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TOO MANY COOKS? COORDINATING FEDERAL AND STATE HEALTH IT

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT MANAGEMENT, ORGANIZATION, AND PROCUREMENT

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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TOO MANY COOKS? COORDINATING FEDERAL AND STATE HEALTH IT

THURSDAY, NOVEMBER 1, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,
ORGANIZATION, AND PROCUREMENT,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 3:10 p.m., in room 2154, Rayburn House Office Building, Hon. Edolphus Towns (chairman of the subcommittee) presiding.

Present: Representatives Towns, Christensen, Clay and Bilbray.

Staff present: Michael McCarthy, staff director; Rick Blake, professional staff member; Cecelia Morton, clerk; Charles Phillips, minority counsel; and Benjamin Chance, minority clerk.

Mr. TOWNS. The subcommittee will come to order.

I want to welcome everyone here today to what I consider to be an extremely important hearing. Our Nation is on the verge of a revolution in health services delivery through health information technology, or health IT. This revolution, the transition from paper to electronic health records, can reduce medical errors, can enhance the security and privacy of medical records, and can enhance the quality of care for medically underserved communities.

I am concerned about how we are currently managing our health IT initiatives. I am concerned that we are developing top-down solutions and not fully connecting them to the reduction of health disparities in the communities that need them the most. I am worried that the programs that State and local governments have started will ultimately be bypassed by a one-sized Federal solution. But I am also concerned that there is too much duplication of effort and expense as different States start different programs.

I know that Dr. Kolodner and his team have been hard at work, with not enough resources, I might add, in terms of developing this health information highway. I just want to make sure that the people from my community, Brooklyn to communities all over the country, don't get left behind and that our State and local and community initiatives are not discarded.

I know that encouraging innovation from our local officials is a policy that Ranking Member Bilbray shares, so I would like our very knowledgeable expert witnesses to tell us how to reconcile national standards that we will ultimately need with existing State, local and community health initiatives.

For those of you who know me, I have worked in a bipartisan fashion regardless of who is in the majority. That's why I hope,

today, we can find some solutions that address everybody's concerns so that we can move forward together. I am going to announce a new House caucus within the next few days, the Health IT Empowerment Caucus, that will focus on doing just that. We plan to work with the administration and the 21st Century Caucus and local and private sector groups to develop inclusive language, programs and grant opportunities that connect health IT with the reduction of health disparities.

In this regard, I would like to welcome other Members who have been active on these issues. I would like to thank Congresswoman and Dr. Donna Christian-Christensen for her work as a leader of the Congressional Black Caucus' Health Braintrust. I know that you have taken a leadership role in working on the reduction of health disparities and I am proud to be an original cosponsor of H.R. 3014, the Health Equity and Accountability Act of 2007.

I would also like to thank Congressman Clay of St. Louis, MO, for his efforts. He especially worked last year on the Electronic Health Information Technology Act of 2006.

I ask unanimous consent that these Members be allowed to participate in today's hearing. Without objection, so ordered.

I would also like to welcome those seated in the audience who have worked long and hard to connect health IT with the reduction of health disparities. I know that you have waited for some time for the formal acknowledgment of your efforts, and I hope that you will work with us and the House Health IT Empowerment Caucus to make this happen.

[The prepared statement of Hon. Edolphus Towns follows:]

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OPENING STATEMENT OF
CHAIRMAN EDOLPHUS TOWNS

"TOO MANY COOKS? COORDINATING FEDERAL AND STATE HEALTH IT"
November 1, 2007, 2:00 p.m. 2154 Rayburn

The Subcommittee will come to order. I want to welcome everyone here today to what I consider an extremely important hearing. Our nation is on the verge of a revolution in health services delivery through health information technology, or health IT. This revolution, the transition from paper to electronic health records, can reduce medical errors, enhance security and privacy of medical records, and enhance quality of care for medically underserved communities, like my own district in Brooklyn.

I will be frank. I am concerned about how we are currently managing our health IT initiatives. I am concerned that we are developing top-down solutions and not fully connecting them to the reduction of health disparities in the communities that need them the most. I am worried that the programs that state and local governments have started will ultimately be bypassed by a one-size federal solution. But I am also concerned that there is too much duplication of effort and expense as different states start different programs.

I know that Dr. Kolodner and his team have been hard at work – with not enough resources I might add – in terms of developing this health information highway. I just want to make sure that the people from my community in Brooklyn and communities like it all over the country don't get left behind, and that our state, local, and community initiatives are not discarded. I know that encouraging innovation from our local officials is a policy that the ranking member Mr. Bilbray shares.

So I would like our very knowledgeable expert witnesses to tell us how to reconcile the national standards that we will ultimately need with existing state, local, and community health IT initiatives.

I don't think health IT is at all a partisan issue. I don't play football with the lives of people in need. For those of you who know me, I have worked in a bipartisan fashion regardless of who is in the majority and I will work hard to do so again. That's why I hope today we can find some solutions that address everybody's concerns.

Because of my concern and the concern of many others in Congress about the need to connect health IT with underserved communities, I am going to announce a new House caucus, the Health IT Empowerment Caucus, that will focus on doing just that. We plan to work with the Administration, the 21st Century Caucus, and local and private sector groups to develop inclusive language, programs and grant opportunities that connect health IT with the reduction of health disparities.

In this regard, I would like to welcome other Members who have been active on these issues. I would like to thank Congresswoman Doctor Donna Christian Christensen for her work as the leader of the Congressional Black Caucus Braintrust. I know that you have taken a leadership role in working on the reduction of health disparities and I am proud to be an original cosponsor of H.R. 3014, the Health Equity and Accountability Act of 2007.

I would also like to thank Congressman Lacy Clay of St. Louis for his efforts, especially his work last year on the Electronic Health Information Technology Act of 2006.

I would also like to welcome those seated in the audience who have worked long and hard to connect health IT with the reduction of health disparities. I know that you have waited for some time for the formal acknowledgement of your efforts and I hope that you will work with us in the House Health IT Empowerment Caucus to make this happen.

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Mr. TOWNS. I yield now, of course, to Congresswoman and Doctor Donna Christian-Christensen for her remarks.

Mrs. CHRISTENSEN. Thank you, Chairman Towns and Congressman Clay. I want to thank you for holding this important hearing today on health information technology, and I want to thank you for the opportunity to be able to provide some comments.

Before I get into the body of my testimony, Mr. Chairman, I wanted to just thank you for your leadership and for your commitment to HIT and for your further commitment to ensuring that the issue of health disparities is addressed in it and through it. You have been at the forefront of successfully amending HIT legislation to ensure that the issues and concerns of minorities have been addressed, and it's been successful at least in this House.

I am here representing the Congressional Black Caucus' Health Braintrust, which has as its chief mission the elimination of health disparities in African Americans as well as in other people of color and the poor and rural populations. Just to single out the African American community, the data shows that we have higher rates of death and disability for almost every disease, from heart disease and cancer to HIV and AIDS. Our infant mortality is more than twice that of the white population, and the life expectancy of the African American male is the lowest of all population groups.

There are many causes for this. Among them are high rates of poverty and social determinants that follow from it, the lack of insurance, the lack of providers who come from the same cultural and racial background, discrimination in health care services, the high-risk lifestyles that are fueled by poverty and discrimination, and a lack of sufficient political will to change it.

Health information technology has the great potential to improve the health of Americans and to raise our country above that 37th WHO rating, the lowest of all industrialized countries, many of which are far ahead of us on health information technology. HIT reduces errors by eliminating the illegible notes like the ones I used to write, by reducing medication interactions and by providing relevant and timely information. It also improves practice through protocols and decision support for providers, and it can empower patients through accurate and consumer-friendly health information.

