.WESTMORELAND. Would you be able to share your template with other internists that were going to get on an IT system? Would you be able to share that with them, or is that now the product of the vendor?

Dr.NAPIER. That is a product of the vendor, and what we end up doing is we create what are called test patients, and we build templates on these test patients, and we will often print these out and share them with other people that use our system to allow them to see how we did it.

But there is not a current way of simply sending that to a practice, for example, in Atlanta for them to integrate into their system.

Mr.WESTMORELAND. Thank you. I see my time is up. I will yield it back.

ChairmanGONZÁLEZ. Thank you very much, and the chair will recognize the gentleman from Pennsylvania, Mr. Altmire, for five minutes.

Mr.ALTMIRE. Thank you, Mr. Chairman.

Dr. Shober, as a rural practitioner, how has the health IT better allowed you to serve your patients? You just said a little bit, but if you could go into maybe some more detail on that with your practice. And do you feel that there are unique challenges for rural practitioners that health IT can help address above and beyond what we have heard from the witnesses today?

Dr.SHOBER. As far as the first question, our practice per se, we have one office which is in a township-type setting, the other is more rural. As I mentioned, we had a hard time obtaining a connection. We had to get a dedicated line with the telephone company, and there is no Internet access. It ended half a mile down the road one way and a mile down the road another direction.

So we bought the system, and then realized that, yes, we had to go to the local information sources, whether that be the telephone company, the cable network, and really negotiate with them to see how best we could be connected. Satellite really wasn't an option, security and all other measures being considered. That was definitely a challenge for that office.

But the nice thing about having the information technology available connecting these two offices live, patients often roam between offices. I mean, they are 12 to 15 miles apart, but they will show up at one on one day and go to another one the next day. And if they are sick driving down the road, they stop in.

And we are linked live right now, so we are able to pull up their record at the front counter when they walk in, address their issue, and know what happened at the other office yesterday, or what happened on the phone call this morning, if they called on a cell phone and spoke to a nurse at the other office on the way in.

So it has really helped us provide much better care, much better continuity of care. As far as the challenges for us in the setting that we are in, we are in a small town. We have one hospital. We have a number of outpatient labs that are national vendors. We have a few outpatient X-ray centers.

The information technology that we have in the office is nice, but, again, our problem is we need to be able to connect to everyone else. There seems to be a lot of apprehension out there in the community as far as the safety of connecting with someone else's software. We hear excuses of, well, we don't know if we could trust that vendor, or we don't know if it is going to cause us a problem running our system.

So I share some of the concerns that some of the experts here have brought forward. There has to be a standardization, so it—we are not on the island. We don't have a beautiful system in the office. We can't use it in the community, to be able to run this out through the community, expand it to the hospital, have a nice flow of information to help everyone.

Mr.ALTMIRE. That actually leads into my next question, and there does need to be widespread adoption of IT for it to be fully—for us to fully realize the benefits. If it is not widespread, then we are not going to see the implementation be beneficial.

So even with financial assistance, many doctors might be reluctant to change from traditional record-keeping. So do you have any thoughts of what methods beyond financial incentives that we would use to encourage doctors to adopt health IT?

Dr.SHOBER. From what I have seen in my experience, when we move from an old X-ray system at the hospital to a PAX or an integrated digital system, the only things that will move physicians oftentimes are deadlines.

And we have to—just like happened with Medicare and billing where you had to submit billing electronically, you have to say to the practicing physicians, "Listen, in X number of years, you need to move forward with this. In order to help you with this, we are going to incentivize you up front financially to help pay for the system, provide financial incentives as we move along." That would help pay for the education, help pay for the extra time in the office, help pay for that consultant to come in.

I think we have to move forward making all of the other media electronic. Cardiology is a good example. That is moving in the electronic direction; cardiology has moved forward in that direction.

When it comes to prescribing, we see a lot of resistance. We have a lot of small-town Mom and Pop pharmacies. They don't want to do it. They actually gave us a very hard time when we started to fax prescriptions to them electronically. We would fill a prescription in the system, and it would be sent to their fax machine, because that was the only mode of communication.

Some of them now complain that it was costing them money on the fax paper. In my mind, the benefit of handwriting inaccuracy is tremendous. But if we help move these other entities forward, then we are all going to move in that same direction.

ChairmanGONZÁLEZ. The chair is going to be recognizing members of the Subcommittee, and then Dr. Gingrey will be able to ask questions. But, first, I will recognize for five minutes of questioning my colleague and member of the Subcommittee, Mr. Jefferson from Louisiana.

Mr.JEFFERSON. Thank you, Mr. Chairman.

I think this is a very important hearing, and I appreciate the chance to participate. We, of course, in New Orleans were made to be well aware of this problem when we lost tens of thousands of medical records of citizens that were simply paper records when the storms came, and for the hospital system and private physicians' offices, all of it.

And had there been some way to electronically preserve these, they would have been somewhere out there safely tucked away in cyberspace in somebody's computer way outside of town. It would have made life a lot more simpler for physicians, and, of course, we would have had better outcomes for patients, especially those that have special issues like young cancer patients, and like people who had diabetic treatments, and all of these things that required so many repeat treatments.

But in any event, we recognize the need for it in our area I think more than most. I want to ask you this about—each of you has talked about developing standards for IT, for the use of IT, I guess for the standards with respect to systems and equipment and all the rest.

Who should develop these industry standards? I mean, should they come from us, should they come from the private—should we just enable the private physicians associations to do it, or should there be some other way that we come up with what we call standard? Because it all depends on who is writing the prescription for the things and who gets the business at the end of it. But how do we end up with the public purpose coming out of this that will just—so who should set these standards?

Dr.LEAVITT. There actually is an effort—and that is a very good question. Standards don't do much good if there is 100 different standards. There actually is already a very powerful effort to—the word is "harmonize" standards, and that is one of the initiatives that was launched in parallel with the Certification Commission.

There is a health information technology standards panel that is also under contract with HHS, and they basically organize—the standards are developed by groups called standards development

organizations, and they actually have to be accredited as such. But the problem is you have competing and conflicting standards, so this harmonization is done by this panel. And as I said, it is a parallel contract to our certification.

So when we test the systems, we make sure they comply with the accepted standard. They can't choose from 100 different standards to comply with. It is the accepted standard for transmitting prescriptions, or the accepted standard for receiving a lab result.

Mr.JEFFERSON. Should the Congress give any guidance with respect to how these standards ought to be arrived at?

Dr.LEAVITT. Congress needs to make sure that it is being done through a transparent and consensus-based process. I think it would be a mistake to try to legislate the details of a standard, because we need these standards to evolve and move forward, so that they can keep up with technology and with the needs of health care.

So I don't think you want to cast standards in law. You actually want to create an office that supervises the harmonization of standards, and you have that in Office of the National Coordinator.

And there is also the question of funding. The funding of these organizations is important. If you leave the funding to chance, then there are issues, because then standards become kind of a commercial football, and you really—they are a public good. And so I think federal funding to help develop the standards to fund the organizations is appropriate.

Mr.JEFFERSON. The other common grain that cuts through all the testimony is the issue of cost that a physician must incur to adapt to this new system. Someone has talked about credit, various other incentives. And there are also—there has also been some talk about credits for the industry representatives as opposed to the physicians.

Who should get the credits in this? If we should authorize credits, how deep should they be, if you have a suggestion that? Who should get the credits? Should there be some for industry? Should it be for the physicians? Or should it be for somebody else up and down the line? And how do you see this whole issue of incentives—having the credits apply not just to what you buy but also to training for physicians and training for staff?

Dr.KELLEY. I personally think that the credits ought to apply to who is expending the money to purchase it, so in practices I believe that it should be—the practice was the one that purchased the information technology. That practice should be able to have a tax credit.

And, furthermore, you have to keep—think about that you have the maintenance costs from here on out once you establish that. That is a tremendous expense for practices, and any tax relief from—that can be given for practices that make that investment would be greatly appreciated.

Dr.KIRK. I think credits, things like credits, tax credits, loans, and grants, for as we have heard the initial startup, which is so expensive, but I think our reimbursement system needs to take health information technology into account in an ongoing fashion to maintain these costs that we all have as we roll these out and con-

tinue on upgrading, training staff, changing our systems to incorporate those.

And I think that needs to be accounted for in the reimbursement system, that if you are using the technology—and I think we are reaching a tipping point here, and it will happen very quickly if some of these incentives can be built in, that it will be much easier for physicians to incorporate those into their practice.

Dr.NAPIER. Congressman Jefferson, if I may add also, if those credits are passed to the vendors, they already, as costs of some of the certifications that are presently there, those costs are simply passed on to the physician practices anyway in the form of the purchase price. And so whatever costs are going to be extra, in order to ensure interoperability, as well as whatever privacy concerns the government may have, those costs will be passed on directly to the physician practices that are implementing these.

And so it is my opinion, and I think most physicians' opinion, that whatever credits are going to be given by the government should be given to the ones who are actually purchasing those systems.

Mr.JEFFERSON. Mr. Chairman, if I might just clarify—I know that the time is up—I didn't mean—I understand what you're saying in that regard, but I meant with respect to having those in industry adopt standards and create the interoperability of this equipment, so that it works, you know, across the board, so that one doesn't necessarily have to exclude the other.

Dr.SHOBER. Can I address that real quickly? If, indeed we create independent systems, in order for them to operate and communicate with each other, I think if you set the standard, they must communicate with each other at no cost to the individual purchasing the system. That mandate alone will drive that industry to sit down and talk to each other.

And if they are going to maintain their licensure, which should be a mission for—we are assuming about paying a physician practice more, you would have to enroll within a licensed program. So you make that a mandate. If I want to buy a program, make it a licensed program. If it is going to be licensed, it has to communicate with everyone else. That way I am going to look at it before I buy it, and the industry itself will have to sit down and they will decide which language they are going to use to communicate or set those—set up those interfaces.

That doesn't fall to our laps. I don't have to understand why one can't talk to the other. Let us let the industry fix their own problem and set that as a condition.

Mr.JEFFERSON. That is what I am talking about. I appreciate that very much.

ChairmanGONZÁLEZ. Thank you. And, Dr. Shober, we are real sensitive to that particular concern, and Dr. Leavitt I know could discuss it with you at length, but we are very, very aware of that being a huge factor.

At this time, the chair is going to recognize our colleague from Georgia, who may not be a member of this Committee, but we welcome his input today, and that is Dr. Gingrey.

Dr.GINGREY. Mr. Chairman, let me first of all thank you, because I know it is not traditional that a guest is allowed the opportunity

to ask a question from the dais, and I really appreciate that courtesy. I am very happy to be here at the Small Business Subcommittee hearing on health information technology as a physician member.

I thank my colleague, Representative Westmoreland, as well for submitting my written statement for the record and for inviting Dr. Napier from his district in Griffin, Georgia.

I want to address my first question, though, to Dr. Leavitt in regard to the line of questioning between Representative Westmoreland and Dr. Napier in regard to the certification process and that it is—I think Dr. Napier recommended that maybe it should be specialty-specific. I think that is a very good recommendation, but Representative Westmoreland was asking you more specifically about what advantage was it, what information could physician groups, subspecialty groups, get from you in regard to the value of a particular vendor.

And you explained that very well, but can you tell us what the value is of a vendor being certified versus one that is not certified. I wanted to particularly ask that question.

And then maybe, Mr. Chairman, if you would indulge me, I have a follow-up question in regard to how to deal with the cost.

Dr.LEAVITT. Certainly. Thank you. The value of certification is that a physician office may not have to spend the one or the two years evaluating 10, 20, or more systems to determine which ones meet their needs. And when we certify a system, we inspect it against some 250 criteria of functionality, which is what it does and how it works; interoperability, how well it connects to other systems; and security, does it protect the information, does it require passwords, does it track every access in an internal audit log.

That would be a lot of work for every physician office to go through with all of these products. So we do it once, and they can all benefit from it at no cost to the physician office. That is really the value. At the end of our first year, we heard from the physician community, "We like this, but we want you to make it more relevant to us, so we want you to address our specialty or our setting, and we actually just announced a launch of an expansion."

So we are going to address professional specialties, which might be obstetrics, it might be cardiology, we are going to address settings—for example, the emergency department, it is not a doctor's office and it is not quite like the rest of the hospital, and we are even addressing populations.

And this is how we are addressing children, because children are not just cared for by pediatricians, they are cared for everywhere, so there are features in the products that should be there for the safety of children, checking the medication dose. It is very dangerous—

Dr.GINGREY. Dr. Leavitt, thank you. I don't mean to interrupt you, but my time is limited. But basically, what you might suggest, then, I guess to any of the three practicing physicians—OB-GYN, family practice, internal medicine—that are part of the witness panel is that maybe you ought to call Dr. Leavitt's office and find out if the vendor—the particular vendor who is in your office trying to sell you a product, are they indeed certified? Would you agree with that?

Dr.LEAVITT. Yes, we have published on the web a list of the certified products, and we have a communication effort to reach physicians everywhere and let them know that that's available.

Dr.GINGREY. Mr. Chairman, my last question before my time expires. In regard to the doctors in private practice—and you mentioned as an example it would be great if there were a tax credit. Now, let me just suggest to you that part of that problem is that we estimate that there are 400,000 physicians in this country who actually do not have electronic medical records systems, certainly not one that is fully integrated.

And if you gave a $1,000 credit, and Dr. Kelley was saying it was going to cost her and her dad $100,000 for a system, if you gave a $1,000 credit to each of those 400,000 physicians, you are talking about—I believe that would be about, if my math is correct, how many—would that be $40- or $4 billion? But what—in any regard, it is a lot of money. And it is not likely that we are going to be able to do that with all of the priorities we have on the taxpayer's dollars.

But what I want to let you know in my time remaining is that I have an idea, and I think it is a good idea, and it is called the Adopt HIT Act, Adopt Health IT Act. And basically what it would try to do would be to incentivize these 400,000 physicians. With the Tax Code, there is a Section 179, which now would allow any small businessman or woman, not just physicians, to write off $100,000, to take a tax deduction, not a credit, in the first year of an expenditure for a capital improvement like an electronic medical record.

And I think this is the way we need to go. We would expand that for the purchase of electronic medical records to $250,000 for, say, doctors in a nine-member group, if that is how much they spend. And then, they would also be able to rapidly depreciate other assets, capital improvements for their practice, also under Section 179.

So if there is any time permitted, Mr. Chairman, for them to respond to that, I would love to know what their opinion is on that.

ChairmanGONZÁLEZ. No. Go ahead. Please proceed. You all may respond if you have your own thoughts regarding that particular proposal. Dr. Shober?

Dr.SHOBER. My only thought with that would be, as with Dr. Napier here, in a larger group, if you have one corporate entity, if that tax credit is based on the single corporation, there would need to be some mechanism in there to allow for that greater cost. I know you mentioned the $250—

Dr.GINGREY. There is a mechanism in the bill to do that.

Dr.SHOBER. Okay. That way, if you have a larger group or there are groups of 30, 40 doctors on a system where it is much more expensive than mine, that credit would be able to roll through.

Dr.NAPIER. And I would echo that an expansion of the deductibility of the cost of these systems would certainly be a dramatic improvement over what we have now.

ChairmanGONZÁLEZ. Anyone else?

[No response.]

Thank very much, Dr. Gingrey.

Dr.GINGREY. Thank you.

ChairmanGONZÁLEZ. We are going to go into a second round of five-minute questioning, because we have that luxury, the few members that are remaining. I do have a couple of questions.

I guess in addressing Dr. Gingrey's proposal, which I would be supportive of, I think we just need to be creative and have a combination, as already—as has been touched on by Dr. Kirk in her presentation this morning, and in her written statement, that it should be a combination of assistance in grants, loans, taxes, and such.

The big thing, of course, is going to be Medicare, and the proposal there of course is simply that government is going to save a lot of money. It is a good investment for government, and I am approaching it from that particular standpoint.

