AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Testimony of

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Before the

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America's Health IT Transformation: Translating the Promise of Electronic Health Reforms into Better Practice

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Chairman Alexander, Ranking Member Murray and members of the Senate Health, Education, Labor and Pension (HELP) Committee, I appreciate the opportunity to testify today on behalf of the American Academy of Family Physicians (AAFP) and the more than 115,900 members we represent.

My name is Robert Wergin, MD, FAAFP. I am president of the AAFP and a practicing family physician from Milford, Nebraska, a small, rural town with a population of around 2,100 residents. I am a meaningful user of an electronic medical record and practice in a patient centered medical home (PCMH).

The AAFP is one of the largest national medical organizations, and we represent the largest number of primary care physicians in the country. We have members practicing in all 50 states and over 90 percent of all counties. The AAFP was founded in 1947 to promote and maintain high-quality standards for family physicians who are providing continuous, comprehensive, and connected health care to the public.[1] Approximately one in four of all office visits are made to family physicians.[2] That is 214 million office visits each year– nearly 74 million more than the next largest medical specialty.[3] Family physicians provide more care for America's underserved and rural populations than any other medical specialty. In addition, family physicians provide a diverse range of care that includes pediatric, women's health and end-of-life.

Today's hearing addresses a significant health practice issue that is on the mind of every physician across the country regardless of geography, practice size or years in service. In recent years, I have traveled around the country and talked with dozens of family physicians whose experiences adopting health information technology (health IT) were much like mine.

Four years ago, my practice implemented an electronic health record (EHR) system. The initial results weren't pretty. Transitioning from paper to electronic files was expensive, time consuming, and resulted in a decline in the productivity of my office. But we worked at it, learned the system and productivity has improved. Although our daily patient volume has not yet returned to pre-EHR volumes, my clinic is running more smoothly than it did initially because my staff and I have adapted. We have embraced this change, and the benefits have been numerous. In fact, our practice successfully met Meaningful Use (MU) Stage 2 requirements late last year.

So, it is with that perspective, both as an AAFP leader and a practicing physician in a rural area that I am speaking with you today. Physicians around the country are anxious to know that policy-makers understand and appreciate the challenges and concerns associated with successfully adopting health IT. Physicians also hope that decision-makers will not simply consider the importance of health regulations but the context in which physicians are implementing a myriad of new requirements with limited financial resources and available time that can distract from the patient-physician relationship and impose significant challenges on physicians' quality of life and for some threaten the viability of their practice.

Family Physicians Are Early Adopters of Electronic Health Records

Physicians have used computerized medical records for well over 20 years. Successful utilization of EHRs, also known as electronic medical records or EMRs, has long been a vision of family medicine well before Congress approved the *Health Information Technology for Economic and Clinical Health (HITECH) Act*, enacted as part of the *American Recovery and Reinvestment Act (ARRA) of 2009*. Over ten years ago, the AAFP encouraged adoption of EHRs as part of its *Future of Family Medicine* initiative.[4] In addition, the AAFP created a Center for Health IT, which is now the Alliance for e-Health Innovation, to educate physicians about issues surrounding adoption and to work with IT vendors on standards for primary care practice. The AAFP also published health IT guides, shared best practices and reported on the most widely used EHR systems. We have also worked to create interoperability standards, which are represented in meaningful use. The organization's leadership boosted EHR adoption among family physicians. In a 2014 survey conducted by the U.S. Department of Health and Human Services' (HHS) Office of National Coordinator (ONC) for Health IT, over 77 percent of primary care physicians indicated that they were using electronic health records and outpacing other medical and surgical specialties.[5]

We are pleased Congress and the administration implemented the Medicare and Medicaid EHR Incentive Programs within ARRA to provide payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. According to the 2014 HHS physician survey, however, lack of financial resources was a significant barrier to adopting or upgrading systems, particularly for physicians operating in rural, small and solo practices.[6]