The potential of HIT to improve health as well as to reduce costs is great but not without deliberate action by this Congress. Without that, it will fall short of the good that could be done. It's imperative that this committee and Congress pass provisions and funding to ensure that HIT reaches all Americans, especially the most vulnerable populations and their providers. It is important because of the extreme burden of disease that these populations bear, and it's important for their providers. Doctors treating vulnerable populations are largely at the mercy of Medicare and Medicaid, and so they receive the lowest reimbursements for the heroic work that they do. Therefore, these patients and providers will require more help from the Federal Government to ensure that the benefits of HIT are equitably available to them.

Reports show that 98,000 deaths occur annually from medical errors, and reports also show that they occur more frequently in minority populations. So we in the Congressional Black Caucus, as

well as in the Tri-Caucus, clearly have a stake in making sure that health information technology is accessible to every community.

In the Federal Government's efforts to fund health IT, there has been very little focus on reducing health disparities, and we've seen the consequences of not having health IT advancements in all communities through the natural disasters like Hurricane Katrina. The victims then were largely those to whom this testimony is focused and who need an extra effort to be reached, minorities and the poor.

I would like to just highlight briefly a Tri-Caucus-sponsored bill that takes a comprehensive approach to health disparity elimination; and it also includes HIT provisions that you, Congressman Towns, amended into H.R. 4157 as one of its key provisions. That's the Health Equity and Accountability Act of 2007, which was introduced this year by Congresswoman Hilda Solis.

Under H.R. 3014, in addition to providing that our communities have access to the programs that improve health care delivery, using language lifted directly from your amendments, Congressman Towns, emphasis is placed on, "ensuring that health information technology and personal electronic health records become a component in the efforts to measure, reduce and ultimately eliminate racial and ethnic as well as geographic health disparities."

The bill also has provisions to increase racial and ethnic minority providers, to bolster data collection and to bolster accountability in Federal agencies that have health and health care oversight. It's a much-needed bill, but it's a bill that we will need your support to pass.

A 2005 Minority Health Disparities Report coming out of the Office of Minority Health stated, "Life expectancy and overall health have improved in recent years for large numbers of Americans due to an increased focus on preventative medicine"—and I don't know where that was"—and by making new advances in medical technology."

However, not all Americans are benefiting equally. There are continuing disparities in the burden of illness and death experienced by African Americans, Hispanic Americans, Asian Americans, Pacific Islanders, and American Indian/Alaska Natives as compared to the U.S. population as a whole.

The expansion of health information technology is vital for our communities, and it will require efforts from the Federal, State and local government levels as well as from the university and private sectors. And, it will require an investment, but it's an investment that will pay and will reduce future costs through better health.

I am proud to say that my alma mater of George Washington University is a longtime leader in health information technology and that my district, the Virgin Islands, has also begun its own HIT initiative, but it is the Federal Government, through its programs and in having the responsibility for more than 115 million Americans, that must be placed in the lead. So we need to continue to work with you, Congressman Towns, and others to ensure that we can get meaningful HIT legislation signed into law, which will improve health care, reduce costs and eliminate health disparities. It's necessary for the health of all of us and for the economic health and continued competitiveness and strength of our Nation.

So thank you again for the opportunity to make comments, and I look forward to hearing from your witnesses.

Mr. TOWNS. Thank you very much for your statement. I also thank you for your involvement in this issue.

At this time, I would like to yield to Congressman Clay from St. Louis.

Mr. CLAY. Thank you, Mr. Chairman.

Let me begin by thanking you and your staff for your leadership on this important issue.

I firmly believe that the Federal Government must take the lead in the development and adaptation of a nationwide Health Information Network that can improve the quality of care provided to all citizens.

During the 109th Congress, I introduced H.R. 4832, the Electronic Health Information Technology Act of 2006. H.R. 4832 sought to codify the current Office of the National Coordinator for Health Information Technology at HHS. In addition, the bill partnered with the private sector by providing grants and incorporating a direct loan program that would offer key economic assistance for institutions seeking to expand their electronic health record capability.

Mr. Chairman, our effective pursuit of health IT standards will dramatically reduce the significant health care disparities that Dr. Christensen mentioned are facing many minority and rural populations. I look forward to today's testimony and in working with you on this issue.

I yield back.

Mr. TOWNS. Thank you. Thank you for your involvement as well.

At this time, I would like to yield to the ranking member of the committee, Congressman Bilbray from California.

Mr. BILBRAY. Thank you, Mr. Chairman.

Mr. Chairman, let me just say that I appreciate your holding this hearing.

As I have stated before, in my previous life, I was the chairman of San Diego County, an area of 3 million people and we provided the health care safety net for the working class people of that region; and health data assessment and information were critical components there.

Also in my previous life, when I served 6 years here in the House before the voters gave me a 5-year sabbatical, I was actually working on a telecommunications bill and the big issue of how much Federal standards should be imposed, how much flexibility has to be encouraged is a legitimate argument in every one of these discussions.

A good example was the fact that if we did not have a minimum standard, we would never be able to get to the issue that you and I had a hearing about last week. It was about making sure that all drivers' licenses in the United States are held to a minimum standard, something the 9/11 Commission wanted to do. There, the DMVs came forward and asked us, as a Federal agency, to create a minimum standard so that we had uniformity there, at least with the standard, even though we had a State-by-State application of those standards.

On the other side, when we were working with telecommunications, we were saying we want to have a network—which is important—that the Federal Government leads on, but we didn't want the Federal Government to set a standard for it. You know, if we'd set a standard for computers back when they came out, none of us would ever have seen Windows. It wouldn't have been legal to have Windows. So just think about how far we've been able to go because the Government wasn't in the way, blocking it.

So, as they say, politics is the art of the possible. Contrary to what the college professors say, it is not a science. It's still an art. You still have to finesse it, and you still have to have that delicate touch of trying to respond to reality.

So I hope as we discuss this today, we look at that balance between the ability for information to be transmitted and read but still the ability for systems to be able to be upgraded with innovation improvement being allowed in the process. Because I'll tell you one thing as somebody who has been in government since I was 24 years old—I was a city council member—so often we legislate our way into dead ends, and some of the greatest challenges we have with technology in America is not to get the technology online but get it legally to go online. So I hope we look at this with the innovation of let's just have just enough guidance to make the system work but keep enough flexibility to where innovation and improvement can go on there.

I think all of us agree that there were a lot of people scared when we busted up the monopoly of Ma Bell, but I don't think any of us are really pining for the days when we had rotary phones and our kids couldn't walk around the house with a cordless phone, and so I hope that we look at it that way. We learn from our successes of the past and from our mistakes of the past and, hopefully, this panel will help set that foundation to make sure that the consumer will be served, the "consumer" being the patient who needs to have this information made available.

I would just like to close by saying, I serve on the Veterans' Committee, Mr. Chairman, and we are looking at this issue from the veteran's point of view, and I would strongly urge that we work with my old friend Bob Filner—and I say "old friend" because we've been working together since the 1970's—at maybe using the Veterans' Committee as a stalking horse here and the Federal Government should get its medical records in order and straight as we move forward in talking about a minimum standard for the rest of the country.

I yield back, Mr. Chairman.

Mr. TOWNS. Thank you very much. I look forward to working with you in every way to try and see if we can move this forward.

At this time, we will ask our first panel to come forward.

Will you continue to stand? It's a longstanding tradition that we swear our witnesses in.