Dr. Kirk, there was a revolution in the legal field when I was a lawyer when we went into—we replaced our libraries with CD-ROM, we went crazy, the old guys anyway. But I know this, that law students that were coming out of law schools and such, they were totally proficient on it. I mean, we were the dinosaurs.

But I did learn this, and that is Einstein once said that information is not knowledge, so you had a lot of information, not necessarily knowledge. But what are the medical schools doing? Because this is really important. It is preparing the doctors, introducing them into the technology, and advise them—and I don't even know if you do that particular aspect in the educative process.

Dr.KIRK. Right. I think we are very good at immersing them in the technologies that we have available at our academic health centers, which can be very variable. I think as the other doctors here mentioned, you remember the day that you switch to an EMR. Mine was October of 2004 in my health system at the University of Texas Southwestern Medical Center, because it is such a change in your life.

I also practice a significant amount of time at Parkland Memorial Hospital, and I must say we are not there yet, because Parkland is a public hospital. We are phasing it in, but we still—I was just in clinic yesterday with charts "this" thick. So what our students and residents get exposed to is variable, depending on the practice they are in, but we have all made a commitment to move in that direction as quickly as we can given the resources of the health care systems in which we practice.

It is an integral part or is becoming an integral part of teaching how staff—looking at clinical decision-making and health information technology. One of the core competencies that is now required for all residents training in the United States through the Accreditation Council for Graduate Medical Education is what we call systems-based care and practice-based learning, which seem real gobbledly-gooky.

But what that means is that we have information at our fingertips from the patient, and information from our fingertips—at our fingertips, like Dr. Kelley mentioned—clinical guidelines, evidence-based medicine, and how to practice, and we bring those together to make the best decisions for the patients.

So we are very facile at doing that, but we need to move more quickly and some of these resources will be helpful there, especially

for reimbursement for a place like Parkland to be able to make that investment.

ChairmanGONZÁLEZ. Thank you, Dr. Kirk.

And then, a question—Drs. Kelley, Shober, and Napier. You all made the decision to go ahead and purchase health information technology. I can't help but think that somewhere along in that consideration there may have been a discussion about maybe additional liability exposure as a result of this type of information that you are maintaining.

First of all, it is a new method, a new manner, you have guidelines, you have mandates, you have all sorts of requirements on privacy, for instance, but now you have it in an entirely different manner or form. That is one consideration. The other is just civil liability. Should you know a lot more, again, your exposure is out there. You have the benefit of the latest technology that would have kept you informed regarding the proper care for a patient.

All of that, the fact that you have a new method that you are utilizing, and somehow you have to apply all of the mandated governmental standards on privacy, and, in addition, the potential, just the potential that there may be greater exposure for you on the civil liability end, was there that discussion? And, obviously, it wasn't something that kept you from actually adopting HIT.

Dr. Kelley?

Dr.KELLEY. Well, in regards to the privacy issues, we are completely—at least in our practice we are dependent on the vendor stating that at the time when we implemented it is when the HIPAA laws were just coming into regulation, and so that was very important, that the vendor was HIPAA-compliant with those issues.

With the issue of patient privacy, one aspect of the system that is available that we decided not to was the ability for labor and delivery nurses to get into patient's prenatal records. And in our practice, we decided not to do that, just because—mainly because of patient privacy issues, that it just didn't seem secure enough to have whatever nurse was there, nurses change at the hospital, being able to get into a patient's prenatal record just to print it out.

So if we need a prenatal record at the hospital, only my father and I will print it out. The nurses—we do now allow the nurses to have accessibility to the patient's record.

ChairmanGONZÁLEZ. Dr. Shober?

Dr.SHOBER. Similar lines. When we initially put our system in—granted, we are wireless within the office, so we are always worried about wireless connectivity. Drug reps would come in, and they tell us they tried to break in and they couldn't. They are all wireless. They are connected all over the place.

So we had mainly the vendor, plus another consultant come by to make sure this place was fireproof and nobody could get in. As far as connectivity to the hospital, very similar to Dr. Kelley here, the only people that could access our records are myself and my partner. We are apprehensive about a free exchange between the ER physician when patient X comes in, or can they be given a code to get into my system.

Granted, we worry about them getting into that patient or another patient or that code being lost. I am very much behind the

development of some type of system whereby that free flow could take effect, where myself as the recordholder would not be held liable in the sense that Dr. X or the emergency department was given access to records on this patient, because they are a mutually cared for patient.

As soon as that patient walks in the ER, he is the patient of that doctor. We really need to give that doctor the opportunity to get all the information he can, whether it be from maybe my office, the X-ray department upstairs, or the lab medical records, whatever it may be, or even the next health system over where the patient was discharged from yesterday.

Again, this bears back to the free flow of information, but you worry about liability. The hospital itself is apprehensive about tying into other systems. Everybody sort of has their own little system, whether it be a larger entity, teaching hospital system, or a community hospital like the one I work in. You have to sit down at your computer, log into one or log into the other.

But, again, if you think about that ER concept, over the care and management of the patient, you need to be able to give that physician the capability to access the information.

ChairmanGONZÁLEZ. Thank you.

Dr. Napier?

Dr.NAPIER. You raise the question, Chairman González, about civil liability risk, and that is something that we were very concerned about, because, unfortunately, in the earlier EHR programs that were available, it looked very dry in terms of the interaction that you had with the patient. And not only in civil malpractice cases did they look at what you did, but, more importantly, why you did that. And that is the thing that is often lost in electronic records is the way, the discussion of why decisions were made.

And as I mentioned to you, we should have taken longer in our customization. That is exactly the thing that we are working continually on is enhancing the ability to integrate into our record the reasons behind the decisions that we are making in order to justify those.

ChairmanGONZÁLEZ. Thank you very much.

The chair recognizes the Ranking Member.

Mr.WESTMORELAND. Thank you, Mr. Chairman.

Dr. Kelley, on coding—and I am assuming that when you—if you are doing it electronically to get your reimbursements, whether it is Medicaid, Medicare—do you do Medicaid and Medicare?

Dr.KELLEY. Yes, sir, we do.

Mr.WESTMORELAND. Or if it is from Blue Cross Blue Shield or United Healthcare, or whoever it is from. Do you see your system, or does it work with all of those insurance—with all of the reimbursements?

Dr.KELLEY. No, it does not.

Mr.WESTMORELAND. Okay.

Dr.KELLEY. And this is an example of evolving technology. When we purchased the system three years ago, it basically was just an electronic medical record. It didn't integrate into the billing system that we have in the office or what you are asking to other insurance companies and things.

So right now, as it stands, it is now—the other aspect of it, to be able to even implement the electronic medical record we had to change the—purchase a new operating system that we use for patient scheduling and billing and all of that, to be able to integrate basically the appointments from the electronic medical record into the operating system for the office.

But still, that automatic billing process, if you see a patient that is coded and you file it with insurance, still, it is in place.

Mr.WESTMORELAND. Okay. And, Dr. Shober, did you find it similar? I mean—

Dr.SHOBER. What we had done—our system allowed us to start with the scheduling. We actually bought a system, a scheduling/billing EHR, with open ends to other possibilities. When we started to build that, we really have to add patient names. You can't work with it until everybody is in it. You have to build and add the names, and we started actually, before we used EHR, to build patient names and demographics.

This is a process of an active office where you have to add your existing patients to that roster. So from our sense it was a process, but it was internal within one system.

Mr.WESTMORELAND. Dr. Napier?

Dr.NAPIER. Yes, we purchased a system that includes both the practice management, which is in scheduling and billing, in addition to an EHR, and they are fully integrated with one another. Furthermore, old practice management software, we purchased an interface that allowed us to simply electronically transfer all of the demographics for our patients, so that our process was a little easier than it sounds like Dr. Shober's was, but that came at additional cost, though, to the practice.

Mr.WESTMORELAND. So can you bill Medicaid and Medicare, United Healthcare, Blue Cross Blue Shield, TRICARE, you are hooked up with them right now and can you get your reimbursements?

Dr.NAPIER. Every practice utilizes a clearinghouse to manage the claims, and so your claims are submitted at the end of each business day to a clearinghouse, and those clearinghouses then have independent contacts with all of our carriers. And so the answer to the question is, yes, it is fully connected, so at the end of each business day we simply enter in the charges and that goes to the clearinghouse, and it is done. and it has dramatically improved our turnaround time for reimbursement, I must add that.

Mr.WESTMORELAND. Well, that is good. A follow-up to what the Chairman asked about the privacy. You know, the HIPAA regulations that you have now, I would assume there has got to be some concern about these records getting out into cyberspace out there and somebody getting hold of all of them.

But has it affected your practice insurance? Do you get a break on it, or is it costing more because you have an IT program?

Dr.KELLEY. Actually, our medical malpractice insurer is Texas Medical Liability Trust. And when we implemented—after implementing the EMR, the malpractice insurance carrier came and did a site visit to make sure they had certain standards that they wanted in place, and after passing that inspection then we did get a discount on our medical malpractice.

Mr.WESTMORELAND. Ten percent? Five percent? One percent?

Dr.KELLEY. Oh, probably more like two, maybe two, three percent. Less than—anything helps, but it was—

Mr.WESTMORELAND. No, I understand.

Similar situation with you, too?

Dr.NAPIER. We did not get any break on our malpractice rates, and they are certainly higher now than they were when we implemented the system.

Dr.SHOBER. Likewise. We had no change. They continue to go up by the year.

Dr.LEAVITT. I think there are three or four malpractice insurers that are offering discounts of two to five percent. I had never heard of a 10 percent discount.

I have not heard, though, of any that increased their rates because of an electronic record. In general, they are associated with higher quality care, and less likelihood to forget something or lose track of a lab result. So they are generally associated with a decrease in liability, but the issue of privacy is still really an open question.

ChairmanGONZÁLEZ. I am happy to welcome my colleague again from the great State of Pennsylvania, and that is going to be Congressman Joe Sestak. And at this time, Congressman, you are recognized for five minutes for questioning.

Mr.SESTAK. Thanks, Mr. Chairman. I apologize I wasn't here. And if my questions are redundant, please, I will move on to the next.

I had been curious, have there been any cost-benefit studies done that are accessible to kind of try to see the tradeoffs between large medical providers versus small medical providers in terms of going into the IT and electronic health records?

I mean, the reason I am fairly interested in this is I have watched what the VA has done and been quite taken with it, sitting over there in the hospital and somebody calls in all of a sudden and I am sitting there and they are doing some checkup, and the doctor goes boom, boom, boom, yes, give her this, and then in seconds it is all done. I was quite taken with the efficiency.

But are there cost-benefit analysis studies on this, if that hasn't been asked already? Please.

Dr.LEAVITT. I don't know of formal studies, but it is generally accepted that the cost-benefit ratio, the return on investment is most favorable for the largest organizations.

Mr.SESTAK. Right.

Dr.LEAVITT. And least favorable for the smallest, and I will mention a few reasons why. This is why the VA, once it computerized, recognized an enormous benefit. The larger the organization, the more different places a paper chart can be. So there is an overhead cost. You know, one doctor office, generally you know where the chart is, generally, although there are still five or six places it can be.

In the VA, the chart could be in thousands of places, so you realize a savings on just managing and finding the paper. You also realize a savings on things such as transcription. Some doctors are able to stop dictating and start clicking or typing in a few notes, and that can be quite a savings. Again, if it is a small office and

it is the front office clerk who does the typing, you are not going to fire your front office clerk if you are not able to realize that benefit.

And, of course, the big system amortizes the fixed costs, like the server and the technical expert. So it is—the bigger the system, the more likely the return. That is why in the largest clinics, over 100, more than a third of them now have EHR, whereas in the solo offices probably fewer than 10 percent have EHR.

Mr.SESTAK. What would one think about, then, as the proper incentive to be able to move smaller ones towards this type of system which bodes so much I think? What are the right incentives to get them? I mean, if you don't have a cost-benefit analysis study done for the break-even point, so to speak—and I gather we don't for smaller ones—I understand the general concept, but what is the right incentive, then, to try to move—which I think our whole national health care has to move. But what is the right incentive financially to move them, do you have any ideas on that?

Dr.LEAVITT. Well, of course, that has been the topic of discussion here, and I think most of the witnesses have agreed multiple mechanisms, whether those be grants, loans, tax credits, tax deductions, and incentives, I would personally suggest that one of the most powerful is an actual incentive payment from Medicare, because anything Medicare does is instantly recognized and often flows out to the private sector.

So even though federal dollars are about half of health care, the other half tends to follow the federal lead. So if there were a bonus payment in Medicare for seeing a patient and using this technology, and eventually there might be a decrement for using paper, so that you're revenue neutral, it not only is a financial incentive, it sends a signal.

Mr.SESTAK. And one last—I am sorry. Please, Doctor.

Dr.KIRK. Just to add—and I think you alluded to this—in terms of the efficiencies, I think both for large and small practices, most of them aren't actually realized by the practice or by the physician. For example, if because you have access to the information you don't order something that has already been done, then that is—the payer saves for that, for not paying for that additional blood test.

And it is very hard for those savings to come back to the physician, because that is in a different bucket of money. So I think multiple mechanisms, depending on the size of the practice and depending on the way that technology is financed, is going to be most helpful to move the most people in that direction.

Mr.SESTAK. And I gather part of the—for the smaller practitioners—last question—is that part of the challenge, then, is not just the changeover, but I gather the administrative staff and the continuing cost of that?

Dr.KELLEY. Correct. One aspect—one additional cost that we now have is having service with a computer technology company. I personally don't—I mean, I never was a computer guru, so when the computers go down I don't have the knowledge to know how to fix it. So you have to have the company that comes in, since the—we call him the "computer dude"—to come in to figure out what is going on.

But it is now an additional expense that we have to have, because we have this technology that we didn't have before, and we don't really have a way to increase revenue to compensate for this cost.

Mr.SESTAK. Thank you. I am sorry to repeat the questions that you already had gone over. I just was so—I spent 31 years in the military, and then I went to the VA system, and I was just so taken by watching the efficiency, and then watching what happened with Katrina, that this bodes well for us. And I am sorry I wasn't here for the rest of it.

Thanks, Mr. Chairman.

ChairmanGONZÁLEZ. Well, thank you for your participation.

And I see that Congressman Altmire is back. We went through a second round of questioning, Jason. Is there anything that you want to ask at this point?

Mr.ALTMIRE. No.

ChairmanGONZÁLEZ. All right. The chair is going to recognize the Ranking Member.

Mr.WESTMORELAND. Thank you, Mr. Chairman, and I just want to close with this. Remember that when government gets involved in stuff, it tends to screw it up. And so what I would like to ask each one of you to do, and especially the doctors, go to your organizations, whether it is internal medicine or the OB-GYN, whatever it is, come up with some solutions and some ways that we can help you.

And I ask Dr. Leavitt the same thing, and Dr. Kirk, with your organizations to come up with what we can do to help you. When we think we are helping you, sometimes we are not. And so you will be better telling us what we can do to help you than—trust me, than us trying to help you on our own.

And that is all I had. Thank you.

ChairmanGONZÁLEZ. Thank you very much.

And, of course, here we go into the philosophical differences.

[Laughter.]

I think government can be an agent of change for good, and if we do it right and if we do it smart. And that is the whole purpose of this hearing. But I think that we recognize that government is going to have to get involved to some extent, whether it is the Tax Code or more aggressively and creatively, and just that we do it right.

But there is no doubt of the advantages that are there to be had by the adoption of health information technology. I applaud and commend the doctors that are here today, that before we had all the incentives in place, because it is going to get better, that you took the bold step. I think it makes you a better practitioner. I think your patients are the true beneficiaries.

And, again, this is going—unless we have anything further, this is going to conclude this hearing. The record will remain open for five days. I want to thank all of you for taking the time to be here. Continue to give us your suggestions.

