

Testimony of Julia Adler-Milstein, Ph.D.

Assistant Professor of Information, School of Information
Assistant Professor of Health Management and Policy, School of Public Health
University of Michigan

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America's Health IT Transformation: Translating the Promise of Electronic
Health Records Into Better Care

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Good morning, Chairman Alexander, Ranking Member Murray, and distinguished Members of the Committee. My name is Julia Adler-Milstein and I am an Assistant Professor at the University of Michigan. It is an honor to appear before you to discuss how our nation can ensure that the substantial investment we have made in health information technology over the past decade translates into improved healthcare for all Americans. My research tracks the adoption of health IT in the U.S. healthcare system as well as assesses the impact of health IT adoption on the cost and quality of care, and it is for this reason that I am here today.

A decade ago, President George W. Bush set an ambitious goal for our nation: by 2014 every American would get their care with the support of an electronic health record.¹ In 2009, President Obama reiterated the same goal, calling for universal use of EHRs by 2014.² Investing in health information technology has been area of remarkable consensus, and the reason is clear: when done right, health IT can have a profound impact on improving virtually all dimensions of care. No one believes that paper-based records are a good way to deliver safe, effective, high-quality care.

In response, an array of federal and state-based strategies has sought to spur the adoption and use of electronic health records. And they have been remarkably successful. Since the last time this committee

met to discuss health IT, the adoption of EHRs, which include key functions known to improve the quality of care, has increased dramatically. Among U.S. hospitals, the increase has been from 9%³ to nearly 60%⁴ in the most recent data (2014). Over the same period, the increase among U.S. physicians has also been large: from 17%⁵ to 48%⁶. These gains can be largely credited to the HITECH Act – which provided nearly \$30 billion in incentives to physicians and hospitals to adopt and meaningfully use an EHR.⁷ For example, if today you were to walk into your local hospital, you would find that the majority of medications are ordered through the EHR⁸. This was not true only a few years ago, and the evidence is clear that just this one use of EHRs avoids errors and saves lives⁹. There is more good news. We have seen EHR adoption among safety net providers mostly keep up with everyone else, partly due to the alternative incentive program that was created for safety-net providers. And the increases in adoption of EHRs have been widespread – across all regions of the country, across a large variety of provider groups from small ambulatory care practices to large teaching hospitals. We should feel proud of these successes.

Adoption of EHRs is, however, only the first step; EHRs are necessary, but not sufficient, to drive large gains in healthcare quality. The evidence to date suggests that EHRs do not consistently lead to better care or lower healthcare spending. In some ways, this should not be a surprise. In most industries, there is a time lag – as much as a decade – between when IT is adopted and when we see large efficiency and productivity gains. In healthcare, we don't have a decade to wait. We need a strategy for figuring out how to use our new information technology infrastructure to truly transform healthcare. Here, there is growing consensus about the challenges that need to be addressed and important places where careful policymaking can make a big difference.

The first challenge is “liberating” the patient data that now sits within electronic health record systems of healthcare organizations across the country. By adopting EHRs, we have made a tremendous investment in “digitizing” clinical data, and have asked busy physicians to take extra time out of their day to enter

this data. Now, we need to enable the data to move to where it is needed: to other providers who cannot provide safe or effective care with missing information, and to patients who can use it to better understand and manage their health and care. Instead, only a small minority – as few as 20 to 30% of physicians and hospitals – exchange clinical data with other providers electronically.¹⁰ That means that if, in the middle of the night, you have to rush your child to the emergency room in your community – the chances are very low that the treating physician will be able to access all of your child’s information. Much of my research has focused on identifying the primary barriers to achieving broad-based health information exchange and interoperability. And it may be surprising to discover that the barriers are largely not technical ones. An agreed-upon set of standards, implemented in a consistent way, would undoubtedly facilitate interoperability. But the underlying issue is that we don’t have the incentives in place to make this a reality. EHR vendors do not have a business case for seamless, affordable interoperability across vendor platforms, and provider organizations find it an expense that they often can’t justify.

We are also struggling to engage patients through health information technology and better access to their data. Despite the fact that IT is deeply interwoven into the fabric of our lives, for most consumers, *health* IT has meant very little if anything at all. Despite much hype that personal health records would engage patients to be far more involved in their care, there is little evidence that this is happening. This is true to such an extent that provider organizations are struggling to meet the Stage 2 Meaningful Use criterion that requires that 5% of patients “view, download, or transmit to a third party” their health information. The reason is straightforward: most patient portals and personal health records are not making patient data understandable, useful, and engaging. The difference between getting my lab test result in the mail versus viewing it online is small. The ability to sync my exercise and other lifestyle data in order to understand how those choices impact my lab results is a whole different ballgame. If we make real progress in patient-centric data sharing, from providers to patients and from patients to providers, there is no shortage of smart, creative, innovative new companies that will work with patients to help them make sense of the data and use it in ways that are valuable.