Family physicians are proud to be early adopters and we remain committed to pursuing the full potential of EHRs to enhance patient care, support new health delivery systems, improve population health, increase access through digital health technologies, and reduce the costs of health care. Most importantly, family doctors recognize successful EHR adoption will be the super highway for 21st century medicine. It is a road stakeholders must travel together: physicians, insurers, government agencies, patients, hospitals, community health centers and other health providers. It also a road EHR manufacturers and vendors must travel with us. It is not enough for them to simply build the products and point physicians on their way; they must accept their responsibility to travel this road with the physicians and hospitals that purchase and rely on their systems. We are not there yet, but we are making progress towards that goal. In the final analysis, we must not lose focus on how our endeavors may ultimately impact patient care.

EHRs and Health Practices

Electronic health records continue to be an important part of the future of health care delivery. There's no going back to paper records – we all recognize this even if our levels of acceptance vary. EHRs represent the potential for changing physician operations at a practice-level and for supporting new health care delivery models. On a simple level, EHRs use software that allows physicians to create, store, organize, edit and retrieve patient records on a computer or other device. But an effective EHR is more than just the electronic equivalent of paper.

Advanced EHRs automate a practice's many time-consuming, paper-driven office tasks. They allow for electronic prescribing and medication refills, automatic formulary checking, electronic lab, imaging and referral ordering, automated charge capture, automated coding advice, intra-office clinical messaging, multiple note creation options, remote access to the chart, results flow charting, clinical alerts, patient education and disease management.[7]

Advanced EHRs and health IT impact every process and individual in a practice. Advanced health IT that is interoperable can improve the safety of care through clinical decision support, robust data analysis, tracking of results, and supporting routine application of evidence based medicine. It also has the capacity to improve care coordination and the collaboration on patient care by our currently fragmented health care system. It can assist in the reduction of duplicative services and inappropriate utilization of services. To achieve these potentials, we must continue to view health IT as a tool for transformative change in health care and not a fancy electronic file cabinet.

The Future of Health Delivery Reform

Health technology also holds the potential to help physicians engage in delivery system reform efforts. EHRs could improve care coordination between primary care physicians and subspecialists, hospitals, pharmacies, labs and state health departments – but this is not possible now in any meaningful way. Common standards are needed across all entities to realize this benefit. Technology also is an integral part of improving care access reform efforts with advances in telehealth and is especially important for improving access to preventive and primary care.

Research shows that preventive care, care coordination for the chronically ill, and continuity of care – all hallmarks of primary care medicine – can achieve better health for individuals and cost savings. Published studies have demonstrated the positive impact of primary care on a variety of health outcomes, including decreased mortality from cancer, heart disease, stroke, and all causes combined. EHRs are essential for many health delivery reforms aimed at improving the quality of patient care and increasing primary health care access.

For example, team-based coordinated care is a foundational piece of the patient-centered medical home (PCMH), and, when coupled with the use of an EHR system, the primary care practice has the best opportunity to improve the quality of care offered to patients.[8] New research shows that organizational changes associated with the PCMH combined with use of an electronic health record can boost the quality of care delivered in primary care practices of all sizes.[9] Researchers found that the odds of overall quality improvement in PCMH practices with an EHR were 7 percent higher than in paper-based practices and 6 percent higher than in non-PCMH practices with an EHR.[10] Specifically, improvement was seen in four of 10 quality measures chosen by six participating health plans. Unfortunately, today's EHRs do not yet possess the needed functionality to fully support a PCMH.

As the health care industry begins to implement new value-based payment models, the use of technology will be essential for collecting patient data, measuring care quality, engaging patients in their health care and evaluating the effective management of chronic care conditions. Other health delivery reforms that rely on health IT include Accountable Care Organizations and telehealth. These also have important implications for our ability to increase access to underserved communities, better serve the homebound, and improve health at a population level.