I do believe we have to move forward. Government, in 1965, decided it was going to take a huge step in covering the medical needs of its population, and we are there today, and we are not going to be retreating from that. That is the reality. Now, let us

just figure out how we are going to do it, and do it where the best interests of all citizens are served.

Again, thank you, and this Committee stands adjourned.

[Whereupon, at 11:36 a.m., the Subcommittee was adjourned.]

STATEMENT
of the
Honorable Charles Gonzalez, Chair
Subcommittee on Regulation, Health Care and Trade of the
House Committee on Small Business
Hearing on
"Medicare's Reimbursement Cuts: The Potential Impact on Solo and Small Group Practitioners and the Businesses they Run""

I now call this hearing to order on "Medicare's Reimbursement Cuts: The Potential Impact on Solo and Small Group Practitioners and the Businesses they Run. "

The practice of medicine is changing. With the rise in managed care, increased insurance consolidation, and growing paperwork, small health care providers face many challenges. Complicating matters is that the physician graduate of today faces a much different business environment than in the past.

Today's hearing will address one of the next great challenges that could affect the small medical practice. In 2008, Medicare is scheduled to cut physician payment rates by 10 percent. These reductions will continue annually, and it is predicted that the total cuts will be about 40 percent by 2016. That could have a devastating impact on the operation of small medical practices.

The potential impact of these cuts must be considered in light of the fact that these medical practices function like any other small business and face low profit margins. Physicians are responsible for expenses like rent, payroll, employee health insurance and malpractice insurance. Beyond the Medicare cuts, these general business costs are expected to increase 20 percent in the next nine years.

Some may find the link between medicine and money objectionable, but the truth is that the current business model for the practice of medicine is not sustainable. At a time when more and more baby boomers are approaching the age of 65, some physicians have simply stopped accepting Medicare patients. Already, some practices lose money every time a Medicare patient is seen.

The problem of access to care will only grow if the Medicare cuts are not stopped. Some seniors are already faced with calling 20 to 30 providers in the desperate hope that someone will accept Medicare.

According to a recent survey by the American Medical Association, 60 percent reported that they would have to limit the number of new Medicare patients they treat due to next year's cut. Half would reduce their staff. Fourteen percent would "completely get out of patient care." That means these cuts in physician payments will affect everyone not just Medicare patients.

It is unlikely that the primary care shortage will improve in the near future, as Medicare reimbursement rates continue to be a primary driver of physician salary. Medical students, already burdened with an average debt in excess of $100,000, are clearly gravitating towards specialties.

According to *Center for Studying Health System Change*, incomes of primary care physicians fared amongst the worst in keeping pace with inflation between 1995 and 2003, while medical specialists fared the best. The report concludes that with "the diverging income trends between these specialties and primary care, the result is likely to be an imbalance in the physician workforce and perhaps a future shortage of primary care physicians."

The facts are clear. Medicare reimbursement cuts are a barrier to the successful operation of solo and small group practice. For many small practices, Medicare is the single most important source of revenue and is often used to extend or supplement charitable care to the uninsured and underinsured. Cutting Medicare's low reimbursement rates would result in many practitioners denying or limiting access to charitable care.

Medicare is an important component in America's health care system. It provides source revenue for physicians to invest in capital projects like Health IT, computers, and expand to offer necessary tests like mammography services, and other preventative screenings. It also enables small practices, particularly in rural and underserved communities, to extend the scope of their charitable services. Without it many of our nation's most vulnerable populations would receive no care.

The question is how we can reform the system to keep the small medical practice viable. There must be careful consideration to how those rates are developed and their impact on small practices. The panel before us today knows firsthand these challenges. Unfortunately, they may be put in a situation where they must deny access to care in order to keep their business running.

I would now yield to Ranking Member Westmoreland for an opening statement.

Opening Statement of
Ranking Member Lynn A. Westmoreland
Committee on Small Business
Subcommittee on Regulation, Healthcare, and Trade

"The Value of Health IT to Solo and Small Medical Practices"

Wednesday, March 28, 2007

Thank you, Mr. Chairman for holding this hearing today. I would also like to thank all of the witnesses for their participation. Mr. Chairman, I am glad this subcommittee's first hearing topic is one of such great importance, and I look forward to working with you on strengthening America's small businesses during our time together on this committee.

Today we live in the age of information. We have all become increasingly dependent on having things at our fingertips at a moment's notice. It is now difficult to remember a time without internet search engines, email devices fastened to our hips, or GPS navigation systems in our cars. However, this wave of technology has not yet been fully implemented in one of the world's most important industries, the healthcare industry.

While the science of medicine makes dramatic advancements almost daily, the method of managing patients' medical records has lagged far behind. This is why I am so glad to be here today to discuss this issue.

I think everyone involved recognizes the tremendous value Health Information Technology provides. Collecting patients' information in a more efficient, productive manner helps prevent medical errors and reduces paperwork. Minimizing these two factors improves the overall health care system, while also lowering costs. I applaud President Bush for his recognition of these benefits, and for his call for the widespread adoption of Electronic Medical Records (EMRs) within the next ten years.

Unfortunately, while these values are understood by all, the financial costs of implementing Health IT are felt by most, and for some, it can be the barrier that prevents establishing IT in their own practices. This is especially the case for smaller health care practices like the ones throughout my district in Georgia. Even after addressing the financial burden, in most cases, a small practice must still confront the complex state and federal laws that entangle all businesses.

There are many proposals focused on addressing these problems, most of which use some mixture of financial incentives and policy changes. Although there is no quick fix for a national implementation of Health IT, there is a considerable desire for it. For that reason, I believe that it is important that we take as many ideas into consideration as possible, in order to make the best decision for our health care system.

This Congress faces a great challenge as it tries to lower the overall cost of health care. I am hopeful that the work of this subcommittee will do its part in answering this challenge.

I welcome this distinguished panel, and thank you all for your willingness to testify.

STATEMENT FOR THE RECORD

OF THE

AMERICAN COLLEGE OF PHYSICIANS

TO THE HOUSE COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON REGULATIONS, HEALTHCARE AND TRADE

"The Value of Health IT to Solo and Small Medical Practices"

March 28, 2007

The American College of Physicians (ACP) -- representing 120,000 physicians and medical students -- is the largest medical specialty society and the second largest medical organization in the United States. Internists provide care for more Medicare patients than any other medical specialty. Of our members involved in direct patient care after training, approximately 20 percent are in solo practice and approximately 50 percent are in practices of 5 or fewer physicians. We greatly appreciate Subcommittee Chairman Charles Gonzalez and Ranking Member Lynn Westmoreland for focusing attention on the barriers solo and small health care practices face in adopting health information technology.

ACP strongly believes the goal of widespread adoption and use of health information technology will only be successful if we first recognize the complex issues surrounding financing, assistance with redesign of practice workflow, and ongoing technical support and training. We believe Congress has an important role to play in these areas, particularly for physicians in solo and small practices, to support the goal of transiting to a paperless office.

Background

The Institute of Medicine's (IOM) 2001 Report, "*Crossing the Quality Chasm – A New Health System for the 21st Century*," suggested that up to 98,000 Americans die each year as a result of medical errors. The report introduced the notion that many of these lives could be saved through advantages of information technology. The IOM report cautions, however, "In the absence of a national commitment and financial support to a build a national health information infrastructure…the progress of quality improvement will be painfully slow."[1] Since then, numerous studies and other policy experts have confirmed

[1] Institute of Medicine, *Crossing the Quality Chasm – A New Health System for the 21st Century*, March 2001, and U.S. Department of Human Services, Information for Health: A Strategy for Building the National Health Information Infrastructure, Report and Recommendations from the National Committee on Vital and Health Statistics, November 15, 2001.

that full adoption and utilization of health information technology (HIT) can revolutionize health care delivery by improving quality of care and reducing high medical costs.[2]

Despite all the positive claims about the value of HIT, however, few physician practices are able to afford the substantial initial capital, or afford the lifetime of costs associated with training and maintaining the technology. According to a 2006 review by the Robert Wood Johnson Foundation, only between 13 to 16 percent of solo practitioners were able to adopt HIT.[3] The National Ambulatory Medical Care Survey (NAMCS), an annual, government-funded, nationally representative survey of all ambulatory visits to physicians whose practices are not hospital-based, recently added questions about Electronic Health Record (EHR) use. While they found that 23.9 percent of physicians were using EHRs, further analysis to physicians who had at least four of the key functionalities of an EHR, as identified by the IOM, adoption rates drop to only 9 percent.[4] Similar studies conducted since 2003 have also shown a steady increase in the rate of adoption, but solo and smaller practices have been slowest among all groups to adopt.[5] The substantial cost of acquiring the equipment is the most-often cited reason.

Meanwhile, the Administration has taken initial steps to advance the adoption of a HIT. The most significant commitment was made by President Bush in April 2004 calling for the widespread adoption of interoperable electronic health records within the next decade. To oversee this bold ten-year initiative, the President announced the creation of the Office of National Coordinator for Health Information Technology (ONCHIT). ONCHIT followed with an ambitious 10-year funding strategy for policymakers to consider in speeding HIT adoption nationwide. According to ONCHIT's "Framework for Strategic Action," *Congress should consider several funding options, including additional Medicare reimbursement as well as the use of loans, tax credits, and grants.* Since that time, however, Congress has introduced dozens of bills to begin to mold the framework for adopting HIT infrastructure. Unfortunately, no single bill has made it out of both Houses, making the President's 10-year goal seem out of reach.

ACP strongly supports efforts by those in the Administration and the Congress to speed the adoption of uniform standards for health information technology. The College is committed to providing its own members with practical tools to help them improve quality. ACP's Physicians Information and Education Resource (PIER) provides ACP members—at no cost to them—with access to "actionable" evidence-based guidelines at the point of care for over 300 clinical modules. PIER has also been incorporated into several electronic health record systems. PIER is also creating paper order sets that imbed such quality measures so that physicians who have not made the transition to

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[2] A 2005 RAND analysis estimated that national adoption of the EHR could lead to between $81 billion and $161 billion in annual savings.

[3] The Robert Wood Johnson Foundation (2006), Health Information Technology in the United States: The Information Base of Progress, chapter 3, p. 26.

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

[5] Jha, Ashish K., Ferris, Timothy G., et al., "How Common Are Electronic Health Records in the United States? A Summary of the Evidence," Health Affairs, web exclusive October 11, 2006.

electronic health records could still utilize PIER content to support their participation in performance measurement initiatives. ACP's Practice Management Center has developed resources to help internists in the decision-making process on electronic health records and is leading an initiative to provide internists with tools and best practices to help them redesign their office processes to improve health care quality.

We also believe, however, that physician practices will not be able to do this alone. Without sufficient financial assistance from the federal government, particularly to those in solo and small medical practices, we will be unable to achieve a smooth transition into a fully-integrated HIT society. **Therefore, we believe it is absolutely essential for Congress, as a first step, to begin to offer targeted financial assistance programs to fund HIT in solo and small medical practices. Solo and small practices, in particular, need financial assistance for the initial start-up costs of acquiring the technology, but also financial recognition of the ongoing costs.**

The Importance and Benefits of HIT

While there is no universal definition of HIT, consensus seems to be building around several key components. Some of the more accepted components include the following items: Electronic Health Records (EHRs); the ability to exchange electronic information across organizations (referred to as "interoperability"); and disease surveillance. Within the EHRs, the IOM offers the following elements: (1) a longitudinal collection of electronic health information for and about persons, where health information is defined as information pertaining to the health of an individual or health care provided to an individual; (2) immediate electronic access to person- and population-level information by authorized, and only authorized, users; (3) provision of knowledge and decision-support that enhance the quality, safety, and efficiency of patient care; and (4) support of efficient processes for health care delivery.

Despite the many components of HIT, the potential benefits are likely to be substantial. The most-often cited benefits include: avoidance of medical mistakes, storage and preservation of medical data, avoidance of medical errors, reductions in malpractice premiums, and improved quality outcomes.[6]

- *Medical mistake avoidance*: The use of clinical-decision support tools at the point of care has the potential to offer a tremendous advantage to both physicians and their patients. Examples of this benefit include alerts about vaccinations and anti-coagulation reminders, diabetes, hypertension, vitamin B12 deficiency, thyroid and anemia screening in the elderly, health maintenance and preventive care measures, etc.
- *Storage of Other Encounter Data*: An often-cited example is the disappearance of paper medical records and charts following Hurricane Katrina. Having medical data stored electronically assures the safe keeping of complete medical histories

[6] Sidorov, Jan, "It Ain't Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs," Health Affairs, Vol. 24, No. 4, July/August 2006.

that can be difficult to duplicate from memory. In addition, where patients become incapacitated, storage of the data can be critical.

- *Medication Error Avoidance*: The use of EHRs has the potential to reduce medication errors substantially. The 2001 IOM report cited medical errors as the most common medical mistake. The use of electronic prescribing offers promise because it eliminates problems with handwriting legibility and, when combined with decision-support tools, automatically alerts prescribers to possible interactions, allergies, and other potential problems.

- *Malpractice Reductions*: It is also widely believed that the reduction of errors and medical mistakes will lead to fewer lawsuits and a reduction in malpractice premiums. While insurers have yet to link the usage of certain HIT equipment to a reduction in premiums, we believe the evidence is clear that HIT reduces malpractice claims.

- *Quality Improvements*: All the above factors, coupled with a reduction in duplicative care, the lowering health care administrative costs leading to lower health insurance rates, and reducing hospital admissions will lead to better patient outcomes.

Privacy and Security Concerns

ACP has long recognized the need for appropriate safeguards to protect patient privacy and security. We believe that trust and respect are the cornerstones of the patient-physician relationship and to quality health care. We further believe that these attributes will enhance treatment by restoring confidence in the health care system. ACP recognizes that patients have a basic fundamental right to privacy that includes the information contained in their own medical records – whether in paper or electronic form.

We strongly believe that physicians -- already governed by strict ethical codes of conduct, state professional disciplinary codes, and the Hippocratic oath -- who collect protected health information have a duty and responsibility to protect patients from violating their privacy. Patients need to be treated in an environment in which they feel comfortable disclosing sensitive and confidential health information to a physician they can trust. Otherwise, there may be a "chilling effect" for patients to fully disclose the most sensitive of information (conditions or symptoms), thereby reducing the effectiveness and timeliness of treatment, or, they may avoid seeking care altogether for fear of the negative consequences that could result from disclosure. Patients must have assurances that adequate firewalls against unauthorized individuals gaining access to sensitive data is in place. Congress must ensure these safeguards are present.

Financial Barriers

The single greatest barrier to achieving fully interoperable HIT across the nation is the substantial cost in acquiring the necessary technology. This obstacle is especially acute for physicians practicing in solo and small office settings, where three-fourths of all Medicare recipients receive outpatient care.[7] The initial start-up costs for the purchase of a fully interoperable HIT system can be substantial. **Depending on the size of the practice and its applications, acquisition costs on average $44,000 per physician. The average annual ongoing costs are about $8,500 per physician.**[8] The ongoing costs associated with training, productivity losses, maintenance and upgrades, and system support of the HIT system make the investment in HIT a financial commitment over the lifetime of the practice. For many physicians, the "business case" does not exist to make this kind of capital investment.