[Witnesses sworn.]

Mr. TOWNS. Let the record reflect that all three answered in the affirmative.

Let me introduce our first panel, the three leaders in the area of health IT. We are delighted to have you.

Dr. Robert Kolodner is the National Coordinator for Health IT, reporting to the Secretary of Health and Human Services. He has served in a number of executive positions in Health IT, including that of Chief Health Informatics Officer in the Department of Veterans Affairs; and, of course, he is responsible for the development of the VA's electronic health records system.

Of course, Cheryl Casnoff manages the Office of Health Information Technology for the Health Resources Services Administration. She oversees the awards of $40 million in new telehealth and health IT grants. She previously directed the State Children's Health Insurance Program at HHS.

Welcome.

Dr. Carolyn Clancy is the Director of the Agency for Healthcare Research and Quality, one of the Nation's most important health research agencies. Dr. Clancy is one of the Nation's leading authorities on health quality and access to care, and she has served in a number of senior academic positions.

Your entire statements will be included in the record. So, if I could, I'll ask each of you to summarize within 5 minutes, which will allow us an opportunity to raise questions.

So, Dr. Kolodner, why don't you start?

STATEMENTS OF ROBERT M. KOLODNER, M.D., NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY, DEPARTMENT OF HEALTH AND HUMAN SERVICES; CHERYL AUSTEIN CASNOFF, ASSOCIATE ADMINISTRATOR, OFFICE OF HEALTH INFORMATION TECHNOLOGY, HEALTH RESOURCES SERVICES ADMINISTRATION; AND CAROLYN M. CLANCY, M.D., DIRECTOR, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

STATEMENT OF ROBERT M. KOLODNER, M.D.

Dr. KOLODNER. Thank you.

Good afternoon, Chairman Towns, Ranking Member Bilbray and members of the subcommittee.

I am Dr. Robert Kolodner, as you heard, and I am pleased to testify before you today on the administration's vision for interoperable health IT and how we are working with agencies and stakeholders to meet the needs of our Nation's medically underserved.

Three years ago, President Bush established the position of the National Coordinator, reporting to the Secretary of HHS, in order to provide leadership and strategic guidance to advance the national health IT agenda in America with the goal that most Americans have access to electronic health records by 2014.

From my 29 years of experience as a physician and as an administrator at VA, I know that information technology is absolutely necessary to be able to improve quality of care, to reduce medical errors, to increase efficiency, and to provide better information to patients and clinicians.

HHS is aggressively working to address the five critical components necessary to achieve widespread use of health IT across the Nation. These are a collaborative decisionmaking process, a secure Nationwide Health Information Network, health IT standards with a certification process to confirm they are incorporated into health

IT products, the adoption and use of interoperable health IT products and solutions, and clear, strong privacy and security and other health IT policies.

The first critical component, a collaborative decisionmaking process, had been served initially by the American Health Information Community [AHIC], which was chartered in 2005 as a time-limited Federal advisory committee to make recommendations to the Secretary of HHS on ways to accelerate the development and adoption of health IT. We are now transitioning this collaborative function to an independent public-private partnership based in the private sector with the Federal Government continuing as an active member and participant. We have taken specific steps to ensure the involvement of consumers, including medically underserved populations, as we transition to the AHIC successor.

The second critical component is the Nationwide Health Information Network to allow health information to be appropriately available in a secure and reliable manner anywhere in the United States. In fiscal years 2006 and 2007, the ONC led a project that confirmed the feasibility of exchanging electronic health information nationwide. In September 2007, we funded multi-stakeholder health information exchanges [HIEs], in nine communities across the country to work together to identify and implement the best solutions for exchanging health information. These nine HIEs will include safety net providers in their communities.

The third critical component is the identification of health IT standards and the incorporation of them into health IT products and services. This activity has been extremely successful. Since May 2006, 93 ambulatory electronic health record products, accounting for 75 percent of those in use in this country, have been certified by CCHIT as meeting their functionality, interoperability and security criteria. The first certified inpatient EHRs will be announced very soon.

The adoption and use of interoperable health IT products and services is the fourth critical component. Today, only about 10 percent of all doctors and hospitals in the United States use EHRs that have even a minimum set of functionality. We have been working across the Federal Government as well as with the private sector to remove barriers and to promote the use of EHRs by health care providers. Actions have included regulatory changes to allow hospitals to donate EHRs to physician practices in collaboration with HRSA regarding their grants to safety net providers. This week, Secretary Leavitt announced a 5-year CMS demonstration project designed to learn how we can most effectively promote EHR adoption by physicians in small to mid-sized practices where the current adoption rate is even lower, being under 5 percent.

The fifth critical component relates to Federal and State health IT policies, including privacy and security policies. HHS is carefully exploring options to address these issues. As part of this activity, ONC and AHRQ have worked collaboratively to bring together a broad range of grassroot stakeholders in 34 States and territories to assess current variations in State-level privacy and security practices and develop State-based solutions and implementation plans. In at least 11 of these States, there have been specific representation for medically underserved populations who participate

in the working groups and steering committees. ONC is also working with the National Governors Association to address cross-State health IT issues and challenges to interoperability.

In summary, the widespread use of health IT is a fundamental change that must occur in order to improve the quality and efficiency of health care and to enable consumers to manage their health and to promote individual and population health. Moreover, the use of health IT has the potential to help decrease significantly disparities in health care quality. We are pleased that over the past 3 years there has been substantial progress in coordinating multiple Federal and State health IT initiatives to ensure that all populations get benefit from advancements in health IT.

Mr. Chairman, thank you for the opportunity to appear before you today.

Mr. TOWNS. Thank you very much.

[The prepared statement of Dr. Kolodner follows:]

Testimony Before the
Committee on Oversight and Government Reform
Subcommittee on Government Management,
Organization and Procurement

Statement of

Robert Kolodner, M.D.

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

November 1, 2007

Chairman Towns, Ranking Member Bilbray, and Members of the Subcommittee. I am Dr. Robert Kolodner, the National Coordinator, Office of the National Coordinator for Health IT (ONC) with the U.S. Department of Health and Human Services (HHS). I am pleased to testify before you on the Administration's Vision for Interoperable Health IT and how we are working with agencies and stakeholders to meet the needs of our nation's medically underserved.

Introduction

On April 27, 2004, the President signed Executive Order 13335 announcing his commitment to the promotion of health IT to improve efficiency, reduce medical errors, improve quality of care, and provide better information for patients and physicians. The President also called for widespread adoption of electronic health records (EHRs) by 2014 so that health information will follow patients throughout their care in a seamless and secure manner. The President directed the Secretary of HHS to establish the position of the National Coordinator for Health Information Technology to provide the leadership and strategy toward the unified advancement of the national health IT agenda in America.

Building on the progress made, on August 22, 2006, the President issued Executive Order 13410 to ensure that health care programs administered or sponsored by the federal government promote quality and efficient delivery of health care through the use of interoperable health IT, transparency regarding health care quality and price, and incentives to seek health care value. The key role for ONC is to provide the leadership for the development and nationwide implementation of interoperable health information technology to improve quality and efficiency of health care, enable consumers to manage their health, and promote individual and population

health. The approach centers on nationwide health IT adoption accomplished through the coordinated effort of many stakeholders, including federal, state and local governments as well as the private sector to benefit all patients, including those in medically underserved populations. Since its establishment, ONC has fostered health IT adoption and implementation through federal, public-private, and state-based activities.