Challenges and Recommendations

So far, I have focused on the great potential we see in health IT. The challenge is that this potential is not being realized in the majority of physician practices today. A recent RAND survey of physicians showed that EHRs are negatively impacting professional satisfaction.[11] The goal of health IT is to make patient care more efficient and less costly. For every success story, there are family physicians and others struggling to make this a reality. While there are many challenges and the testimony will not cover them all or in great detail, I have highlighted the major concerns for AAFP's members, along with potential solutions.

Current Documentation Requirements Distract from Patient Care. Physicians are deeply concerned that federal and state regulations associated with EHRs can interfere with patient care and reduce patient and physician satisfaction. Instead of interacting with patients, physicians are typing into their computers and must spend hours keeping up with paperwork requirements. This can be distracting for patients and their doctors. In addition, physicians feel it can create a barrier to the patient-physician relationship. A 2014 Physicians Foundation survey indicated face time with patients care was among physicians' top five concerns. A majority of the 20,000 physicians surveyed expressed anxiety that patient care was suffering because they are spending more time on administrative responsibilities.[12]

When my practice implemented EHRs, I certainly experienced this challenge of balancing the need to provide the face-to-face care I know patients need and fulfilling my paperwork requirements.

We need the government to take a new critical look at the current medical documentation requirements required for Current Procedural Terminology (CPT) coding. The current requirements were developed in an era dominated by paper records and fee-for-service models. These antiquated requirements are time-consuming for physicians and other clinicians and lead to bloated medical records, both of which do not lead to better patient care.[13] The current documentation requirements cause the generation of lengthy documents with critical clinical data buried within them. Physicians waste their time sifting through pages and pages of external "billing" documentation to find the critical data to inform treatment for the patient.

Encouraging a wider range of patients to view or download their data continues to be a challenge. A 2014 *Health Affairs* study found that only 30 percent of physicians reported using secure messaging to communicate with patients. And although 40 percent of physicians said their systems have the ability to allow patients to view, download or transmit information online, only half of those physicians said they were using that technology.[14]

Patients who have chronic disease and elderly patients whose care is being managed remotely by their children are among the individuals most likely to use patient portals. When my practice worked to achieve Stage 2 Meaningful Use status, meeting the patient portal requirement was particularly challenging. We have strong concern with requirements for action by those outside the control of the practice to avoid financial penalties.

The AAFP is pleased the Centers for Medicare and Medicaid Services (CMS) has announced proposed rules to reduce the reporting period for Meaningful Use from 365 days to 90 days, and we hope CMS will provide physicians with certainty regarding this decision as soon as possible. This type of flexibility will give physicians more time to implement the guidelines without compromising patient care. We would like to see further flexibility to address the all-or-nothing nature of meaningful use. Today if a physician misses a single requirement by a mere one percent, the physician is ineligible for an incentive payment and will see a penalty the following year under Medicare.

EHRs Have Limited Functionality for Physicians. Physicians across specialties are deeply frustrated with EHR functionality and the fact that systems do not meet their workflow needs. In addition, these systems can reduce efficiency and have limited interoperability. These concerns are reflected in a January 21, 2015 letter to ONC that AAFP, along with 40 other medical and health organizations signed urging a serious review of the current certification standards.[15]

The letter outlined the following recommendations:

(1) Decouple EHR certification from the Meaningful Use program;

(2) Re-consider alternative software testing methods;

(3) Establish greater transparency and uniformity on UCD testing and process results;

(4) Incorporate exception handling into EHR certification;
(5) Develop C-CDA guidance and tests to support exchange;
(6) Seek further stakeholder feedback; and
(7) Increase education on EHR implementation.

The letter stated the urgent need to change the current certification program to better align end-to-end testing to focus on EHR usability, interoperability and safety. AAFP stands with the medical community in urging ONC to address these certification standards.

EHR Systems Lack Full Interoperability. The issue of interoperability between electronic health records represents one of the most complex challenges facing the health care community as we pursue patient-centered health care reform. The ability to share and utilize information between two or more information systems is critical in today's increasingly interconnected health care environment, yet significant challenges have impeded information exchange across the spectrum of care.