An additional related barrier is that savings from interoperable HIT will largely go unrecognized for those physicians making the initial and lifetime investment to convert their practices. In other words, public and private payers -- not the physicians -- will realize the savings from physician investment in acquiring the necessary HIT. The savings will come in the form of a reduction in duplicative care, the lowering health care administrative costs leading to lower health insurance rates, avoiding costly medical errors, and improving quality outcomes and reducing hospital admissions. **Therefore, ACP strongly believes that physicians' collective and individual contributions must be recognized in order to achieve Medicare and Medicaid savings through HIT adoption. Current reimbursement policies should allow for individual physicians to share in the system-wide savings that are attributable to their participating in HIT and other quality improvement programs.**

While the College and the physician community recognize the great potential for improving the overall quality of care that HIT brings, the majority of solo and small practices cannot afford to expend the necessary capital to make the initial investment. For physicians dealing with a multitude of financial issues – ranging from low reimbursement under Medicare and Medicaid, declining fees from managed care, the rising costs of medical malpractice insurance, and the cost of compliance under increasing state and federal regulation – the majority are not in any financial position to make the per physician initial $44,000 investment or commit to the ongoing annual $8,500 cost.

Even for those physicians who able to afford the initial costs, many challenges await. As described in the August 2, 2005 *Annals of Internal Medicine*, the conversion to electronic medical records impacts a practices finances, productivity, and office environment. According to the authors of this 4-internist medical practice in Philadelphia, Pennsylvania:

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[7] Center for Studying Health System Change, "Most Medicare Outpatient Visits Are to Physicians With Limited Clinical Information Technology," July 2005.

[8] Miller, Robert, West, Christopher, et al., :The Value of Electronic Health Records in Solo or Small Group Practices." Health Affairs, Vol. 24, No. 5, September/October 2005.

> "Its financial impact is not clearly positive; work flows were substantially disrupted; and the quality of the office environment initially deteriorated greatly for staff, physicians, and patients. That said, none of us would go back to paper health records, and all of us find that the technology helps us better meet patient expectations, expedites many tedious work processes (such as prescription writing and creation of chart notes), and creates new ways in which we can improve the health of our patients."

The experience of this small practice is not atypical. While this practice should be commended for weathering the myriad of challenges in adopting EHRs, Congress needs to recognize that most physician practices are not financially positioned to absorb the many hardships that lie ahead.

The Need for Congressional Involvement

The current Medicare physician reimbursement system, the Sustainable Growth Rate (SGR), does not reward physicians for quality or the use of HIT. Because physicians are paid on a per-procedure or per-service basis, the Medicare reimbursement structure emphasizes volume over quality. In recognition of the need for a Medicare reimbursement system that rewards innovation and quality, Congress is examining the role that reporting on approved quality measures might play in the Medicare program. Meanwhile, physicians are facing an estimated 9.9 percent payment cut in January 2008. This continuous threat of payment cuts deprives physicians of the resources needed to invest in HIT and quality improvements. Therefore, the SGR should be repealed and replaced with a system of payment that is more predictable and keeps pace with the actual cost to provide medical care.

ACP strongly believes a solution to this problem lies in changing the Medicare physician payment policies to reward physicians who incorporate either some or all aspects of HIT and participate in reporting on endorsed performance measures.[9]

As a first step, the College recommends Congress consider legislation that builds into the Medicare physician payment system an add-on code for office visits and other evaluation and management (E/M) services. The amount of the add-on should relate to the complexity of HIT adopted by the practice. This approach would more fairly recognize the lifetime costs associated with maintaining such systems. This payment mechanism should identify that a service was facilitated by electronic health data systems, such as electronic health records, electronic prescribing and clinical-decision support tools, and/or the use of a patient registry, and reimburse the physician accordingly.

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[9] Similar to the Bridges to Excellence program which provides physician offices with a bonus of up to $50 per patient per year if they have certain systems in place to improve quality care.

As a second step, Congress should also allocate the necessary funding for solo and small practices to make the *initial* HIT investment to purchase the necessary hardware and software. The majority of bills that have been introduced in the last Congress included the option of grants, loans, tax credits, or a combination of the three. We believe those funding mechanisms, coupled with a Medicare add-on, are sufficient to put the necessary HIT systems into the hands of solo and small physician practices. We believe the offering of SBA loans, which what the Small Business Committee has jurisdiction over, is an appropriate mechanism to accomplish this goal.

As a third and final step, we and many others believe that HIT alone will not lead toward full recognition of the potential benefits that include improved quality and better outcomes.[10] We believe that directly linked to the use of HIT should be the concept of organizing care around primary and principal care. This model, called the "medical home," is based on the premise that the best quality of care is provided not in episodic, illness-oriented care, but through patient centered care that emphasizes prevention and care coordination.

Attributes of the medical home include promotion of a personal relationship with your physician who knows your medical and family history. Physicians in the medical home practice are responsible for working in partnership with patients to help them navigate the complex and often confusing health care system. They provide the patient with expert guidance, insight and advice, in language that is informative and specific to the patient's needs. In the medical home, patients will have a personal physician working with a team of health care professionals in a practice that is organized according to the needs of the patient.

ACP envisions that qualified practices will have the following kinds of services in place:

- Primary care physicians who practice in a medical home would be responsible for partnering with the patient to assure that their care is managed and coordinated effectively;

- The practice would use innovative scheduling systems to minimize delays in getting appointments;

- Physicians in the medical home would use evidence based clinical decision support tools at the point of care to assure that patients get appropriate and recommended care;

- They would partner with patients who suffer from with chronic diseases, like diabetes, better understand and manage their own conditions to prevent avoidable complications. Patients would have access to non-urgent medical advice through email and telephone consultations;

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[10] Sidorov, "It Ain't Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs."

- The practice would have arrangements with a team of health care professionals to provide a full spectrum of patient-centered services; and

- Medical home practices will also be accountable for the care they provide, by using HIT to provide regular reports on quality, efficiency, and patients' experience measures.

Dr. Jaan Sidorov, an associate in the Department of General Internal Medicine, Geisinger Medical Center in Danville, Pennsylvania, recently wrote in *Health Affairs*:

> "Patient-centeredness, shared decision making, teaming, group visits, open access, outcome responsibility, the chronic care model, and disease management are among the proposals intended to transform medical practice. The EHR's greatest promise arguably lies in the support of these initiatives, versus the prospect of less efficiency, greater cost, inconsistent quality, and unchanged malpractice burdens resulting from a simple engraftment onto the current health care system."[11]

Of course, all three of these innovative ways of assisting physicians will come at a cost, so Congress should seek to reform the scoring models used by the Congressional Budget Office (CBO) to more accurately reflect the anticipated savings from efficiencies and cost savings that will result from the use of HIT linked to coordination of care, prevention, and other quality initiatives.

Legislation in the 109th Congress

In the 109th Congress, a flurry of legislative proposals were introduced that tried to define the federal role in speeding the adoption of HIT. ACP was supportive of many of the bills that came forward, especially of those that we believed would place the emphasis on the greatest need: those in solo and small physician practices.

The College was particularly supportive of the bipartisan bill, H.R. 747, the "National Health Information Incentive Act," sponsored by Reps. Charles Gonzalez (D-TX) and John McHugh (R-NY), because it specifically targeted those solo and small physician practices who are in need of the most financial assistance. Like most of the legislative proposals introduced, H.R. 747 sought to offset the initial start-up costs of acquiring interoperable HIT systems by providing grants, loans, and refundable tax credits. But more importantly, the legislation would have built into the Medicare physician payment system an add-on code for office visits and other evaluation and management (E/M) services, care management fees for physicians who use HIT to manage care of patients with chronic illnesses, and payments for structured email consults resulting in a separately identifiable medical service from other E/M services. Under the Gonzalez bill, these fees would be triggered if the procedure or service was facilitated by an electronic health data system (such as electronic health records,

[11] Sidorov, "It Ain't Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs."

electronic prescribing and clinical decision support tools) when used to support physicians' voluntary participation in performance measurement and improvement programs.

In addition, the College was also strongly supportive of the bipartisan bill, S. 1227, the "Health Information Technology Act," introduced by Sens. Debbie Stabenow (D-MI) and Olympia Snowe (R-MA). Like the Gonzalez-McHugh bill, S. 1227 included one-time tax credits and grants for the purchase of HIT as well as Medicare physician payment changes that recognize the ongoing costs in maintaining HIT by authorizing adjustments to Medicare payment when an identifiable medical service is provided using HIT. We supported these approaches because we believe that recognition of the ongoing costs is absolutely essential to making the "business case" for those in solo and small practices to make the capital investment.

In summary, the College strongly believes Congress should provide the necessary funding to offset the initial costs in obtaining HIT, but it should also recognize the unquantifiable and ongoing costs in utilizing HIT. It is this combination of *one-time* and *on-going* financial incentives put forward by H.R. 747 and S. 1227 that, we believe, will substantially speed HIT adoption and improve access to physician practices with HIT, resulting in tremendous system-wide savings. **Only when Congress begins to recognize the collective and individual contributions of physicians will we begin to achieve savings through the adoption of HIT. Therefore, we believe funding initiatives should allow for individual physicians to share in the system-wide savings that are attributable to their participating in HIT and other performance measurement and improvement programs.**

Conclusion

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

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Health IT in Medical Practices: The Need, the Barriers, and How the Government Can Encourage Adoption

Statement by

Mark Leavitt, MD, PhD
Chair, Certification Commission for Healthcare Information Technology (CCHIT)

Before the

UNITED STATES HOUSE OF REPRESENTATIVES
Committee on Small Business
Subcommittee on Regulations, Health Care and Trade

Hearing on
"The Value of Health IT to Solo and Small Medical Practices"

Washington, DC
March 28, 2007

Introduction

Mr. Chairman, Mr. Ranking Member, and distinguished Members of the Subcommittee, thank you for inviting me today. My name is Mark Leavitt, and I am here in my capacity as Chairman of the Certification Commission for Healthcare Information Technology (CCHIT), an independent, nonprofit organization with the mission of accelerating the adoption of health IT.

The topic of health IT in small practices has been a focus of my professional efforts for many years. When I started solo medical practice 25 years ago, I saw that paper-based recordkeeping would be inefficient for me and dangerous for my patients, so I created one of the first electronic medical record programs for myself. From those beginnings, a career and a business evolved. Yet today, 25 years later, fewer than 1 out of 10 small practices have fully electronic health records (EHR).[1] Today, I will review the need for this technology, examine the barriers to its adoption, and conclude with a discussion of possible ways the federal government can help overcome these barriers.

Health IT in Small Medical Practices: The Need

While hospitals have the most visible buildings, and transplant surgeries make the most headlines, physicians in their office practices quietly go about delivering the majority of health care to the American people. Most office practices are small businesses, with 75% of all US physicians practicing solo or in a group of 5 or fewer.[2]

Almost all physicians today are fully computer literate, going online to manage their finances, arrange travel, or read publications. Yet, when managing patient information, they take a big step backward in time, with their patients' records kept in paper-filled folders. Prescriptions are written by hand, without any automatic error-checking. Without the benefit of computerized reminders, Americans are only receiving 50% of the generally accepted treatments and preventive measures they need.[3] And with thousands of paper charts filed on shelves, there is no way to quickly search out patients whose drugs have been recalled, or to generate meaningful reports on the effectiveness of care.

Besides addressing these quality issues, the Center for Information Technology Leadership estimates that computerized ordering technology in ambulatory care could save $44 billion annually.[4] Once electronic health records are connected together through a network, an additional $78 billion could be saved every year.[5]

The Barriers to Adoption of Health IT

With obvious benefits for the quality of care and such large potential cost savings, why does IT adoption in medical practices lag so far behind other business sectors? The dominant barriers are *cost* and *risk*.

Purchasing a comprehensive electronic health record system, including hardware, software and training, costs $15,000 - $50,000 per physician.[6] The smallest practices

experience the highest of those per-physician costs because of their limited ability to amortize fixed expenses. The return on this investment is also lowest for small practices, with most of the cost savings (89% by one estimate) accruing to health care payers, not to the practice.[7] Except for a few pilot IT incentive programs, the healthcare payment system provides *no additional reimbursement* to physicians for employing EHR technology.

Besides costs, small physician practices face significant *risks* when moving to electronic records. Many have made serious mistakes when selecting and implementing these products, sometimes losing their investment and even threatening the financial stability of their small businesses. Finally, the risks to patient privacy when computer systems are inadequately secured are becoming all too familiar.

How the Government Can Accelerate Adoption of Health IT in Small Practices

President Bush called attention to this situation in 2004, appointing the first National Coordinator for Health IT. Dr. Brailer noted the IT *adoption gap* that was leaving small practices behind, and launched initiatives to address the problem. The Secretary of HHS, Mike Leavitt, has made health IT one of his major priorities, creating an advisory committee and workgroups that are now actively addressing many health IT challenges.

In September 2005, the Certification Commission for Healthcare Information Technology, which I chair, was awarded a 3-year contract by HHS, and initially tasked

with reducing the barriers faced by office practices. Certification of EHR products is expected to help these practices in four ways:

- First, by reducing the risk they face when purchasing health IT
- Second, by ensuring that the systems they buy are *interoperable* – in other words, compatible with other systems so data can be exchanged electronically
- Third, by enhancing the availability of financial incentives and regulatory relief
- Fourth – and perhaps most critical – by ensuring that these systems will be secure, thoroughly protecting the privacy of personal health information

Even though certification was launched less than one year ago, there are signs of success. By establishing transparent, fair and balanced decision-making processes, CCHIT has gained the confidence of its stakeholders. In just 9 months, 57 office-based EHR products have been inspected and certified, providing a wide selection of qualified systems for medical practices to choose from. Incidentally, over 70% of these products are from vendors that are themselves small businesses. Several payers are now offering financial incentives to physicians for EHR adoptions, keyed to certification. And several health information networks are relying on certification to ensure that physician office systems have adequate security to receive confidential data.

Besides CCHIT, there are complementary components in the administration's strategy. Other contractors are harmonizing standards, clarifying privacy policies, and architecting a national network to allow secure exchange of health information. For this momentum

to continue, it is critically important that adequate funding be continued for the Office of the National Coordinator as well as these projects.

Recent industry surveys have shown the adoption of health IT to be accelerating, with the small office segment predicted to enjoy the fastest growth. In considering legislation, it would be important to build on this momentum and not disrupt it by sending confusing signals to the industry. For example, simply giving health IT to doctors falls short; without deep commitment by staff to the hard work of training and implementation, the equipment ends up on a shelf. In my experience, the most effective policy would be to restructure physician payments to include an incentive – first, for IT adoption, and subsequently, for using that IT to measure and improve quality. The Medicare Physician Voluntary Reporting Program (PVRP), which offers a 1.5% bonus for reporting certain quality measures, is a step in the right direction, but too small in magnitude -- by a factor of 5 to 10 -- to impact an office's IT buying decision.

Conclusion

To sum up, health IT offers enormous potential quality and cost-saving benefits, but small physician offices which are the mainstay of our healthcare delivery system are lagging badly in adopting it. A strategic Federal initiative launched in 2004, including certification of health IT products for medical practices, is showing positive results. Legislation offering financial incentives to small offices, tied initially to their adoption of

certified health IT and later to demonstrated quality improvement, could build on this momentum successfully.

Mr. Chairman and members of the Subcommittee, thank you for your time. I would be pleased to answer any questions you have.

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[1] George Washington University, Massachusetts General Hospital, Robert Wood Johnson Foundation: *Health Information Technology in the United States: The Information Base for Progress.* P 4-36, Sept 2006. Accessed at http://www.rwjf.org/files/publications/other/EHRReport0609.pdf
[2] Ibid, p4-37.
[3] McGlynn EA, Asch SM, Adams J, et al: The quality of healthcare delivered to adults in the United States. *New Engl J Med.* 348(26): 2635-2645, June 26, 2003.
[4] Center for Information Technology Leadership: *The Value of Computerized Provider Order Entry in Ambulatory Settings,* March 2003. Accessed at http://www.citl.org/research/ACPOE.htm
[5] Walker J, Pan E, Johnston D, Adler-Milstein J, Bates DW, Middleton B: The Value Of Health Care Information Exchange and Interoperability, *Health Affairs* (Web exclusive) W5-10, Jan 2005.
[6] Kilo, CM, Leavitt, M: *Medical Practice Transformation with Information Technology.* P 29, June 2005.
[7] Walker, op. cit.