ONC provides leadership under the direction of the National Coordinator to advance the national health IT agenda through coordination and leverage of federal programs to increase access and use of electronic health information for the following:

- Providers in the coordination and delivery of high quality, efficient patient-centric care;
- Individuals in working and communicating with their health care providers; and
- Communities to improve quality of care, conduct research, and support public health.

Public and Private Partnerships Addressing the Medically Underserved

ONC is ensuring the coordination of federal and state government, and private sector activities through five key components to advance the national health IT agenda while meeting the needs of the medically underserved:

- American Health Information Community (AHIC)
- The Nationwide Health Information Network (NHIN), including input from the Federal Health Architecture (FHA);
- Standards in health IT products and services;
- Adoption of interoperable health IT; and

- Privacy, security and other health IT policies.

American Health Information Community (AHIC)

The AHIC is a federal advisory body chartered in 2005 to make recommendations to the Secretary on how to accelerate the development and adoption of health IT. It has been invaluable in helping to advance efforts to achieve President Bush's goal for most Americans to have access to secure electronic health records by 2014.

We are in the process of transitioning the AHIC to a public-private partnership based in the private sector, with the federal government as an active member and participant. The AHIC successor will be independent and sustainable and will bring together the best attributes and resources of the public and private sectors. This new public-private partnership will build from current accomplishments to accelerate the movement toward an interoperable nationwide health information system. The AHIC successor transition will be completed by fall 2008.

We have taken specific steps to include medically underserved populations as we transition to the AHIC successor. In the Notice of Funding Availability (NoFA) dated August 13, 2007, to provide resources for an entity to design and establish the successor organization to the AHIC, the NoFA specifically requires that the AHIC successor organize the membership into sectors that are inclusive of all relevant and affected parties in the health community.

The Nationwide Health Information Network (NHIN)

The NHIN is a "network of networks" built from a set of policies, standards and architecture to allow different electronic systems to communicate health information. In 2005, ONC led a broad project in communities across America to develop models that would demonstrate how nationwide electronic health information exchange might work. As a result, ONC initiated the next phase of trial implementations in 2007 involving nine multi-stakeholder health information exchanges (HIEs) across the country to cooperatively identify and implement the best solutions for exchanging electronic information.

We have included specific requirements in the NHIN trial implementation contracts to work with providers that serve medically underserved populations. The inclusion of safety net providers who serve low-income and other vulnerable populations can help ensure that the medically underserved community benefits from interoperable health information exchange throughout the country.

HHS and other federal agencies are investing significant resources and efforts in our national health IT agenda to work together on a common strategy to develop and connect to the NHIN. The Federal Health Architecture (FHA) is led by ONC and engages 26 federal agencies, all with health-related activities, to collaborate in the advancement of health information exchange across the federal government and with the tribal, state and private sectors. These agencies are working to achieve quality improvement, with greater efficiencies and streamlined processes for federal health care expenditures, which currently account for 40 percent all national health care spending.

The FHA includes federal agencies that address medically underserved populations. The increased use of interoperable health IT by these federal agencies and their contractors benefits the medically underserved populations they serve. Listed below are some agencies involved in the FHA:

- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- Centers for Medicare & Medicaid Services (CMS)
- Agency for Healthcare Research and Quality (AHRQ)
- Substance Abuse & Mental Health Service Administration (SAMHSA)
- National Institutes of Health (NIH)
- Food and Drug Administration (FDA)
- Administration for Children and Families (ACF)
- United States Department of Agriculture (USDA)
- Social Security Administration (SSA)
- Department of Veterans Affairs (VA)
- Department of Defense (DoD)
- National Cancer Institute (NCI)

Standards in Health IT Products and Services

ONC is supporting the harmonization of standards needed for incorporation into products that enable the movement of electronic health information from one entity to another. We use the priorities identified by the AHIC to determine the areas to focus standards harmonization.

Standards harmonization is conducted by the Healthcare Information Technology Standards Panel (HITSP), an ONC-established cooperative partnership between the public and private sectors. To ensure that these standards are incorporated into products, we set up the Certification Commission for Healthcare Information Technology (CCHIT) to establish functionality, interoperability and security certification criteria for EHRs and other health IT products. The CCHIT is a public-private entity recognized by the Secretary as a certification body. This activity has been extremely successful. Since May 2006, 93 ambulatory EHR products accounting for 75% of products in use have been certified by CCHIT and the first certified inpatient EHRs are due to be announced in the next few weeks.

Adoption of Interoperable Health IT

A key component of the national health IT agenda is to remove barriers and advance incentives to create an environment that promotes the adoption and use of EHRs by health care providers in both hospitals and physicians' offices and of personal health records by individuals and their designees. Increased adoption and use of EHRs will decrease medical error, increase quality of care, and provide better information for clinical care. We engage in multiple initiatives to help foster this environment through targeted coordination with federal agencies, cross-departmental collaboration, and environmental assessment.

ONC is coordinating closely with HRSA and CMS on health IT adoption initiatives. HRSA recently awarded grants specific to providers who deliver care to medically underserved populations that focus on increasing the adoption of health IT. In fiscal year 2007, ONC worked closely with HRSA to assure that single-entity, multi-site organizations adopt systems that will

allow for the type of information exchange that will support bettor coordinated care and greater patient engagement.

ONC participated in the Medicaid Transformation Grants review process, ensuring coordination with the national health IT efforts. The Deficit Reduction Act authorizes new grant funds to states for the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. Attached as an appendix is a CMS statement providing additional information on the Medicaid transformation grants.

The HHS workgroup on Health IT and underserved populations was established to look at the impact of departmental activities around health IT and underserved populations including an assessment of ongoing activities, challenges, and potential opportunities to further incorporate a focus on disparity populations. The workgroup is chaired by the Office of Minority Health (OMH) and HRSA and includes representation from ONC, CMS, IHS, SAMHSA, AHRQ, the National Library of Medicine (NLM), NCI, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the Office for Civil Rights (OCR). ONC helps the workgroup identify opportunities to improve access to health IT for underserved populations including recommending the addition of language to certain contracts and grants.

To assess the HIE environment, ONC led a project in conjunction with the with the Foundation of Research and Education (FORE), a component of the American Health Information Management Association (AHIMA), to research and report on the experience of leading state-level HIEs to identify guiding principles for developing state-level HIEs. From the current

preliminary report, the study identified that "State-level health information exchange initiatives play an integral role in balancing the rights and needs of all residents, including the underserved, while facilitating the removal or mitigation of statewide barriers to health information exchange through state-level policy changes."

In previous reports, guiding principles that were developed included ensuring that stakeholders from the medically underserved are engaged in the HIE development process and that HIE business models accommodate populations unable to pay for services. Additionally, it was suggested that state-level HIEs work with state government and others to identify and remove barriers for medically underserved participation in health information exchange.

The national adoption survey includes a broad sample of the population to determine the rate of health IT adoption in America. As a part of the broad sample, we took special care to include community service providers to better understand the drivers and barriers to health IT adoption among providers that service medically underserved populations including, but not limited to, community health centers in inner city and urban areas. The information derived from this survey will help ONC to identify new strategies to help increase health IT access among providers servicing underserved populations.

Privacy, Security and Other Health IT Policies

Two critical elements to safe exchange of health information at a national level are privacy and security. We are working to achieve a balance between our technical capabilities to exchange health information and the privacy and security policies that protect that information. Our

national health IT agenda approaches privacy and security through activities that both inform current work and prepare for future needs. HHS has undertaken the development of a national privacy and security framework that will incorporate the needs of health care consumers and foster the adoption of practices that promote trust in this new environment.