To achieve better care, smarter spending and healthier people, both patients and physicians must be able to securely access their health care information when and where it is needed. When our patients leave our practice and go to another -- for a subspecialist consultation, for example -- my EHR most likely will not be able to communicate with the subspecialist's EHR.

This is a major flaw in our health care system, and the AAFP continues to push the Office of the National Coordinator for Health Information Technology and EHR vendors on this important issue.

AAFP leaders continue to advocate for requirements that demand interoperability from health IT vendors. The federal government should require that vendors achieve a high level of interoperability before expecting physicians and other clinicians to achieve current EHR and MU requirements. We have expressed our concern with the lack of interoperability and are pleased that the ONC has identified critical actions and outlined a timeline for implementation. We are making progress, such as with the Direct Project. This project was a partnership between the federal government and the private sector to establish the needed standardization for secure "email" in health care. We encourage continued support for this exchange and agree with many others that more work is needed to define the underlying data standards.

Physicians Face Expensive Regulatory Burdens. Physicians face what has been described as a tsunami of regulatory burdens associated with health IT that include Meaningful Use, ICD-10, and CMS' Patient Quality Reporting System (PQRS). Implementing each requirement requires a time commitment, financial investment, and training to integrate into the physicians' practices. In addition, physicians face growing Medicare payment cuts for non-compliance. A 2014 *Washington Post* article states that paperwork is contributing to physician burnout, particularly among primary care physicians.[16]

We have written numerous letters to CMS calling for improvements to the Meaningful Use program to ensure that family physicians can qualify and thus avoid the penalties associated with non-compliance. In addition, the AAFP has urged the administration to push implementation back to 2017.

The federal government's strategic plan for the future of health information technology encompasses worthy goals. It should both seek to ease the administrative burden physicians confront and build on goals set a decade ago. The AAFP wrote in response to a public request for comments on the draft strategic plan that the ONC released in December of 2014 which outlines a working plan for the next five years. As the AAFP outlined in our comments, we urge greater coordination among agencies and efforts to reduce administrative burdens on physicians.

Another area of concern regarding administrative burden with little impact on improved patient care is ICD-10. Many physicians worry that even if they successfully transition to ICD-10, they may still face potential claims denials or delays. Avoiding a disruption in the practice's cash flow remains a serious concern with this transition. Physicians heavily depend on electronic system vendors, claim clearinghouses, and payment administrators and need to know that testing is available and will be conducted to allow for corrections prior to the transition date. ICD-10 transition concerns are particularly acute for rural, small and solo practices.

We strongly urge CMS to establish contingency plans or establish task forces that include payers, clearinghouses, and software vendors to ensure that a system is in place to identify and address unexpected process failures. In 2012, CMS mandated the roll-out of Health Insurance Portability and Privacy Act (HIPPA) 5010 rule for claims submissions. There were major issues across the nation with payment to providers. With many practices operating on very thin budget margins and depending on normal revenue cycles, a payment delay of even two weeks could be harmful to the financial health of a clinic, regardless of its size.

We urge Congress to make sure that legislation includes adequate timelines that take into account the complexity of health systems, the many competing demands for physicians' time and planning to mitigate the unintended consequences that could jeopardize patient care.

Vendors Engage In Data Hoarding. The AAFP also has written to the Federal Trade Commission about anti-competitive practices that hinder interoperability. The AAFP is concerned with the utilization of health information technology to create competitive barriers against physicians and patients. The lack of interoperability makes it practically infeasible for a physician practice to switch electronic health records should the vendor or health care community use anticompetitive methods to limit the practice's access to needed health information on their patients. This hoarding of data – this vendor lock – negatively impacts care and distorts market forces trying to decrease health care costs and improve quality. It is critical that health data flow to where patients wish to be treated – in fact, these records are the patient's records and should be

electronically available to any physician or other provider of care at any time. These records and data do not belong to the EHR vendor. The current market forces for EHR vendors and large (quasi-monopoly) health systems limit interoperability to retain customers and patients and to elevate prices artificially. We need to make sure the business incentives are aligned to ensure continuity of care for patients and appropriate access to data by providers.