Testimony of Dr. Margaret Kelley
On Behalf of the American College of Obstetricians and Gynecologists

Submitted to the
U.S. House of Representatives
Committee on Small Business
Subcommittee on Regulations, Healthcare and Trade

March 28, 2007

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Chairman Gonzalez, Ranking Member Westmoreland, and all of the Members of the House Committee on Small Business Subcommittee on Regulations, Healthcare and Trade, thank you for inviting me to share my experience in converting my ob-gyn practice from paper records to electronic medical records (EMR). I am speaking today both from my own experiences as a physician with a small practice and on behalf of the American College of Obstetricians and Gynecologists (ACOG) and their 51,000 physicians and partners in women's health.

My father, Dr. Harmon Kelley, and I operate a two-physician practice, Southeast Ob-Gyn Associates, P.A., in San Antonio, TX. Our practice has about 14,000 patient visits and delivers approximately 300 babies a year. In 2004, we made the decision to convert our old, paper record system to an EMR system. I am grateful that our practice decided to convert to an EMR system, but our three-year journey has been fraught with challenges. Upgrading our system required making a significant upfront investment, facilitating intensive staff training, and reducing the number of patients we were able to see during the nearly two year start-up phase. The difficulties that my father and I encountered are the same ones frequently cited by small practices across the country when implementing new health IT systems.

We decided to move to an EMR to make our office a more efficient and productive environment. Also, given the litigious environment that surrounds the practice of obstetrics and gynecology, my father and I wanted to make sure that we were able to document everything we do in our practice for legal reasons. An EMR would allow us to keep a much more comprehensive and legible record than our paper-based system did.

Implementation of our EMR was challenging, costly, and time-consuming, and required everyone in our office to think in new ways. Three years ago, our office was primarily a pen and paper operation. The transition to a fully-integrated, electronic recordkeeping system greatly upset the way in which our staff, my father and I, had learned to function within the general workflow of our practice.

The initial cost of upgrading our practice to an EMR system was about $100,000, or $50,000 per physician. My father and I had to carefully weigh the pros and the cons of purchasing such an expensive system, but ultimately decided that it was an investment we had to make so we could better meet our patients' needs. In addition to these upfront costs, we pay a quarterly maintenance fee to receive all of the technical support and software upgrades that an electronic system requires.

On the initial start-up, we lost many patient care hours while training our staff of ten, including my father and myself, to use the new system in an integrated, patient-friendly way. Our EMR vendor provided us with training sessions over a two-week period, with two trainers coming to our office for each session. Our staff, my father and I lost two full weeks that could have been spent addressing the needs of our patients.

But formal training was just the beginning. Virtually every aspect of our practice had to be modified. Where we used to simply jot down a note on a patient chart, we now had to learn how to navigate the new system and type our notes into an electronic form. Because of our "learning curve," each patient visit took longer, reducing the number of patients we could see in a given day. This caused patients to wait longer to schedule appointments. Because we were seeing fewer patients, our practice revenue dropped as well. Ours was a frustrating transition for staff, physicians and patients alike.

It took our practice nearly two years to be able to accommodate as many patients as we could before we invested in our EMR system. The investment of $100,000 upfront and the diminished number of patients that we could see made the initial months of implementation very lean indeed.

Key Benefits of Health IT

After the initial setbacks we faced during the first two years of using an EMR system, our staff and our patients are finally able to appreciate the full potential of health information technology in our practice. In fact, our old way of doing things seems completely archaic in retrospect. Though it took two years to fully integrate and implement our EMR system, I could never go back to our old paper-based system now that I am familiar with all of the benefits of our

integrated EMR system. There are several aspects of upgrading to an EMR that have been extremely positive for both our practice and our patients.

The first is 24-hour access to all patients' charts. If I am at the hospital in the middle of the night with a laboring patient and I need her prenatal record, I can view and print it through any computer with internet access. When I'm on-call, I can view the patient's medical records, including their plan of treatment and medications, with ease from home. I can record why the patient called and, when necessary, prescribe treatment or medications much easier than I could before.

There are also obvious patient safety benefits. Our EMR allows me to view a record of a patient's drug allergies and check for potential drug interactions so medications are more safely prescribed. It also links with ACOG guidelines to facilitate the practice of evidence-based medicine. We also add the patient's picture to her medical record - it helps us remember our patients, but also is one more protection against medical errors.

Also, the patients' medical records are protected. If there was a fire or a flood in our office, the patients' records would be safe.

Another extremely beneficial aspect of EMR has been the positive response we have received from our patients. Patients have been impressed with the use of modern technology in our office. Many of my patients also recognize that ways health IT can enhance patient safety and are reassured that their safety and health are our top priority.

Barriers to Health IT for Small Practices

The most obvious barrier to the adoption of health IT in small practices is the initial cost, which is commonly at least $50,000 per physician. Because interoperability standards are still in their infancy, this investment is something of a gamble. The technology changes rapidly and systems often do not communicate well with each other. Many physicians are fearful that this year's investment will be outdated or obsolete in a few short years.

Some people mistakenly believe that physicians will easily recoup their investment because the new technology will make them more efficient and able to see more patients. The irony is that health IT makes many offices significantly less efficient for months or even years after upgrading to an EMR. Only after two years were we able to handle our previous patient load. And even when efficiencies are realized, it doesn't necessarily translate into more patients or more revenue. For many ob-gyns, the goal is not to see more patients, but to devote more time and promise better care to the patients we already have. There have been many pressures over the last decade to compress the office visit into a few short minutes. We want to use technology to make those minutes more meaningful, not to strip additional minutes off a too-short office visit.

Many people estimate that huge savings to the American health care system could be achieved through greater use of health information technology. This is undoubtedly true. Health care payers will save by reducing unnecessary tests, patients will benefit from a reduction in medical

errors and the health care system overall will benefit. These are all important goals. However, these system-wide benefits don't necessarily translate into cost savings or additional revenue for physician offices so the value of health IT, from a business perspective, is not always apparent.

In fact, by not recognizing the value of technology and by underpaying for much of the care we deliver, Medicare and private sector health insurers are complicit in keeping us in a paper-based system. Private insurers and Medicare constantly expect us to deliver more care in each visit, for less money. The global fee for prenatal care and a normal delivery paid by one of my local insurance companies is only $1,200 -- for nine months of care, a full night or more in the hospital during the delivery and 60 days of postpartum care. Medicare is slated to cut physician payment by 10% in 2008 and nearly 40% over the next eight years, and private health insurance reimbursement rates are likely to follow. As our rates continue to be cut from all angles, it can be difficult for many practices to justify such an investment in health IT. With payment rates in Medicare and private insurance that are falling and unpredictable, and with no specific incentives for the investment in electronic record systems, it is that much more difficult for risk-averse doctors to make the plunge into health IT.

ACOG's Activities to Facilitate Health IT Adoption

As the professional association of the nation's obstetricians and gynecologists, ACOG plays an important role in ensuring that electronic medical record systems reflect the necessary content, encouraging interoperability, and assisting our Fellows in making the decision to adopt health IT.

ACOG is now making its women's health records, the gold-standard template for paper-based recordkeeping, available to developers of electronic medical records through nonexclusive licensing. The records currently available for such use are the ACOG Woman's Health Record, ACOG Antepartum Record, ACOG Discharge/Postpartum Form, and ACOG Obstetric Medical History Form. Even for those ob-gyns who cannot afford the expense of a complete EMR system, it is hoped that this initiative will provide a clinical data model of ob-gyn care that will ultimately be portable among EMR vendors, transferable into a patient-owned personal health record, and interoperable between ambulatory and inpatient systems.

ACOG is also working with two organizations to ensure appropriate content and interoperability standards for antepartum electronic medical records. The first is the ASTM E-31 Committee working on the Continuity of Care Record. The second is IHE - Integrating the Healthcare Enterprise - Patient Care Coordination Technical Committee to define the implementation of HL7 CDA documents for the Antepartum Summary Profile. By working with these two large coalitions, ACOG hopes to encourage vendors' adoption of consistent content and encourage ob-gyns' confidence that the record they select will be appropriate for their practice.

ACOG is a long-standing member of the Physician's Electronic Health Record Coalition (PEHRC) and has recently become a member of the Health Information Technology Standards Panel (HITSP). The PEHRC is a coalition of over 20 medical societies, established to assist physicians, particularly those in small- and medium-sized practices, to acquire and use affordable, standards-based electronic health records and other health information technology for the purposes of improving quality, enhancing patient safety, and increasing efficiency. The

HITSP is a cooperative partnership between the public and private sectors that aims to achieve a widely accepted and useful set of standards specifically to enable and support widespread interoperability among healthcare software applications, as they will interact in a local, regional and national health information network for the United States.

ACOG encourages legislation, such as that introduced in the 109th Congress by Chairman Gonzalez and Representative McHugh, to provide federal assistance to physicians for the purchase and use of health information technology. Such federal support for small group and rural practices is necessary to put the purchase and implementation of integrated health IT systems in the reach of more physician practices. Certainly, it would have made our practice's transition into the electronic world much less difficult financially. Currently many small practices see health IT systems as simply unattainable given the financial burden and interruption to their practices.

Conclusion

I am now a firm believer in the enormous potential that health information technology holds in revolutionizing the practice of medicine. But leadership from the federal government, spearheaded by this Subcommittee, is necessary to make this possible for small and rural physicians. With some help and encouragement, many of my physician colleagues would be willing and eager to make the transition in their practices to health IT.

I would like to thank the members of this Subcommittee for taking the time to hear about my practice's experience and for your willingness to help small practices provide the best care to their patients.

David R. Shober, D.O.
2520 Wilmington Road
New Castle, PA 16105

Date of Presentation: March 28, 2007

Presentation
"The Value of Health IT to Solo and Small Medical Practices"

Location
Congressional Subcommittee on Regulations Health Care & Trade of the House Committee of Small Business.
Chairman, Representative Gonzalez

CHALLENGES/BARRIERS TO IMPLEMENTATION

- **Set up/maintenance**
- **Secure connection**
- **Reliance on electricity**
- **In house computer expert**
- **Interface with other electronic data sources**
- **State dependent pharmacy issues**
- **Acceptance of electronic signature**
- **Government/work forms**
- **Insurance audit and review**
- **Medical/legal risk**

BENEFITS

Chart

- **Legibility**
- **Accuracy**
- **Immediate access**
- **Standardized format**
- **Self audit/interrogation**
- **Fast templates**
- **Ease of coping/transfer**
- **Reduction in duplicate testing**

Patient Care

- **Improved Quality**
- **Improved Efficiency**

FEDERAL GOVERNMENT INTERVENTION

- **Funding**
- **Pharmacy**
- **Standardized pharmacy laws**
- **Acceptance of electronic signature**
- **Connectivity**
- **Electronic data storage; private versus regional**

Chairman Gonzalez, Congressman, congresswoman, it is a pleasure to have this opportunity to meet with you today. As a practicing rural family physician I am challenged with the management of health information and integration of technology in my office.

I feel that it is important that you know my background so that you can understand my perspective on this topic. I practice medicine full time. My partner and I own and manage our business. We purchased an electronic health record in 2004. We operate a two-physician practice. We have two offices which operate simultaneously, one in the township and the other in a rural setting. We provide inpatient medical care at one hospital and four nursing homes.

In addition, I presently serve as the president of the medical staff at Jameson Memorial Hospital. This is a two hundred-bed community hospital. Just as I am challenged in my office with the management of health information this hospital is challenged on a much larger scale. In a small community the hospital and physicians are dependent upon each other to deliver quality medical care.

I have been practicing medicine for fifteen years. I have seen the transition from handwritten medical record to the current electronic health record. Over this time span the requirements of record keeping have increased dramatically. The records in the 70's and 80's were sometimes written on index cards containing little documentation. The current insurance and medical/legal requirements demand extensive documentation, making a more efficient charting method necessary.

We were motivated to purchase an electronic health record for a number of reasons. We were a four-physician practice anticipating growth to a third office. We wanted instantaneous connectivity between all offices and access to our files from outside

locations. With the insurance and medical/legal requirements for more thorough documentation, we were spending a considerable amount of time documenting, subsequently reducing our time for direct patient care. We wanted to reduce documentation errors by eliminating the handwritten record. We wanted to standardize our record to level not possible with a handwritten chart. We wanted to be able to electronically audit our performance.

Unfortunately, as you will see, the road to using an electronic health record in the community setting is a difficult one.

The return on investment, whether that be improvement in patient care, or financial savings is really not known.

We purchased our system three years ago. The financial cost of this was considerable. The initial investment was two hundred thousand dollars. Our annual costs for support and updating average fifty to sixty thousand dollars. All of the electronic health record companies will tell you that you will save money due to reduced employee time and benefits and increased efficiency. However, as businessmen, we had to take a long hard look at the numbers in order to justify such expenditure. When it came down to the bottom line, we felt that the system would help us improve our quality of patient care. While we have been able to realize some savings, the electronic record is still an expenditure for us.

As a medical practice, we are required to keep records for extended periods of time. In Pennsylvania, these limits were now extended further with the new malpractice legislation. The pressures of medical record keeping and maintenance are tremendous. As a small businessman with the prospect of retirement in the future, you are always

concerned about how you will maintain or transfer your records. With paper charts this could be very costly, not the type of expense one would like to have at the end of a career. These concerns also prompted us to move toward an electronic record.

We have realized a number of benefits and challenges with our implementation of an electronic record. Our first challenge was deciding which medical record system to purchase, this was lengthy process that took us at least six months to research the options available. With no independent computer consultants available with family practice experience we took this responsibility upon ourselves.

Our next challenge was to develop the necessary electronic connections between our two offices. Our rural office had no internet access subsequently we installed dedicated a T1 line. This creates a direct and secure phone connection.

The implementation of our record system required considerable staff and physician education and training. This created a financial challenge for our business. As physicians this required a commitment of time and effort. This was difficult for us in a busy practice. This was also challenging for us as physicians since neither of us were educated, at a time, when computer use was common. This challenge tends to discourage many physicians from investing in electronic health records.

As a medical office, our positions require some degree of front office business training, medical office or clinical training. Some of our clinical employees had a very difficult time learning how to use a computer and the program effectively. We had to offer some employees different positions since they could not master the electronic record. As part of our hiring process we now screen for computer literacy in addition to the screens for basic math and communication skills, which were performed in the past.

In order to maintain and operate our system we created a job position with one of our established employees. He now serves as our in house computer consultant, responsible for training, maintenance and upkeep.

We have benefited from the efficiency of our electronic record, which requires less maintenance and less space compared to a paper chart and we have eliminated the costs of creating a paper record. However, we still have the cost of receiving faxes, scanning written material and then shredding all paper correspondence that continues to arrive at our office from other entities. Unfortunately, this will continue to occur until these entities develop the ability to communicate with us electronically after the development of interfaces.

Our electronic record allows multiple users simultaneous and immediate access to a legible, accurate and standardized chart. This instantaneous access has definitely improved our capabilities. Now when we receive a phone call about a patient, I have all patient information at my fingertips.

With the electronic record you are forced to record data in a standardized manner that is easily retrievable. This further adds to the value of the record.

The electronic health record has allowed us to create more thorough and in depth notes than anyone could create with a handwritten chart. The creation of templates for commonly performed components of the history and physical examination or other items creates further efficiency and reduces transcription costs. However it has come to our attention that the use of templates are often scrutinized by insurance chart reviewers, claiming that it is an easy way to create documentation in order to bill at higher levels. For those of you who are not familiar with this, your billing codes are divided into five

levels. Justification for billing at a higher level is dependent upon the content of the physician's documentation. A larger amount of documentation substantiates a higher-level code, which pays a higher level of reimbursement.