The Privacy and Security Solutions contract awarded to RTI International (RTI), and co-managed by ONC and AHRQ, to coordinate the work of the 33 states and 1 territory that make up the Health Information Security and Privacy Collaboration (HISPC) involved the engagement of a broad range of stakeholders to assess current variations in state-level privacy and security practices and to develop consensus-based solutions. In this fiscal year, we will be encouraging more states to participate in HISPC. There are at least 11 states (Alaska, Arkansas, California, Kansas, Louisiana, Maine, North Carolina, New Hampshire, New Jersey, Oregon, and Wyoming) involved with the HISPC that have specific representation from medically underserved populations who participate through working groups and steering committees. For example, the Center for Rural Health Research and Education at the University of Wyoming leads the HISPC activities in its state and is closely attuned to the unique circumstances of rural and Native American populations. Their efforts include workgroups in rural areas throughout the state, including Laramie, Buffalo and at Fort Washakie, on the Wind River Indian Reservation to gather information about the issues they confront when exchanging information.

In addition, ONC is working with the National Governors Association Center for Best Practices to establish the State Alliance for e-Health (State Alliance). The goal of the State Alliance is to improve the nation's health care system through representation that brings together key state

decision-makers. The Health Care Practice Task Force, one of three task forces under the State Alliance, is responsible for examining issues regarding the regulatory, legal, and professional standards that have an impact on the practice of medicine and create barriers to interoperable, electronic health information exchange. This task force has made recommendations for simplifying the process of obtaining medical licenses. A simplified licensure process, as recommended, would remove barriers to providing high quality care to medically underserved populations in remote areas through telemedicine.

Conclusion

Finally, I am pleased to point out that, Secretary Leavitt recently announced a five-year electronic health record (EHR) demonstration project conducted by CMS. This EHR demonstration project to be conducted by CMS starting in 2008 will measure the effects of EHR adoption and level of use on physician practice costs and performance quality and is designed to encourage higher quality care through EHR use. This demonstration is designed to show that streamlining the health care system with electronic health records can reduce medical errors and improve quality of care.

The advancement of the national health IT agenda can transform the landscape of health care in America. Broad application and use of health IT has the potential to decrease and even prevent disparities in health care access and quality. ONC has been increasing activities to ensure the coordination of federal, state and local government and the private sector efforts to transition to an environment of electronic health information exchange. ONC aims to lead the nation in the

development and nationwide implementation of interoperable health IT to improve quality and efficiency of health care and allow consumers to manage their health.

Coordinated efforts across the public and private sectors are working to make sure all communities benefit from the nationwide implementation of interoperable health IT utilizing existing infrastructure. Through our work together with stakeholders, HHS has made more progress in moving health IT forward in the last three years than in the previous two decades.

Mr. Chairman, thank you for the opportunity to appear before you today.

Appendix

Transformation Grants

Generally, the Federal Government supports the adoption of HIT as the normal cost of doing business. The Administration does not support the provision of financial incentives to encourage the adoption of HIT – adoption should be market driven. Section 6081 of the Deficit Reduction Act (DRA) of 2005 appropriated $150 million in non-Medicaid grant funds to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under the Medicaid program (P.L.109-171). These Medicaid "transformation grants" are to be distributed over fiscal years 2007 and 2008. Transformation grants represent a limited demonstration, funded by mandatory funding, and are considered outside of typical Medicaid reimbursement.

The CMS issued two grant solicitations, in July 2006 and April 2007, to States for transformation grant applications. All State Medicaid agencies were eligible to apply. Grant awards were based on the number of States that applied and met the grant criteria by following the statutory requirements to implement innovative methods to administer the Medicaid program. The DRA called for proposals for the following program categories:

- reducing patient error rates by developing and implementing interoperable health information technology;
- decreasing Medicaid waste, fraud and abuse;
- increasing the use of generic drugs; improving quality of health care and health outcomes;
- implementing medication risk management programs;

- increasing access to primary and specialty physician care for the uninsured; establishing medication risk management programs; and
- improving rates of collection from estates owed under Medicaid.

States could develop more than one program to achieve the DRA objectives through transformation grant awards. An overwhelming number of proposals received by CMS involved health information technology (health IT). Health IT has the potential to impact all phases of health care delivery in the United States, but for the purposes of these transformation grant awards, the development of interoperable electronic health records, electronic clinical decision support tools, and e-prescribing programs were all permissible uses. A smaller number of grants are using health information technology as a vehicle to collect, track and analyze clinical data for quality and programmatic benchmarks.

Collectively, almost $150,000,000 has been awarded by CMS to States for the development of innovative programs to improve health care delivery under Medicaid. States are required to submit a program evaluation report, as a condition of receipt of funding, and CMS will then evaluate the use of transformation grants across the nation.

Mr. TOWNS. Ms. Casnoff.

STATEMENT OF CHERYL AUSTEIN CASNOFF

Ms. AUSTEIN CASNOFF. Good afternoon, Mr. Chairman and members of the subcommittee. Thank you for the opportunity to meet with you today on behalf of the Health Resources and Services Administration [HRSA], to discuss the health information technology programs we administer. I appreciate your support and awareness of the importance of health information technology in underserved communities.

Consistent with the President's goal of the adoption of electronic health records for most Americans by 2014, HRSA has a number of grant programs already in place to assist safety net providers in accomplishing this important goal. HRSA promotes the adoption and effective use of HIT, including telehealth, to meet the needs of people who are uninsured, underserved and/or have special needs. HRSA also provides technical assistance to health centers and to other HRSA grantees in adopting model practices and technologies, in promoting grantee HIT advances and innovations as models and in ensuring that HRSA HIT policy and programs are coordinated with those of other U.S. Department of Health and Human Services' components and those of other Federal programs.

HRSA is working with many different stakeholders. Collaboration and coordination is key to the successful implementation of HIT. At HRSA, I'd like to give a few examples of how we're doing this.

We are working with internal and external partners to make sure the medically underserved and the safety net providers are a part of every component of the HIT agenda. Reducing health disparities is a key goal of our agency. To this end, we have formed a coordinating group with the Office of Minority Health specifically to address the potential of HIT to reduce health disparities. We are translating and customizing priorities of the National Coordinator's Office and standards for our grantees. We serve on several coordinating committees to help ensure that the medically underserved will benefit from the promises of HIT. We participated in AHRQ's ambulatory safety and quality grant application review process as well as in their contract for Medicaid HIT technical assistance. We are working closely with CMS and with State Medicaid agencies that receive Medicaid transformation grants, and we are linking our grantees to these opportunities.

At this point, I would especially like to thank Dr. Kolodner for all of his support and the support of the National Coordinator's Office in recognizing the special goals of our agency to provide quality care to vulnerable populations. He has worked with us to establish a new grant program, and he took the time personally to visit some of our health center sites.

HRSA's Office of Health Information Technology was formed in December 2005, as the principal advisor to the HRSA Administrator in developing in an agency-wide HIT strategy. OHIT, as we're called, was specifically created to promote the adoption and effective use of HIT in the safety net community. Our office awards planning and implementation grants for telehealth, electronic health records and other HIT innovations, while encouraging mar-

ket-based solutions and while encouraging providers to incorporate HIT as a normal cost of doing business. Our office also provides leadership and representation for HRSA grantees with other Federal and State policymakers, researchers and other stakeholders.

For fiscal year 2007, we funded four new types of grants targeted specifically to health centers for a total of $33 million. These grants were based on specific comments that we received from the safety net community about how we could best support HIT in that community.