There are other key challenges to ensuring that our national investment in EHRs improves care. We need to address the competing burdens on clinical documentation that are compromising the quality and usability of the data captured within EHRs. EHRs serve multiple masters, and there is a tension between the information that needs to be captured in EHRs for clinical care and the information that needs to be captured for billing (as well as other administrative and regulatory requirements). We need to think creatively about how to resolve this tension, and there is an opportunity for CMS to experiment with solutions. Finally, we know that when some physicians adopt EHR systems, they are worse off – slower, less efficient, struggling to provide high-quality care. But for others, the experience is very different: they see big gains in productivity and the quality of care they provide.¹¹ Why do some do so well with technology while others struggle? The answers are not as simple as age or tech savviness. It's likely much more about how the IT is used, and the context in which it is used¹². We need to identify these factors and work to spread them in order to ensure that all providers translate EHR use into better care.

We are at a critical moment for our healthcare system. We are nearing the five-year anniversary of the passage of the Affordable Care Act and six years after the passage of HITECH. Whatever our beliefs of those laws, we can all agree that our healthcare system has to get better – and we can all agree that newly adopted health information technology has a critical role to play. But it won't happen on its own. Smart policy interventions can push to improve the data, as well as liberate it, in order to let physicians, patients, and the broader market use it to innovate and create value. Many other industries have shown us the power of what can happen when high-quality data are at our fingertips and incentives are aligned behind innovation. Of course, we need not be overly coercive or prescriptive. Policymakers won't have all the solutions – but if we ask that, in exchange for the large amount of public funding that has been dedicated to EHR adoption, vendors be willing to facilitate and participate in a robust market of new tools and technologies, we will begin to deliver on the promise of EHRs to drive improvements in care and to engage patients and their families. We have made great progress – now is the time to do the things we need to make sure that the investments lead to safer, more efficient, more effective care for all Americans.

¹ “President Bush continues EHR push, sets national goals.” Healthcare IT News. April 26, 2004. Available at: <http://www.healthcareitnews.com/news/president-bush-continues-ehr-push-sets-national-goals>.

² “Obama: EHRs for Americans by 2014.” Healthcare IT News. January 8, 2009. Available at: <http://www.healthcareitnews.com/news/obama-ehrs-americans-2014>.

³ Adler-Milstein J, Desroches CM, Furukawa MF, Worzala C, Charles D, Kralovec P, Stalley S and Jha A. More than half of US hospitals have at least a basic EHR, but stage 2 criteria remain challenging for most. *Health Affairs (Millwood)*. 2014;33(9):1664-71.

⁴ Adler-Milstein J, Desroches CM, Furukawa MF, Worzala C, Charles D, Kralovec P, Stalley S and Jha A. More than half of US hospitals have at least a basic EHR, but stage 2 criteria remain challenging for most. *Health Affairs (Millwood)*. 2014;33(9):1664-71.

⁵ Desroches CM, Campbell EG, Rao SR, Donelan K, Ferris T, Jha A, Kaushal R, Levy D, Rosenbaum S, Shields A, Blumenthal D. Electronic health records in ambulatory care--a national survey of physicians. *New England Journal of Medicine*. 2008;359(1):50-60.

⁶ Furukawa MF, King J, Patel V, Hsiao C-J, Adler-Milstein J, Jha AK. Despite Substantial Progress In EHR Adoption, Health Information Exchange And Patient Engagement Remain Low In Office Settings. *Health Affairs (Millwood)*. 2014;33(9): 1672-1679.

⁷ Public Law 111-5, Title XIII.

⁸ Hospital Performance on Stage 2 Meaningful Use Measures. http://www.healthit.gov/FACAS/sites/faca/files/HITPC_Data_Analytics_Update_2014-11-04.pdf. Page 8.

⁹ Ammenwerth E, Schnell-Inderst P, Machan C, Siebert U. The effect of electronic prescribing on medication errors and adverse drug events: a systematic review. *Journal of the American Medical Informatics Association*. 2008;15(5):585-600.

¹⁰ Adler-Milstein J, Jha A. Health information exchange among U.S. hospitals: who’s in, who’s out and why? *Healthcare*. 2014; 2 (1) 26-32.

¹¹ Adler-Milstein J, Green CE, Bates DW. A Survey Analysis Suggests That Electronic Health Records Will Yield Revenue Gains For Some Practices And Losses For Many. *Health Affairs (Millwood)*. 2013;32(3):562-70.

Kern LM, Edwards A, Kaushal R. The Patient-Centered Medical Home, Electronic Health Records, and Quality of Care. *Annals of Internal Medicine*. 2014;160(11):741-9.

¹² Adler-Milstein J, Scott KW, Jha AK. Leveraging EHRs to Improve Hospital Performance: The Role of Management. *American Journal of Managed Care*. 2014;20(11 Spec No. 17):SP511-SP519.