Clearly as a physician running a small business, I need to be able to document efficiently so that I can continue to provide my services to patients in the community. Ethically I have a very difficult time justifying spending two hours a day documenting my visits so that I could pass a chart review when there is a shortage of physicians in the community.

Likewise, a medical legal concern is that template notes are often attacked in the courtroom or in a deposition. An insinuation is made that the examination was not done and the documentation was not appropriate. While I accept that the template examination may not be as precise as a narrative dictated exam, the essential documentation in support of ones medical actions and decision-making are clearly present in both. It is my belief that as we move into an electronic health record, templates must be accepted as a standardized type of record keeping. I believe that congressional support of this would be beneficial.

Federally mandated forms and documents need to be standardized. Employers and organizations interpret government forms differently, a good example of this being the FMLA form. I currently fill out at least six different versions of this form. Some are two pages long and some our six to eight pages long. Employers will only accept "their form". The same goes for the Department Of Transportation Commercial Drivers License forms. As we move into an electronic health record, I believe that Congress needs to standardize these forms and not allow individual interpretation and design. The

standard form can then be incorporated into all electronic health records. We can then print or send their form. Electronic signature must be recognized on these forms. I ask your assistance to make the system more efficient.

The copying of medical records is now easy for us to accomplish. However we are still limited by the fact that other entities are not capable of accepting electronic transfer of information and until this occurs we recreate a paper chart by printing our electronic records and then inefficiently mailing them to another entity. All health care entities must be required by some point in time to have the capability of accepting the electronic transfer of information. Only then can the efficiencies of an electronic health record be truly realized.

Currently we can hand write, print, or fax prescriptions. As soon as our local pharmacies come on line we will E-Prescribe. The most error prone and inefficient prescription is the handwritten/hand signed prescription. Unfortunately not all states or suppliers accept electronic signatures, or my typed prescriptions. Some even demand a signed prescription from a pad or that there own forms with bar codes and cut/paste format be completed. This doubles my workload. I believe that all pharmacies should be mandated to accept the E-prescriptions with an option to use their original forms. I believe federal regulation would be beneficial in this regard.

Pharmacy rules and regulations do not appear to be consistent in all states. Most times mail order pharmacies are located out of state. These pharmacies then apply their own state laws when prescriptions are being filled. Some pharmacies have refused to accept our electronic signature, while other states have no problem with it. I believe it is

time for the federal government to standardize pharmacy laws as they pertain to the interstate filling of prescriptions if we are going to move this process forward.

One of our major barriers is our ability to communicate with other electronic health record media, whether this be radiology centers, x-ray departments in the hospitals, laboratories in the hospitals or labs in the outside community. In order for us to communicate with these different types and brands of programs, a interface between them must be built or purchased to allow effective communication. Unfortunately these are costly and the individual vendors are certainly never interested in building an interface with another vendor's software. They would rather have you buy their software program. Certainly from my standpoint as a small businessman, I cannot pay for multiple interfaces. Until EHR application is universal there is little incentive for these entities to invest the time or the money to build interfacing software. This threat of isolation is used by companies to help encourage you to buy more of their product where there would be no interfacing issues. This is very frustrating, and I believe there should be regulation that forces all electronic health record programs to have the capability to interface with any other licensed program. This would allow the free market pricing of different technology systems and break down the communications barriers, which are currently penalizing me and dissuading many physicians from investing in electronic health records.

As you can see from my presentation above, my practice currently suffers from a number of inefficiencies because we cannot interface electronically with the other medical providers in the community. A cost savings would be available to everyone if medical information were moved electronically. We waste countless hours of employee

time trying to have information faxed to us or mailed to us. Hospitals waste countless hours of employee time searching for old records, copying mailing old records, faxing lab results and x-ray results unnecessarily. We must then receive them on a fax machine, print them and pay someone to scan them into our system electronically. As you may be aware a scanned document consumes a much larger amount of disc space than an electronically submitted document at a further cost over the long term. If an electronic record were in place these inefficiencies would be eliminated. Most importantly the information would be available to help provide effective patient care.

From a payor standpoint as electronic health record with universal connectivity could eliminate the unnecessary repetition of testing. Tests are repeated because of physician concern for the patient and also because of medical legal concern, if the results from a contemporaneous test are not immediately available. I have seen tests repeated unnecessarily in the same day because results from the first test were not available.

I think that the only way to provide incentive for the adoption of Health IT is to provide financial assistance. The burden of financing an electronic record is significant. My practice has spent over $400,000, starting and maintaining a EHR. I believe physicians and hospitals should be given no interest loans from the government to adopt this technology. Providers should then be paid a higher reimbursement fee for a limited period of time such as a five or ten year period. In that period of time their loans are paid back and the efficiency of the system is realized by the payer physicians and the providers and in effect what the government has done was to front the money, recoup their loan, provide financial support for the physicians to cover the expense of the upstart cost and in the long run create a safer and more efficient health care delivery system.

Local community hospitals, which make up the backbone of medical support in suburban and rural communities, are struggling with the acquisition of information technology. They do not have in house experts. They can't afford to keep these individuals on a full time basis like major teaching hospitals or regional health systems. When it comes time to develop the information technology systems they are very reliant on consultants. They don't have the staffing or the financial resources of large institutions for the training and retraining of their staff.

I see my local health system struggling and performing a balancing act trying to fund emergency room expansion, operating room expansion, and move toward a scanned inpatient record.

Jameson Hospital is at a crossroads when it comes to delivery of outpatient health information to the physicians in the community. Presently, they fax or courier results to offices as they try to map their way through the difficult process integrating internal computers based record systems. These individual systems such as lab, x-ray and pharmacy have been acquired at different times and it is difficult to interface these systems. It is not financially feasible for a hospital to discard all the existing systems and purchase a whole new system. They just do not have the money for that, so they try to run a balancing act of providing the necessary hospital services for the community and improve IT both in the hospital and in the community.

Many physicians will rely on medical hospitals for guidance and direction. Again, this all comes down to the financial challenge and hardship that is faced by these small health care institutions trying to perform a balancing act in providing healthcare in the community with a dwindling income stream.

As you can see, I function in a small town and rural community where health care is fragmented between multiple physicians, multiple hospitals, which includes one main community hospital, multiple lab services and multiple x-ray services. We don't have the asset of having one large health care system, like a university hospital that owns all the practices and owns most of the facilities and has these tied up in one medical record system. I believe I practice in the same type of environment as most physicians. Clearly, there are a number of financial barriers and a number of logistic barriers, however I am confident that if the financial incentives are in place and there is a uniform adoption of electronic health record the efficiencies of this system will be realized by both the payers, physicians and other healthcare providers. Most important the quality of patient care will improve.

In summary, as a small business it has been quite costly from the financial perspective for my practice to implement an electronic health record. We have not yet realized financial gain because of this. As a businessman I would like to at least break even on my investment. As a physician it is gratifying to see electronic health record eliminate handwriting errors improve efficiency, and create an immediately available medical record. Clearly, I have concerns regarding connectivity of different electronic media. I believe it is essential that all software used in medical application be able to communicate with other software packages in order to prevent a progression of the barriers that are already in place. I believe that federal regulations need to be placed to standardize the states pharmacy laws as they apply to the interstate transmission of prescriptions. I believe that funding needs to be put in place to help individual physician,

physician practices, and the smaller health care institutions to acquire the hardware and software necessary to bring an electronic health record to reality.

David R. Shober, D.O.

DRS/sc

House Committee on Small Business
Subcommittee on Regulation, Healthcare, and Trade

"The Value of Health IT to Solo and Small Medical Practices."

March 28, 2007

Statement by Kevin T. Napier, M.D.

Chairman Gonzales, Ranking Member Westmoreland, and Members of the Committee, thank you for the opportunity to testify before you today regarding my experience in Information Technology in Health Care. My name is Kevin Napier, M.D. and I practice Internal Medicine in Griffin, Georgia. Information technology is a subject of great importance to members of the medical community and government, as well as the general public.

Internal Medicine of Griffin has nine physicians and admits patients to Spalding Regional Medical Center (a facility with 180 beds). We made the transition to Electronic Health Records (EHR) in February, 2005. Prior to that point, the health records were in traditional folders where loose paper was placed in the order it was generated (which included office visit notes, laboratory reports, radiology reports, physician correspondence, insurance company correspondence, and Medicare correspondence). This led to frequent episodes of the inability to locate items needed for care and occasionally not being able to locate the chart at all on the day of the visit.

Internal Medicine of Griffin evaluated systems for 2 years prior to our selection of a vendor. After that decision was made, it was nearly another year prior to implementation of the system due to hardware installation and training needed for physicians and staff. It was recommended to us by our vendor that, due to the complexities of the system, we should consider reducing our schedules for a short period

of time to allow the practice to adjust. The final cost, including training, was nearly $400,000. Six of the physicians in my group are primary care physicians and we quickly learned that we were going to be financially impacted during this transition period. We financed the cost of this IT implementation and began paying $1000.00 per month per doctor and we will continue that for another 3 years. After considering the yearly threat of payment reductions from the Centers of Medicare and Medicaid Services (CMS), it is easy to see why more practices do not quickly transition to EHR.

In the first year after implementation, we did see a reduction in both the number of patients treated as well as a reduction in our incomes. However, as we start our third year on the system, I am pleased to report that we have become more proficient and are now seeing more patients than ever.

The benefits for our patients and physicians now include immediately available and legible office notes, laboratory data automatically entered into the system by the laboratory company, digital EKG's, and remote access to the entire record. We believe this has improved the quality of our care for both office based and hospitalized patients. Recently the hospital we utilize announced that its Emergency Department was also implementing an Electronic Record and they selected the same vendor that we did. This further promises to improve information flow and quality.

Our story is not unlike most practices that have made this transition. I had the opportunity to meet with several solo practitioners from southern Georgia, some of which also utilize EHR. The number one barrier to full implementation reported by these physicians was cost. Another area of concern includes a lack of a uniform standard between EHR vendors. If a solo practitioner were to join another group, he could not

integrate his old patient files into the new practice without a costly conversion process. Physicians also worry that the increased productivity offered by the system does not balance the additional costs. Due to the nature of health care, certain specialties feel that EHR is not easily adaptable to their style of practice. However, despite these reservations, I feel that the benefits of IT in health care outweigh these risks.

There are several options for fostering implementation of IT in health care. These include offering tax credits (rather than deductions) for IT implementation and offering technology bonuses for practices treating Medicare beneficiaries that utilize IT. The creation of a common standard for EHR companies would further enhance the portability of the public's health records.

It is my belief that physicians want to adopt information technology into their practices, but simply allowing market forces to steer that change is not enough. Health care providers are feeling pressure more than ever and assistance with this transition is greatly needed.

Thank you for the opportunity to testify.

Congressman Phil Gingrey
Statement for Subcommittee Hearing on the Value of Health IT to Solo and Small Medical Practices
Small Business Subcommittee on Regulations, Healthcare and Trade
March 28, 2007

Chairman Gonzalez, Ranking Member Westmoreland, and Members of the Subcommittee on Regulations, Healthcare and Trade, thank you for allowing me the opportunity to testify before you today. I want to take this time to discuss with you what I have discovered as I have researched and investigated economic viability of healthcare information technology.

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

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

The common denominator to the RAND study and my personal research is the concept of "widely adopted" and this is the question posed to the committee today. What are the current barriers to physician adoption and what role can and should the government play in ensuring healthcare information technology is "widely adopted?" There a variety of thoughts, opinions and pieces of legislation centered on this question. The RAND study simply states that in order to take full advantage of this potential savings we need incentives for physicians to buy quality systems. So the

question becomes not only what would be the most effective way to encourage physicians, but what is the most fiscally-responsible way.

As a physician Member of Congress, I was anxious to visit doctors' offices that were utilizing health information technology to see what difference it makes out in the real world. I stopped practicing medicine just a few years ago, and I remember vividly the overwhelming burden of administrative paperwork. It robbed physicians of time with their patients, replacing it with regulations and onerous bureaucracy. It took away from them the very reason they had decided to go to medical school in the first place: patient care. During my visits, I was amazed at what I saw put into practice.

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

My discussions with these physicians, their office managers and representatives from vendor companies, left me astounded by the recurring theme of satisfaction. The physicians I spoke with are enjoying a higher quality of life, more efficiency in follow up with their patients and the flexibility to complete charts and take "call" from their own homes. The office managers spoke emphatically about the benefits to automating their coding and billing process; higher efficiency, increase in percentage of claims being paid, and shorter billing cycles. Not only did they receive payment from insurance companies more quickly, they received more accurate payments.

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

The perceptions in the health care system that there are numerous hurdles preventing physicians from practically incorporating health IT into their offices are real and are slowing the adoption rate among healthcare providers. There are several valid reasons physicians cite as to the nature of their hesitation to implement this technology. They include excessive time and energy required to learn a new system, decreases in productivity, uncertainty around the longevity of the HIT systems and whether they will be interoperable and of course the natural apprehension that comes with any large financial investment. The foundation of a nationwide health information network starts in the physician offices across our country; it does not matter what size they are or what their specialty is, if physicians do not invest in this technology any and everything else the government does on this issue is moot.

It is for this particular reason that I believe the best thing Congress can do is to create incentives for physicians to incorporate health information technology into their practices. This is why in the 109th Congress I introduced H.R. 4641, the ADOPT Health IT Act, and plan on reintroducing it again this Congress. This legislation takes current tax code and strengthens the incentive for healthcare providers interested in purchasing HIT. I have heard from physicians and industry alike that section 179 of the US tax code is the strongest element of their decision to move into the world of health IT; but it is not extended far enough to be as useful as possible.

Presently, section 179 of the US tax code allows small businesses to deduct up to $100,000 of qualified business expenses every year, including information technology. However, since the majority of healthcare in this country is delivered by physician small physician groups, groups that have between 4 and 7 healthcare providers, the $100,000 maximum is not a sufficient incentive. Therefore, my legislation increases this maximum amount to $250,000, creating a more realistic

incentive to spur adoption amongst physician practices of all sizes. The logic behind this idea is that physicians, like all small business owners, look at what the tax code can offer them as they consider purchasing equipment for their business.

Basically, the ADOPT Health IT Act allows Section 179 of the tax code to better represent the actual cost of an EHR system. For example, the cost of a system for an average practice that includes between 4 and 6 physicians can be as much as $200,000. By appealing to a physician's business instinct and allowing the tax code to provide incentives, we can create a much more effective way of getting health care information technology into every physician's office around the country.

In closing, I again want to express my gratitude for this opportunity and respectfully ask for your consideration of the initiative I laid out today.

Statement

For the Record

of the

American Medical Association

to the

Subcommittee on Regulations, Healthcare and Trade
Committee on Small Business
U.S. House of Representatives

Re: Small Medical Practices' Health IT

March 28, 2007

Division of Legislative Counsel
202 789-7426

Statement

for The Record

of the

American Medical Association

to the

Subcommittee on Regulations, Healthcare and Trade

Committee on Small Business

RE: "Small Medical Practices' Health IT"

March 28, 2007

Chairman Gonzales, Ranking Member Westmoreland, and Members of the Committee on Small Business, Subcommittee on Regulations, Healthcare and Trade, the American Medical Association (AMA) appreciates the opportunity to submit our statement for the record for "Small Medical Practices' Health IT." The AMA commends the Subcommittee for recognizing the importance of moving toward an interoperable HIT infrastructure and the crucial role that physicians will play in fostering the adoption of HIT. We share the widespread optimism over the promise that HIT holds for transforming patient care if properly developed and carefully integrated into the existing health care delivery system. If carefully structured, HIT has the potential to raise the overall quality and safety of patient care, put vital information at practitioners' fingertips at the point of care, improve efficiencies in electronic communication, and serve as a powerful tool in biosurveillance and public health monitoring.