Implementing HIT innovations and transforming health care through HIT is a huge undertaking that should not be underestimated. Some of the barriers that safety net providers face are the scarcity of funding, expert staff and resources, sorting through the flood of information on HIT, selecting software, hardware, appropriate tools, partners, and vendors and, perhaps most significantly, using HIT to achieve real change in clinical practice operations' staff and duties.

HRSA is continually looking for ways to overcome these barriers for our grantees. We have compiled and shared lessons from grantees with others and have provided technical assistance.

In partnership with AHRQ, we have established an HIT community specifically for HRSA grantees. It serves as a virtual community for health centers, our health center networks and State primary care associations, as well as other grantees, to collaborate around the adoption of technologies that are promoting patient safety and high-quality care. This portal creates a central hub for communication across geographic areas, and it allows our grantees to talk about and to gain information about HIT advances.

We have also developed a toolbox, which is a compilation of HIT planning, implementation and evaluation resources, to support our grantees, and it will be expanded to include rural health, maternal and child health, HIV/AIDS, and telehealth. We will be releasing that shortly.

In conclusion, the Department of Health and Human Services has identified furthering the use of HIT as a key priority. This focus supports the President's goal of the adoption of electronic health records for most Americans by 2014. We are diligently working with our grantees and with our partners in ONC, in CMS, in AHRQ, and other Federal and State public and private organizations to meet this important goal. We are very proud of our efforts and progress to date.

Thank you for giving me the opportunity to come here today to update you on the progress of our agency in the area of HIT and for your dedication and interest in underserved communities. I will be very happy to answer your questions.

Mr. TOWNS. Thank you very much.

[The prepared statement of Ms. Austein Casnoff follows:]

Testimony
Before the Committee on Oversight and Government Reform
Subcommittee on Government Management, Organization and Procurement
United States House of Representatives

Statement of

Cheryl Austein Casnoff, M.P.H.

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HRSA
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Good afternoon, Mr. Chairman, Members of the Subcommittee. Thank you for the opportunity to meet with you today on behalf of the Health Resources and Services Administration (HRSA) to discuss the health information technology programs we administer. I appreciate your support and awareness of the importance of health information technology in underserved communities.

Background

Consistent with the President's goal of adoption of electronic health records for most Americans by 2014, HRSA has a number of grant programs already in place to assist safety net providers in accomplishing this goal. HRSA promotes the adoption and effective use of health information technology (HIT) including telehealth to meet the needs of people who are uninsured, underserved, and/or have special needs. HRSA provides technical assistance to health centers and other HRSA grantees in adopting model practices and technologies, promotes grantee HIT advances and innovations as models, and ensures that HRSA HIT policy and programs are coordinated with those of other U.S. Department of Health and Human Services components and other Federal programs, for example, the Federal Communications Commission (FCC) Rural Health Care Pilot Program. The FCC's pilot program is an innovative, enhanced funding initiative intended to help public and non-profit health care providers construct state- and region-wide broadband networks to provide telehealth and telemedicine services throughout the Nation.

HRSA Programs

HRSA is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. HRSA provides national leadership, program resources, and services to improve access to culturally competent, quality care. Some examples of HIT activities at HRSA include:

The Office of Health Information Technology (OHIT)

HRSA's Office of Health Information Technology (OHIT) was formed in December 2005 as the principal advisor to the HRSA Administrator in developing an Agency-wide HIT strategy. The OHIT promotes the adoption and effective use of HIT in the safety net community. The goal of the office is to bring HIT to America's safety net providers; in particular HRSA grantees, to improve quality of care, reduce health disparities, increase efficiency in care delivery systems, increase patient safety, decrease medical errors, prevent a digital divide, and allow providers to improve quality and efficiency of the care they provide. HRSA's goal is not simply for safety net providers to collect data; the data must also be used to improve individual and population health. The long-term vision of HRSA and OHIT is to transform systems of care for safety net populations through the effective use of HIT.

OHIT awards planning and implementation grants for telehealth, electronic health records (EHRs), and other HIT innovations, while encouraging market-based solutions, and encouraging providers to incorporate HIT as a normal cost of doing business. The Office provides technical assistance to HRSA grantees and staff related to effective HIT adoption and Federal and State policies and legislation. OHIT also provides leadership and representation for HRSA grantees with Federal and State policymakers, researchers, and other stakeholders.

For fiscal year (FY) 2007, OHIT funded four new grants targeted to HRSA health centers for a total of $33 million. Health centers are community-based and consumer-run organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing. These grants were based on comments that we received from our safety net providers about how best to support HIT adoption.

Health Information Technology Planning Grants

We understand that not all health centers are ready to adopt EHRs. The HIT Planning grants are designed to support health centers in structured planning activities that will prepare them to adopt EHRs or other HIT innovations. Planning activities for EHR adoption may include readiness assessment, workflow analysis, due diligence in selecting a vendor, business planning, and determining specific network HIT functions. Planning activities for other HIT initiatives may include marketplace assessment, initial stages of collaboration with partners, and business planning. Eight health centers were awarded HIT Planning grants in FY 2007.

Electronic Health Record Implementation Initiative

This funding opportunity supports implementation of EHRs by health center controlled networks. Health-center controlled networks are networks of safety net providers that ensure access to health care for the medically underserved populations through the enhancement of health center operations, including health information technology. OHIT sees EHRs and other forms of HIT as tools to improve quality of health care and health outcomes. In addition, it is important to note that HRSA supports

health center controlled networks for HIT adoption, rather than individual health centers in order to reduce the risk of investing in HIT and improve the efficiency and effectiveness of our investment. Networks of health centers reduce the risk of investing in HIT by leveraging scarce resources including funding, staffing, and HIT expertise.

The EHR implementation initiative supports new health center networks as well as existing networks interested in spreading their capacity to additional health centers. Eight health center networks were awarded EHR Implementation grants in FY 2007.

High Impact Electronic Health Records Implementation

This grant program promotes the high impact implementation of an EHR through either a health center controlled network or a large individual health center with 30 or more sites. Funds must be used for implementation of new EHRs in at least 15 sites. This grant funding opportunity supports the use of EHRs as a tool to improve the safety, quality, efficiency, and effectiveness of health care delivery. Eighteen health centers were awarded High Impact EHR grants in FY 2007.

Health Information Technology Innovation Initiative

The purpose of the Health Information Technology Innovation Initiative is to implement health information technologies other than EHRs. This funding may be used for other HIT advances including electronic prescribing, physician order entry, personal health records, community health records, health information exchanges, smart cards, using telehealth to advance previous investments (e.g., using e-prescribing to build a telepharmacy), and creating interoperability with outside partners such as health departments and other HRSA grantees. Thirteen health centers were awarded HIT Innovation Initiative grants in FY 2007.

Telehealth

HRSA also works to increase and improve the use of telehealth to meet the needs of underserved people, including those living in rural and remote areas, those who are low-income and uninsured, or those who are enrolled in Medicaid. HRSA promotes the use of telehealth technologies by fostering partnerships within HRSA, with other Federal agencies, States, and private sector groups to create telehealth projects; providing technical assistance; evaluating the use of telehealth technologies and programs; developing telehealth policy initiatives to improve access to quality health services; and promoting knowledge exchange about "best telehealth practices."

HRSA, through OHIT, supports a portfolio of telehealth grants including the Telehealth Resource Center Grant Program, the Telehealth Network Grant Program (including home health) and the Licensure Portability Grant Program.

The Office of Rural Health Policy

The Office of Rural Health Policy (ORHP) promotes better health care service in rural America. ORHP has aligned some of its programs to adopt and implement the President's Health Information Technology Initiative.

