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

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

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

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

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

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

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

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

Costs

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

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

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

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

Benefits

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

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

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

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

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

Challenges

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

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

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

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

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

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

Recommendations

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

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

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

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

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

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

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

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