The AMA supports the development, adoption, and implementation of national HIT standards through collaboration with public and private stakeholders, and consistent with current efforts to establish HIT standards for use by the federal government. We support the principle that HIT systems must be interoperable, allowing data to flow smoothly between health professionals and the differing HIT systems they rely upon. It will be essential to dedicate adequate resources and capital to realize policymakers' vision of a nationwide health information network. The AMA stresses the importance of the proper alignment of incentives so that the predicted cost-savings associated with HIT is shared with physicians and others who will be expected to invest most heavily in HIT systems. Also, in an era when a patient's private and sensitive health care information can be made public with the touch of a button, it is imperative that adequate privacy and security standards and protections be developed.

HIT has the potential to raise the overall quality and safety of patient care. It could revolutionize the practice of medicine and the delivery of health care by putting real-time, clinically relevant patient information and up-to-date clinical decision support tools in practitioners' hands at the point of care. Similarly, it holds potential to improve preventive care, chronic disease management, biosurveillance, public health monitoring, and could produce increased efficiencies in electronic communication.

In this era of shrinking physician margins due to decreasing revenue from public and private payers, considerable medical liability insurance premiums, and state and federal mandates, the cost associated with implementing HIT is a significant impediment. This is particularly true for physicians practicing in small office settings. A study by Robert H. Miller and others found that initial electronic health record costs were approximately $44,000 per full-time equivalent (FTE) provider, and ongoing costs were about $8,500 annually per FTE provider. (Health Affairs, September/October, 2005). In its report entitled "Health Information Technology: Promoting Electronic Connectivity in Health Care," the Congressional Research Service estimated that the average per physician cost for start-up ranges from $16,000 to $36,000. This does not take into account lost revenues during start-up, lost staff time, or additional downstream investments in technology upgrades. An Annals of Internal Medicine study released August 1, 2005 estimates that the creation of a national health information network could cost an estimated $156 billion over the next five years, with $48 billion in annual operating costs. Moreover, the business case has yet to be made for physician office implementation. While HIT is expected to generate systemwide savings, those who are expected to pay for such systems, namely physicians and other practice organizations, will only see 11 percent of that return on investment, while the remaining 89 percent goes to those who typically do not pay for HIT directly, such as insurers, laboratories, patients, and private and government payers.

Accordingly, the AMA encourages Congress to ensure that physicians are not disproportionately burdened with the cost of developing and maintaining the national health information network that will benefit all sectors of the industry. A transformation of the health care delivery system of this magnitude—which will benefit payers such as the federal government, private insurance, and industry, as well as patients and providers—carries with it enormous costs. The AMA strongly urges Congress to consider direct means to assist physicians such as grants, low-interest loans, increased reimbursement for the use of HIT, accelerated depreciation for HIT investments, tax credits, and other economic incentives.

The AMA also supports efforts to moderate unduly restrictive provisions in the Stark self-referral and anti-kickback laws that presently impede physicians from working in partnership with other providers and accepting assistance in adopting HIT. Donated hardware, software, and technology should be permitted, not "exclusively," but rather "primarily," for the purpose of the electronic creation, maintenance, and exchange of clinical health information to improve health care quality or efficiency. This would afford physicians a realistic safe harbor and a reasonable measure of confidence that receiving assistance to adopt HIT will not expose them to civil or criminal liability. It will also prevent the donation of technology that is too tightly constrained to be of

practical use in the physician office. While the AMA supports assistance to physicians purchasing HIT, we strongly believe that such assistance should not unreasonably restrict physicians' choices regarding which HIT system to use. In addition, the AMA believes that any assistance must promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA – PHI) with the assisting facility consistent with the patient's wishes as well as applicable legal and ethical considerations.

Likewise, the AMA believes that the list of acceptable donations should be expansive in the Stark and anti-kickback exceptions. In addition to the allowable non-monetary remuneration, the safe harbors should include donations of maintenance, associated costs related to implementation, and upgrades, as well as any costs associated with licenses, rights of use, or intellectual property. There will be numerous unanticipated costs associated with implementation and use of HIT. There will also be extended maintenance fees incurred as a result of the 24-hour-day, 7-day-a-week online technical support required by physicians' schedules. Further, due to constant advances in technology, there will undoubtedly be costs associated with upgrading HIT in the future. Any safe harbor for donations of technology, therefore, should address not only the costs of acquisition, but the costs of implementing, maintaining, and upgrading HIT systems.

The AMA also urges Congress to make privacy and security of patient medical information a top priority when creating an HIT infrastructure. Recent polls by Harris Interactive indicate that approximately 60 to 70% of Americans polled believe that EMRs will provide important benefits, including the potential for decreased medical errors, decreased health care costs and improved quality. However, despite these potential benefits, 62 percent of respondents still agree with the suggestion that adoption of EMRs will make it "more difficult to ensure patients' privacy." While several aspects of health IT and EMRs are appealing to many people, 42 percent of the public contends that the privacy risks of EMRs outweigh the potential benefits, according to the research firm. Eighty-three percent of patients report that they are concerned about the security and privacy of their health records while these records are electronically stored and accessed, according to another recent survey from Time Warner Cable Business Class.

These concerns are identified at a time when HIT is being promoted as a platform for initiatives by the Department of Health and Human Services such as "personalized medicine," which capitalizes upon the use of a patient's genetic information to optimize health outcomes as well as increased transparency in health care. At the same time, private sector efforts are proliferating to establish medical record banks and health information exchanges. For example, in December, 2006, Wal-Mart, Intel, and other companies announced the creation of a database that could store the personal health records of more than 2.5 million employees and retirees. Meanwhile, there is a growing consensus among policymakers that existing federal privacy protections provided to patients' personally identifiable health information under HIPAA are not adequate to address the many emerging scenarios or uses for health data that HIT adoption will facilitate. While such data collection efforts hold tremendous potential to improve public health when data is appropriately deidentified and utilized for population-based health

studies, ensuring the privacy and security of patient data should remain a priority for policymakers.

Safeguarding the privacy and confidentiality of patient information is a professional responsibility that physicians take very seriously. Under AMA ethical policy and the pysician licensing laws of all fifty states, information disclosed to a physician during the course of the patient-physician relationship is confidential to the greatest possible degree. Respect for patient privacy is a fundamental expression of patient autonomy and is a prerequisite to building the trust that is at the core of the patient-physician relationship. Patients' reliance on this confidential relationship allows them to reveal personal information to their physicians that is essential to the therapeutic relationship. However, the changing landscape of health care that includes the increased use of HIT means that many others besides the physician and the patient have access to personal information divulged in the context of a relationship of trust and confidence. We encourage policymakers to ensure that comprehensive privacy and confidentiality protections are in place to adequately protect this information exchange, and that the emerging trend of "consumer driven health care," which grants the patient additional autonomy over the flow of their health information, does not unwittingly weaken or eliminate some of the most strongest patient confidentiality and privacy protections that currently exist—a physician's professional ethical obligation to safeguard patient information.

Despite the complexity and cost of developing a national health information network, physicians are optimistic about the transformative power that adoption of this technology promises for the future of patient care. The AMA appreciates your consideration of our comments and we look forward to working with you on forging policies that will improve the health care system for all Americans.

The Computing Technology Industry Association

Statement for the

Subcommittee on Regulations, Healthcare and Trade

of the House Committee on Small Business

"Value of Health IT to Solo and Small Medical Practices"

by

Roger J. Cochetti,

Group Director-U.S. Public Policy

Computing Technology Industry Association

Wednesday, March 28, 2007

The Computing Technology Industry Association (CompTIA) is the largest computer industry trade association in the United States. We represent over 20,000 companies in the information technology (IT) industry, including hardware, software and service providers as well as virtually every large company in our industry. In particular, however, we represent over 15,000 "Value Added Resellers" or VARs. VARs are small system integrators that design, install and maintain computer systems and networks, typically for other small businesses.

An estimated 32,000 VARs, most of which are small businesses themselves, sell approximately $43 billion dollars worth of computer hardware, software and services annually. This means that over one-third of the computer hardware sold in the United State today is sold by VARs. VARs are the IT departments of most small businesses, including small medical service providers, and our members are essential to the smooth operations of most sole practicing doctors, dentists, and other medical service providers.

For 25 years, CompTIA has provided research, networking and partnering opportunities to its 20,000 mostly American member companies. And while we represent nearly every major computer hardware manufacturer and software publisher, nearly 75% of our membership is comprised of American VARs – the small business component of the tech industry.

Like other small businesses, VARs are very concerned with the increasing costs of health care and support efforts that aim to improve the delivery of health care, while controlling

or reducing the associated costs. Consistent with this goal, CompTIA believes that health care costs can be contained and that the delivery of health care can be improved through a sound and effective health information technology (HIT) system.

Employee health care costs make up an ever-increasing percentage of expenditures for both IT and other employers. On an annual basis, small businesses are being confronted with double-digit percentage increases for such costs. While some small businesses simply cannot afford these spiraling prices, those that opt to eliminate employee coverage face a new struggle in recruiting and retaining a competent workforce. While many factors contribute to this ever-increasing cost spiral, there is one prominent factor that could lead both to containment of health care costs and to improved health services: Health Information Technology.

It is appropriate that the Subcommittee examine this topic today. Small medical service providers are the backbone of America's health care segment, yet -for a number of understandable reasons- they significantly lag behind their large corporate competitors in adopting IT in their workplace. This lag makes them less effective, less efficient, less secure, and less competitive than they could be. And the Congress can, and should, act to change that.

When a person visits their sole practice primary care physician, the medical records of that patient are frequently recorded and stored in paper files. If the patient changes physicians, the new physician must physically obtain the patient's medical file. This is always time-consuming, but in some situations, this also can be life-threatening. If a patient requires emergency medical services, there is real risk that the needed records cannot be obtained in time to support a proper diagnosis for treatment. In comparison, while our financial credit history is fully accessible on line, our medical history is not. *It is time for our health care system to move into the 21st century.*

CompTIA supports the increased use of information technology in our health care system:

1. *At the provider level,* we support incentives for converting paper files to digital media that can be easily transferred to and viewed by other health care providers for the benefit of the patient;

2. *At the patient level,* we support access to digital medical files and the right of a patient to dictate to whom and under what circumstances such information can be disclosed; and

3. *At the community level,* we support the building of a standardized system that will allow health care providers in different parts of the world to share medical information as required for the benefit of, and permitted by, the patient.

A key concept in HIT and of particular relevance to small medical practices, is a medical electronic health record ("EHR"). An EHR would contain an individual's medical history in digital form. Health care providers would be able to enter patient information into the EHR, such as test results, medications, procedures, etc. This EHR could then be transferred from one medical care provider to another, enabling each provider to make a more informed decision concerning patient treatment. While a number of issues must be resolved, such as privacy concerns, EHR standardization and systems interoperability, health care providers – especially small providers – must be encouraged to purchase and maintain HIT systems for their practices.

We believe that one of the most critical steps on the path to a functional and successful HIT system is to assure that small health care providers migrate to HIT and EHR systems for their practices. This would promote several goals at once:

1. HIT will allow small health care providers to deliver more effective medical services; having ready-access to a patient's medical history will certainly promote better diagnosis and treatment.

2. HIT will allow small health care providers to operate more efficiently; entering information into a patient's paper medical file, filing and retrieving that information all bear a cost in time and money, and this will be greatly streamlined by the development and use of electronic health records.

3. HIT will allow small health care providers to become more competitive with larger providers, such as HMOs; access to a patient's medical history by small health care providers will make it easier a patient to move from large provider, to a small health care provider that provides more personalized care.

4. HIT will increase the security and reliability of the medical services offered by small medical practitioners. When medical records are stored in paper form, they are vulnerable to destruction and damage due to fire, hurricane, flood, or other disasters. Digitized files can be securely stored in multiple locations, making them nearly invulnerable to damage and destruction.

As a national legislative goal, CompTIA supports legislation that would:

1. Establish a national coordinator for HIT to improve the quality and efficiency of health care through the use of HIT;

2. Establish national standards for HIT data and communications;

3. Establish compliance with national HIT standards through certification of hardware, software and support services; and

4. Provide assistance – including grants, loans and tax incentives – for the implementation of HIT systems to local health organizations, small health care providers and other entities.

Today, we ask the Subcommittee to consider the urgency of creatingincentives that encourage the adoption of HIT by small medical practitioners. Small health providers deliver the majority of health care for American, and we believe it is vital that this segment of the health care community become full participants in the HIT revolution.

While many larger providers have already moved to adopt and maintain HIT systems, we see that many small health care providers have been less willing – and less financially able – to make the required investments of time and money. This disparity in HIT adoption between large institutions and small practitioners will lead to an increasing gap in the quality of care that can be offered by a small provider as compared to their larger competitors.

Accordingly, we call for incentives that would aid and assist small health care providers to purchase, install and maintain hardware and software, as well as other IT services. We believe that tax incentives, such as an enhanced IRC §179 provision that would specifically allow for an accelerated deduction of HIT costs, is needed. Without added incentives, we fear that the costs of acquiring and operating HIT systems would prevent many small practitioners from participating in this important and vital advancement for health care in the United States.

Statement of:

The National Association of Chain Drug Stores

Submitted To:

U.S. House of Representatives

Committee on Small Business,
Subcommittee on Regulation, Healthcare, and Trade

April 4, 2007

"The Value of Health IT
to Solo and Small Medical Practices"

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Thank you for the opportunity to present testimony on behalf of NACDS on the important topic of accelerating the adoption of health information technology in the United States.

The National Association of Chain Drug Stores (NACDS) represents the nation's leading retail chain pharmacies and suppliers, helping them better meet the changing needs of their patients and customers. Chain pharmacies operate more than 37,000 pharmacies, employ 114,000 pharmacists, fill more than 2.3 billion prescriptions yearly, and have annual sales of nearly $700 billion. Other members include almost 1,000 suppliers of products and services to the chain drug industry.

NACDS and the National Community Pharmacists Association ("NCPA") created SureScripts in 2001 as the foundation for an electronic prescribing network. Their mission was to improve the overall prescribing process and to ensure, among other things, neutrality, patient safety, privacy and security, and freedom of choice of a patient's choice of pharmacy and a physician's choice of therapy. Under the leadership, and with the backing, of the pharmacy industry, SureScripts has created an open, neutral, and secure information system, known as the Pharmacy Health Information Exchange, that is compatible with all major physician and pharmacy software systems.

NACDS supports the written testimony on this topic already submitted to this Subcommittee by SureScripts. NACDS would like to reinforce three points made in SureScripts' testimony: (1) Our industry is committed to the widespread adoption of electronic prescribing (e-prescribing) technology, (2) We fully support the federal government's providing financial assistance to implement interoperable health information technology (HIT), and (3) We ask that financial assistance include other providers in addition to medical offices, such as pharmacies.

NACDS and the chain pharmacy industry strongly support the widespread adoption of e-prescribing technology and practices, as evidenced by our creation of SureScripts. The case for e-prescribing is compelling. Seven years ago, the Institute for Safe Medication Practices (ISMP) published a white paper entitled "A Call to Action: Eliminate Handwritten Prescriptions Within 3 Years." In this white paper, ISMP urged health care practitioners and providers to eliminate handwritten prescriptions by 2003. ISMP's bold goal has yet to be achieved.

As ISMP recognized, a paperless prescribing system is preferable because it would add a new dimension of safety and efficiency to current practice. Errors can occur at many points in the medication prescribing and delivery system; many of these potential points of error are due to failures in process and communication. Electronically created and transmitted prescriptions streamline this process and reduce the potential for failures in communication. ISMP noted that some of the most common sources of medication errors occur when a prescription is ordered/written, and when a prescription is entered into the computer system at the pharmacy. Electronically created and transmitted prescriptions can reduce or eliminate errors caused by these sources, especially when prescriptions are transmitted to a pharmacy's computer system.