Reimbursement for Care Coordination is Inadequate. The biggest barrier to usable and interoperable health IT is the nation's current fee-for-service business model that stresses volume rather than value. The system we have now is all about getting widgets out the door. But, in this case, those widgets are real live people who depend on their family physicians to provide quality care. It takes time and energy to improve quality in a busy medical practice. But moving to a value-based payment system can set the stage for a revolution in health IT that will move us from automating the business of health care to automating the delivery of that care. In a value-based payment driven health care system, interoperability is desired not mandated.

On January 26, 2015, HHS announced that a higher percentage of Medicare payment systems would be tied to quality-based systems by the end of 2016. Also, Medicare began paying for chronic care management (CCM) effective January 1, 2015, recognizing the value that primary care brings to health care. In addition, the bipartisan, bicameral legislation to repeal the Medicare Sustainable Growth Rate (SGR) proposes a payment system that focuses on the value of the health care delivered and that supports health care delivery models centered on care coordination. We support the administration's efforts to advance a quality-based payment system. We strongly urge CMS to expand this program and to eliminate the co-payment requirement. Ultimately, physicians need a long-term and permanent solution. Congress should repeal and replace the SGR based on the 2014 legislative framework that supports value-based payments, encourages health delivery reforms and streamlines administrative requirements.

Conclusion

Again, thank you for inviting me to testify before the Committee today. I would like to reiterate our key recommendations to Congress:

1) **Overhaul the current documentation requirements.** The current standards are time-consuming, lead to bloated medical records which emphasize billing information rather than helpful and important clinical data.

2) **Provide flexibility from regulatory burdens.** The Meaningful Use 90-day reporting rule is a good example of the type of flexibility physicians need. In addition, HHS should establish a minimum threshold necessary to meet the Meaningful Use standards instead of its all-or-nothing requirement.

Regulatory implementation is as important, in some cases, as the regulation, itself. AAFP urges policy makers and the administration to take a "do no harm" approach when considering current and future standards that factor in the current physician workforce shortages, practice viability and patient care and safety. Harmonizing quality and reporting standards across all payers, especially for primary care, would also help physicians successfully implement federal standards and similar requirements in the private sector.

3) **The administration should take steps to put an ICD-10 contingency plan in place.** Although the initial testing reports were favorable, physicians have been advised to take out loans to prepare for potential billing denials. Rural, small and solo practices may be especially hard hit if the transition process is not implemented as anticipated and there are weeks or months of claims denials.

4) **Congress and the administration must step up efforts to require interoperability and functionality.** It has been 10 years since the EHR incentive program was created, yet we have not reached an adequate level of interoperability. This is not acceptable. HHS should use its authority to strengthen certification requirements to advance interoperability requirements and improve EHR functionality. We also believe that Congress should take action to delay federal penalties for Meaningful Use until interoperability is achieved. In addition, until national standards are established, EHR vendors should be required, at a minimum, to use open Application Programming Interfacing technology, which experts indicate would significantly advance interoperability, by the end of 2016.

5) **Review current consumer and privacy data protections.** Patients' information should be fully protected and not hoarded for commercial purposes, and physicians' should not be at the mercy of their vendors as they are now. Physicians should not be charged by their vendors for accessing their own patients' data. Congress should consider amending medical privacy laws to strengthen consumer protections in ways that address both patients' concerns as well as physicians' data management responsibilities.

6) **Congress must pass a permanent SGR repeal legislation this year**. The SGR bicameral, bipartisan legislation included policies that help bring the health care industry into the 21st Century through value-based payment reform. This level of patient care emphasized in the legislation is intensive, but it is not adequately reimbursed right now. We urge Congress to enact SGR reform in 2015.

I appreciate the opportunity to share the perspective of America's family physicians on what's working well and what challenges remain in implementing successful health IT systems.

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