The Flex Critical Access Hospital Health Information Technology Network Implementation (Flex CAH HIT Network Implementation) grant program promotes the implementation of HIT and EHRs in Critical Access Hospitals (CAHs). CAHs are rural community hospitals that receive cost-based reimbursement from Medicare. This program provides funds for up to 16 grantees to support the development of 1 Flex CAH HIT Network pilot program in each State that is awarded a grant. Examples of HIT may include practice management systems, disease registry systems, care management

systems, clinical messaging systems, personal health record systems, electronic health record systems, and health information exchanges. Sixteen awards were made under the Flex CAH HIT Network Implementation grant program in FY 2007.

Network Development Grants provide funding to help rural communities strengthen their health care systems. Grants support rural providers for up to 3 years who work together in formal networks, alliances, coalitions, or partnerships to integrate administrative, clinical, financial, and technological functions across their organizations. This integration of functions and services helps to overcome the fragmentation of health care services in rural areas, improves coordination of those services, and achieves economies of scale. The ultimate goal of the program is to build continually self-perpetuating sustainable networks with business (network partner return) and social (community return) competencies that increase access and quality of rural health care and ultimately, the health status of rural residents.

The HIV/AIDS Bureau

The Ryan White HIV/AIDS Program funds primary care and support services for individuals living with HIV disease who lack health insurance and financial resources for their care. One component of the Ryan White HIV/AIDS Program is the Special Projects of National Significance (SPNS). The purpose of the SPNS program is to identify and disseminate innovative models that advance knowledge and skills in the delivery of health and social services to people with HIV infection who are disadvantaged financially and medically underserved. HIT includes tools that allow health care providers to enhance service provision through a variety of ways, including (1) communicating electronically with existing HIT systems as a means to provide comprehensive HIV care

and (2) linking two or more disparate networks to enhance the quality of care provided. The electronic exchange of health information among HIV medical and ancillary care providers could integrate a fragmented health and social service care system and make a range of individual client health information available across numerous providers in the network. In FY 2007, the SPNS Information Technology Networks of Care Initiative awarded 7 grants for up to 4 years to fund organizations that promote the enhancement and evaluation of existing health information technology for people living with HIV/AIDS in underserved communities. The organizations included local governments, universities, and hospitals.

Barriers to HIT Adoption and HRSA's Efforts to Eliminate Barriers

Implementing HIT innovations and transforming health care through HIT is a huge undertaking that should not be underestimated. Some of the barriers that safety net providers face are scarcity of funding, staff, and resources; sorting through the flood of information on HIT; selecting software, hardware, appropriate HIT tools, partners, and vendors; and perhaps most significantly, using HIT to achieve real change in clinical practice, operations, staff responsibilities, and duties.

HRSA is continually looking for ways to overcome these barriers for its grantees. We have compiled and shared lessons learned from grantees with others and provided technical assistance. In partnership with the Agency for Health Care Research and Quality (AHRQ), HRSA has established a HIT Community for HRSA grantees. It serves as a virtual community for health centers, networks, and State Primary Care Associations and other grantees to collaborate around the adoption of technologies promoting patient safety and higher quality of care. The HRSA Portal creates a central hub for

communications across geographically disparate sites, and allows team members to view important announcements, documents, tasks, events, and discussions related to their initiative. HRSA has also developed a HIT Toolbox, which is a compilation of HIT planning, implementation, and evaluation resources to support HRSA's Section 330 Federally funded health center grantees (will be expanded to include rural health, maternal and child health, HIV/AIDS, and telehealth portals). It is designed to serve the needs of a broad audience within health centers and the health center controlled networks. The HIT Toolbox is scheduled for release later this month.

Conclusion

The Department of Health and Human Services has identified furthering the use of HIT as a key priority. This focus supports the President's goal of adoption of electronic health records for most Americans by 2014. HRSA is diligently working with our grantees and with our partners in the Office of the National Coordinator for Health Information Technology, Centers for Medicare and Medicaid Services, AHRQ and other Federal and state public and private organizations to meet this goal. We are proud of our progress and efforts to-date.

Thank you for giving me the opportunity to come here today to update you on the progress the Health Resources and Services Administration is making in the area of HIT and for your dedication and interest in underserved communities. I would be happy to answer your questions.

Mr. TOWNS. Dr. Clancy.

STATEMENT OF CAROLYN M. CLANCY, M.D.

Dr. CLANCY. Good afternoon, Mr. Chairman and members of the subcommittee. I am Dr. Carolyn Clancy, the Director of the Agency for Healthcare Research and Quality [AHRQ], a component of the Department of Health and Human Services. I, too, would like to thank you for the opportunity to discuss the role that health IT can play in improving the quality of health care for underserved populations across the Nation.

It is an understatement to say that health care quality in this country is nowhere near as good as it could or should be and we also have wide racial, socioeconomic and geographic inequities in health care and how it's delivered.

So, according to research from RAND, partially funded by AHRQ, Americans have a little bit better than a 50 percent chance of receiving the recommended care they need when they go to a doctor's office and serious problems with health care quality exists in all areas of health care. These problems are pretty pervasive across communities.

It actually doesn't matter where you live, we have quality challenges. In fact, according to data from our annual congressionally mandated National Healthcare Quality Report and our National Healthcare Disparities Report, health care quality improved just 3.1 percent in 2006, the same rate of improvement as the previous 2 years. At that rate, it will take us about 20 years to close the gap between best possible care, and care that's routinely provided.

From these reports, we know that we have wide racial, ethnic, economic, and geographic disparities in health care. For example, rural Americans are more likely to be elderly, poor—in fair or poor health—and to have chronic illnesses. They are less likely to receive recommended preventative care and report, on average, fewer visits to health care providers. Unfortunately, we don't have data specific to urban underserved Americans.

So the good news here is that we're working to resolve these quality problems, and we are making some progress. The bad news here is that the pace is slow, and we could move a whole lot faster.

So the big question then is: How do we accelerate the change that we need? How do we engage all stakeholders so that we can make sure that everyone, every American in this country, receives the highest quality and safest health care possible?

Well, first, we have to recognize, as Secretary Mike Leavitt often says, "We don't have a health care system. We have a health care sector that's rapidly growing and is increasingly fragmented." Health IT becomes a critical connector for the multiple parts of this system that, today, are not very nicely connected.

It is very important to note, though, that health IT is not a magic bullet. It alone will not transform the health care system, but it's impossible to envision how the transformation could occur without the capacities that it brings. So AHRQ's health IT initiative includes more than $166 million in grants and contracts to 41 States to support and to stimulate investment in health IT with a particular focus on rural and underserved areas. Through this ini-

tiative, we are working to ensure that the promise and potential of health IT is available to all Americans.

More than 50 percent of our health IT funding has targeted rural populations. So, from 2004 to 2006, the amount spent for rural health IT projects totaled $75 million. Under our more recently funded ambulatory safety and quality initiative, we're spending $6.5 million for health IT grants targeting priority populations, out of a total of $21 million in these grants in fiscal year 2007.

Mr. Chairman, we recently awarded one such grant to the New York City Department of Health and Mental Hygiene to enable the meaningful measurement of the quality of care with a focus on public health priority issues, disadvantaged populations and small office practices.

We are very pleased to be collaborating with Dr. Kolodner's office on the funding of a report to review and analyze the best clinical evidence on the use of health IT by the underserved, elderly and disabled. We believe the findings from this analysis will give us critical information that we need to ensure that these populations reap the benefits of health IT. We have also just recently funded a $3 million contract to provide technical assistance to up to 20 States on the best use of health IT to improve the quality of health care for Medicaid and SCHIP beneficiaries.