By eliminating paper from the prescribing process, e-prescribing has also been proven to offer significant time-savings by eliminating the need for phone calls and faxes, allowing prescribers, pharmacists, and their staff more time to care for their patients. A study by the Medical Group Management Association's (MGMA) Group Practice Research Network (GPRN) estimated that administrative complexity related to prescriptions costs a practice over $15,000 a year for each full time physician on staff. Multiplying that figure by an estimated 527,000 physicians currently practicing in a physician office environment and prescribing medications in the United States reveals an opportunity to save more than $8 billion from conversion to e-prescribing.

Most pharmacies in the United States have the capability today to receive electronic prescriptions. More than 95% of the nation's retail community pharmacies have tested and certified their pharmacy applications through SureScripts.

In the future, pharmacies and pharmacists will play a much greater clinical role in the care of the patient. However, the implementation of the technologies pharmacists need to provide these services will require significant capital. As this Subcommittee heard, physicians are not always in a position to devote the capital resources necessary to implement the software and hardware needed to permit e-prescribing. Similarly, funding to support efforts by pharmacies to implement new patient care tools, such as medication therapy management and new medication adherence/compliance approaches, is necessary. Accordingly, we encourage governmental financial incentives to promote and foster the adoption of interoperable healthcare information technologies. Such incentives, however, should be provided not only to small physician practices, but also to other providers who may not have the necessary capital to implement health IT strategies, including pharmacies.

We believe that there are a number of stakeholders that have an interest in promoting healthcare information technology and the safety and efficiencies that come with it, and in particular such stakeholders are willing to fund the technology necessary to promote e-prescribing. Accordingly, we wholly support the government's current attempts to provide a clear framework in which the stakeholders with the financial resources to promote the electronic healthcare infrastructure may donate hardware, software, training, and other services in order to foster and promote the implementation of electronic healthcare information technology.

Any discussion and legislation about healthcare information technology must address privacy and security of patient data as well as user authentication requirements. There must be adequate laws regarding the privacy and security of healthcare information and

vigorous enforcement of those laws. The public must have faith and confidence that the laws will protect their privacy and the security of sensitive information.

The HIPAA Privacy and Security Rules establish the appropriate standards for the protection and security of personal healthcare information. Both rules received significant public comment during the rulemaking process. We believe that the rules strike the proper balance between protecting patient information and allowing health care practitioners to perform their lifesaving duties. Many states have laws that create requirements that are divergent from the HIPAA rules. Given the scrutiny that the HIPAA rules received on a national level, we question the need for additional laws and regulations in these areas.

The reality is that the patchwork of federal and state privacy and security laws, both statutory and common law, creates a barrier to the rapid adoption of healthcare information technology in the United States. In order to identify the various applicable laws and assess the impact the various laws have on health IT adoption, the Health Information Security and Privacy Collaboration, a partnership consisting of a multi-disciplinary team of experts and the National Governor's Association, pursuant to a contract with the Department of Health and Human Services, will work with 34 states and territories to address variations in state laws that affect privacy and security, and pose challenges to interoperable health information exchange. We believe this is an extremely important effort, and are pleased with the federal and state collaboration in this effort.

We would like to reiterate our industry's commitment to the widespread adoption of e-prescribing technology. Moreover, we anticipate pharmacy and pharmacist adoption and involvement in additional interoperable health information systems. We support the federal government's providing of financial incentives to promote the adoption of interoperable health care systems, and ask that such incentives include retail, community

pharmacies. NACDS would like to thank the Subcommittee for the opportunity to provide our perspectives on these matters.

Statement of

SureScripts, LLC

Submitted To

The House Committee on Small Business, Subcommittee on Regulation, Healthcare, and Trade

April 4, 2007

The Value of Health IT to Solo and Small Medical Practices

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Statement of
SureScripts, LLC
Submitted To
The House Committee on Small Business,
Subcommittee on Regulation, Healthcare, and Trade
April 4, 2007
The Value of Health IT to Solo and Small Medical Practices

Thank you for the opportunity to present testimony on behalf of SureScripts, LLC on the important topic of accelerating the adoption of health information technology ("Health IT") in the United States, and the value of Health IT to solo and small medical practices.

SureScripts was created by the National Community Pharmacists Association ("NCPA") and the National Association of Chain Drugs Stores ("NACDS") in 2001. Our mission is to improve the overall prescribing process and to ensure, among other things, neutrality, patient safety, privacy and security, and freedom of choice of a patient's choice of pharmacy and a physician's choice of therapy. Under the leadership of, and with the backing of, the pharmacy industry, SureScripts has created and operates an open, neutral, and secure information system, known as the Pharmacy Health Information Exchange™, that is compatible with all major physician and pharmacy software systems.

SureScripts was created to *improve the overall prescribing process* by focusing on the efficiency, safety, and quality of medication decisions made as part of that process. We have found that all too often, the popular but narrowly focused term "e-prescribing" has caused confusion and misunderstanding about the true scope of what we hope to accomplish for patients and the health professionals who care for them. As with all health information technology, the solution must be comprehensive, taking into account all aspects of the work flow in the pharmacies and the providers' office and care setting. The prescribing process is not just the act of writing a new prescription or a refill request. Moreover, the prescribing process does not begin merely when the physician's pen first touches the prescription pad, nor does the process end when the pharmacist hands the medication to the patient.

Looking at the prescribing process from the standpoint of the physician, one can see there are numerous indispensable steps that occur before the creation of the prescription. The patient's chart is pulled and reviewed, the patient is interviewed and examined, a diagnosis is decided upon, and a course of therapy is contemplated and then decided upon. If it is decided that medication therapy is an appropriate choice for the patient, it is at this point that a prescription is created and noted in the patient's chart.

When it comes time to authorizing a refill renewal request for the patient, many of these activities are repeated. All in all, considerable time, effort, expertise, and judgment are invested in these activities, and we believe there are several points in the process that can be improved by a comprehensive and interoperable health information technology solution beyond the simple act of generating a prescription.

At the pharmacy end, much more is involved in dispensing a prescription medication than simply placing tablets or capsules in a vial and handing the vial to the patient. You would be hard pressed to find a pharmacy anywhere in the United States that does not store all of its patient records electronically today. Electronic pharmacy patient records include allergies and existing medical conditions. Prescription insurance information must also be entered and updated periodically. Upon receipt of a prescription for a patient, the prescription information also is entered in the pharmacy computer, which immediately performs a drug interaction check against medications listed in the patient's pharmacy record. Once the pharmacist has reviewed any potential drug interactions flagged by the pharmacy system, the prescription is billed to the insurer; during the billing process an additional interaction check is performed by the pharmacist against the insurer's medication records; any resultant payer issues, whether financial, claim, or clinically related, are resolved by the pharmacist; the prescription is dispensed to the patient; and the patient is counseled on its use by the pharmacist. In the future, pharmacies and pharmacists will play a much greater clinical role in the care of the patient, providing medication therapy management services and assisting in medication adherence and reconciliation programs.

Our point in going into all of this detail is to emphasize to the Members of the Subcommittee that our goal as a nation, and certainly ours as a Company, must be to *improve the overall prescribing and care giving process.* From our perspective, to focus too narrowly on just the act of generating a prescription and transmitting it to a pharmacy ignores many opportunities to enhance the level of safety and quality of health care delivered to patients.

The case for electronic prescribing is compelling. More than one and a half million Americans are injured each year by medication errors, including adverse drug events. According the 2006 report by the Institute of Medicine, more than 25% of these injuries are preventable through the use of e-prescribing systems with a network connection between providers and pharmacies and advanced decision support capabilities.

By eliminating paper from the prescribing process, e-prescribing has also been proven to offer significant time-savings by eliminating the need for phone calls and faxes, allowing prescribers, pharmacists, and their staff more time to care for their patients. A 2004 study by the Medical Group Management Association (MGMA) estimated that e-prescribing with pharmacy interoperability can significantly reduce the $10,000 spent annually per physician on phone calls with pharmacies related to prescription refills.

The pharmacy industry has contributed millions of dollars to SureScripts in order to fund its development and operation. All of this without the expectation of a financial return in the form of dividends. In fact, our charter mandates that we operate as a nonprofit, cost-recovery model, with a mission to drive down costs for electronic prescribing. During its first two years, the Company focused on development of its technology necessary to transmit prescription information electronically. The Company's services were first put into production, sending and receiving electronic prescription transactions, in January, 2004. Today, more than 95% of the nation's retail pharmacies have now tested and certified their pharmacy applications on the Pharmacy Health Information Exchange, and physician software vendors whose customer base represents over 150,000 prescribing

physicians today have contracted with SureScripts, and most have completed the process of certifying their applications on the Pharmacy Health Information Exchange.

The first step for improving the prescribing process was focused on new and renewal requests, and accompanying response messages. We have now started rolling out Step Two to include other prescription messages, including a message confirming that a prescription has been dispensed, known as the prescription fill, and messages related to change requests. The prescription fill message can be used to let physicians know when patients pick up their medications or let a patient know their prescription is ready to be picked up. We also are rolling out the exchange of patient medication history between pharmacies and physicians, and formulary/eligibility messages between payors and physicians. All of this information, delivered in a secure and private manner to the point of care, will make the healthcare delivery system more efficient, more cost effective, and will save lives.

We are proud to say that the rate of adoption of electronic prescribing technology is increasing at a rapid rate. In fact, recently, community pharmacies, including NACDS and NCPA, sponsored the SafeRx Award. The annual SafeRx award recognizes the top ten e-prescribing states in the nation, along with three physicians in each winning state who have demonstrated outstanding leadership through their use of e-prescribing technology. The winning states in 2007 included Massachusetts, Rhode Island, Nevada, Delaware, Maryland, Michigan, North Carolina, New Jersey, Ohio, and Washington.

But much more needs to be done. The technology exists and is readily available today. The problem is that there are other barriers to the adoption of healthcare information technology. Traditionally, these include a lack of interoperable standards (outside of electronic prescribing), a lack of appropriate financial incentives to adopt technological advances, and a resistance on the part of providers to change the historic modes of operating and workflows.

In implementing our electronic prescribing network, we selected the nationally recognized NCPDP SCRIPT Standard to serve as the foundation for our network. The NCPDP SCRIPT Standard was developed by the National Council for Prescription Drug Programs, or NCPDP, an ANSI-accredited standards development organization, to facilitate the electronic, bidirectional transmission of prescription information between prescribers and pharmacies. It is our experience that the use of the NCPDP SCRIPT Standard improves patient safety, quality of care, and efficiency, without presenting an undue administrative burden on prescribers and pharmacists. We believe that NCPDP SCRIPT is the best standard to meet the e-prescribing needs of patients and the physicians and pharmacists who serve them. This opinion was further endorsed when the Medicare Modernization Act of 2003 adopted the NCPDP SCRIPT standard as the standard for the electronic transmission of prescriptions for patients under Medicare Part D.

The NCPDP SCRIPT Standard was developed through a consensus process among community pharmacy organizations, pharmacy software vendors, database providers, and other stakeholders. Currently, the standard addresses the electronic transmission of new prescriptions, prescription refill requests, prescription fill status notifications, formulary lookups, cancellation notifications, and medication history exchange – the nuts and bolts of e-prescribing, if you will.

Future enhancements will address other possibilities that may include patient eligibility, compliance, lab values, diagnosis, disease management protocols, patient drug therapy profiles, and/or prescription transfers.

The implementation of healthcare information technologies requires a capital commitment on the part of pharmacies, physicians, and other providers. Physicians and small independent pharmacies in particular might not always be in a position to devote the capital resources necessary to implement the software and hardware needed to permit electronic prescribing. In addition, funding to support efforts by pharmacies to implement new patient care tools, such as medication therapy management and new

medication adherence/compliance approaches, is necessary. Accordingly, we encourage governmental financial incentives to promote and foster the adoption of healthcare information technologies that satisfy certain standards, including those of interoperability. Such incentives, however, should be provided not only to small physician practices, but also other providers who may not have the financial wherewithal necessary to implement Health IT strategies, including pharmacies. As was discussed during the Hearing before your Subcommittee on March 28, the value of Health IT can reach its highest potential only if all providers – physicians, pharmacies, labs, etc. – have the capability to communicate with each electronically in a private and secure fashion.

In addition, we believe that there are a number of stakeholders that have an interest in promoting healthcare information technology and the safety and efficiencies that come with it, and in particular such stakeholders are willing to fund the technology necessary to promote electronic prescribing. Accordingly, we wholly support the government's attempts to provide a clear framework in which the stakeholders with the financial resources to promote the electronic healthcare infrastructure may donate hardware, software, training, and other services in order to foster and promote the implementation of electronic healthcare information technology. For instance, because of the value that laboratories convey in the data they transmit, they pioneered the provision of secure, efficient IT solutions to order and transmit laboratory tests to physician offices and hospitals throughout the country. These same tools could be expanded to include additional clinical functions like electronic prescribing at low or no cost to a physician. As the Administration and Congress seek to expand the permissive donation of healthcare information technology, we strongly recommend that laboratories be included among the list of permissible donors to facilitate the exchange of their current offerings (i.e. lab test requisition and results) as well as other healthcare information.

Any discussion and legislation about healthcare information technology must address privacy and security of patient data as well as user authentication requirements. There must be adequate laws regarding the privacy and security of healthcare information, vigorous enforcement of those laws, and the public must have faith and confidence that

the laws will protect their privacy and the security of their information. Privacy and security is an important policy matter that must be addressed. The HIPAA Privacy Rule is the benchmark for patient privacy, and establishes the minimum standards for the protection and security of personal healthcare information. Many states have laws that go further than HIPAA. While we applaud the efforts of the states to maximize the protections afforded to their citizens, the reality is that the patchwork of federal and state privacy laws, both statutory and common law, creates a barrier to the rapid adoption of healthcare information technology in the United States. In order to identify the various applicable laws and assess the impact the various laws have on Health IT adoption, the Health Information Security and Privacy Collaboration, a partnership consisting of a multi-disciplinary team of experts and the National Governor's Association, pursuant to a contract with the Department of Health and Human Services, will work with 34 states and territories to address variations in state laws that affect privacy and security, and pose challenges to interoperable health information exchange. We believe this is an extremely important effort, and are pleased with the federal and state collaboration in this effort.

The adoption of healthcare information technology not only is a matter of the nation's health, but we believe it is also a matter of national security. There is an acute need for reliable healthcare information to be available to healthcare providers in the event of a national emergency, whether man made, such as a terrorist attack, or caused by nature, such as a hurricane or an influenza pandemic. The experiences after Hurricane Katrina exemplify the acute need for healthcare information to be readily available to care givers throughout the nation. Hurricane Katrina destroyed millions of medical records, and approximately 40% of the 1.5 million evacuees were taking a prescription drug. Many of these evacuees fled their homes and were displaced without knowing what drugs they were taking, or their medication regimes. Following Hurricane Katrina's landfall near New Orleans last August, a group of private and public health and information technology experts created www.KatrinaHealth.org, an online service for authorized health professionals. The web site provided access to evacuees' medication information in order to renew prescriptions, prescribe new medications, and coordinate care. KatrinaHealth.org provided authorized users with access to the medication history of

evacuees who lived in the areas affected by Hurricane Katrina, with data or prescription information made available from a variety of government and commercial sources. Sources included electronic databases from community pharmacies, government health insurance programs such as Medicaid, private insurers, the Veterans Administration, and pharmacy benefits managers in the states most affected by the storm.

Privacy and security were central to the design of KatrinaHealth.org. KatrinaHealth was accessible only to authorized healthcare providers and pharmacists who were providing treatment or supporting the provision of treatment for evacuees. In addition, consistent with many state privacy laws, highly sensitive personal information was filtered from the site.

Much work has been done, and there is enormous momentum both in the public and private sectors with respect to the adoption of Health IT. But much more needs to be done – and lives are at stake. We at SureScripts thank the Subcommittee for the opportunity to share our experiences with respect to electronic healthcare.