Technical assistance is critical to the successful adoption and implementation of health IT and we take this so seriously that, from the outset, we have created a national resource center for health IT. This resource center leverages our investments by offering help where it's needed most in real-world clinical settings that may feel ill-equipped, as my colleague described, to meet the implementation challenge. So, by way of example, this resource center has assisted States in their initiating Statewide clinical data-sharing and these include New York, Wyoming, Montana, Maryland, Georgia, and others. As my colleague noted, the resource provides a Web portal with capabilities to convene practitioners, to encourage collaboration and to disseminate best practices.

Through our collaboration with HRSA, we have a special portal for the Nation's community health centers. We've also supported providers in the Medicare health IT initiative and the Indian Health Service, and we've seen some dramatic improvements in care in the IHS.

So, Mr. Chairman, I'd like to conclude by offering just a few brief observations on our work to date.

First, health IT alone cannot improve our health care system unless it is integrated and embedded in the very fabric of how we provide care.

Second, for most health care settings, health IT is not likely to be an out-of-the-box solution. Effective use of health IT has to be linked with a very careful examination of how care is delivered and so that the power of health IT can be harnessed to enhance the effectiveness and the efficiency of care.

Third, accelerating the pace of adoption and implementation requires the sharing of both knowledge and experience through opportunities for voluntary peer-to-peer learning. It's a fairly local phenomenon.

Finally, the development of interoperable health IT can accelerate the pace of innovation and the speed with which patients will benefit from new medical breakthroughs.

So I'd like to thank you for the opportunity to be here today. I am confident that, in working together, we can ensure that all Americans receive high-quality, safe health care services.

[The prepared statement of Dr. Clancy follows:]

Carolyn M. Clancy, M.D.
Director
Agency for Healthcare Research and Quality (AHRQ)

Testimony on Health Care Information Technology

before the

House Subcommittee on Management, Organization, and Procurement

November 1, 2007

Testimony

Carolyn M. Clancy, M.D.

Health Information Technology and Underserved Populations

November 1, 2007

Mr. Chairman and Members of the Subcommittee, I am Dr. Carolyn Clancy, the Director of the Agency for Healthcare Research and Quality, known as AHRQ, a component of the Department of Health and Human Services. I would like to thank you for the opportunity to discuss the role that health information technology can play in improving the quality of health care for underserved populations in this Nation.

The mission of the Agency for Healthcare Research and Quality is to improve the quality, safety, effectiveness, and efficiency of health care for all Americans. As part of this mission, AHRQ has worked for many years to harness the power of health information technology to improve how health care is delivered, and ultimately, the health of the American people. To that end we work closely with the Office of the National Coordinator of Health IT and other Federal agencies to assure that our investments are closely aligned and concentrate specifically on the use of health information technology to improve safety and quality in diverse health care settings, with a strong focus on those organizations providing care to underserved and rural populations.

Inequities in Care

It is an understatement to say that health care quality in the United States is nowhere near as good as it could or should be. We also have wide racial, socioeconomic, and geographic inequities in how health care is delivered in this country.

According to research from RAND, partially funded by AHRQ, Americans have just a 50 percent chance of receiving the care they need when they go to a doctor's office. Other research indicates that as many as 1.5 million medication errors occur in hospitals each year; serious problems with health care quality exist in all areas in health care.

According to data from AHRQ's annual, congressionally mandated *National Health Care Quality Report,* health care quality improved just 3.1 percent in 2006 — the same rate of improvement as the previous 2 years. Data for these measures come from a variety of databases including CMS data, vital statistics, NHIS, and MEPS.

Its companion report, the *National Health Care Disparities Report*, found that access to high quality care varied widely between racial, ethnic and economic groups. This report focuses on a number of health care processes and outcomes that are useful for tracking quality of care. Of the 22 core measures that support comparisons across racial and ethnic groups, African Americans received poorer

quality care than whites for 73 percent of the core measures included in the disparities report. Hispanics received poorer quality of care than non-Hispanic whites for 77 percent of the measures. Poor people received lower quality of care than high-income people for 71 percent of the measures.

The Disparities Report also documents the quality of care for residents of rural America. We know that compared with their national counterparts, rural residents are more likely to be elderly, poor, in fair or poor health, and to have chronic conditions. Rural residents are less likely to receive recommended preventive services and report, on average, fewer visits to health care providers. Unfortunately, we do not have data specific to urban, underserved Americans.

Improving Health Care for All Americans

The good news is that we are working to resolve these quality problems and we are making progress.

According to AHRQ's quality and disparities reports, the greatest quality gains occurred in U.S. hospitals, where quality improved 7.8 percent. Ambulatory care—health services provided at doctors' offices, clinics or other settings without an overnight stay—improved by 3.2 percent. Nursing home and home health care improved by 1 percent.

The bad news is that this pace is slow, and it is even slower for minorities, the poor and other priority populations.

So how do we accelerate change? How do we engage all health care stakeholders to ensure that our Nation's citizens receive the highest quality, safest health care possible?

First, we must recognize, as HHS Secretary Mike Leavitt has said, that we don't have a health care ***system*** in the United States. We have a large, rapidly growing health care sector.

Then we need to find ways to connect the various parts of this sector to function more like a system, and an important connector is health information technology. It is important to note that health IT is not a magic bullet. It alone won't transform the health care system but it is impossible to envision that the transformation we need can occur without the capacities it brings.

Think for a moment about what is happening in health care settings around the country. Millions of decisions are being made about people's lives without the right information in hand:

- Is chemotherapy alone the best treatment for a patient with breast cancer, or should she be treated with radiation and chemotherapy?
- How do persons with diabetes, high blood pressure, and obesity manage all the different demands of their conditions?

Patients and consumers struggle with even more basic decisions:

- Which provider to see?

- When to seek care?
- Which treatment option is best for their needs?

Many of these decisions are difficult even in the most ideal circumstances, when there is sufficient time to assess good, reliable information. But as we all know, these decisions frequently must be made at times and places where information is not available, and time is of the essence. The power of health IT can help us to harness the power of large amounts of data to regularly assess quality and outcomes, and to put the analysis of the reliable data into the hands of a provider or patient in a usable format when they need it most - at the point of care or at when making decisions about care.

Health IT can be a tool to help bind our health care delivery sector together and bring much-needed information, services, and innovations to anyone who needs health care.

AHRQ, Health IT, and Underserved Populations

AHRQ's initiative on health information technology is a key element to the nation's 10-year strategy to bring health care into the 21st century by advancing the use of information technology.

The AHRQ initiative includes more than $166 million (FY 2004-FY2006) in grants and contracts in 41 states to support and stimulate investment in health IT, especially in rural and underserved areas. Through these and other projects,

AHRQ and its partners will identify challenges to health IT adoption and use, solutions and best practices for making health IT work, encourage the use of health information technology as a normal cost of doing business, and market-based tools that will help hospitals and clinicians successfully incorporate new IT.

Through this initiative, AHRQ is working to ensure that the promise and potential of health IT is available to all Americans.

More than 50 percent of AHRQ's health IT funding has targeted rural populations. From FY2004-FY2006, the amount spent for rural health IT projects totaled $75M.

Under our newly funded Ambulatory Safety and Quality Initiative, we are spending $6.5 million for health IT grants targeting priority populations of a total $21 million in grants in FY07. Mr. Chairman, we recently awarded one such grant – of nearly $700,000 – to the New York City Department of Health/Mental Hygiene to enable the meaningful measurement of the quality of care, with a focus on public health priority issues, disadvantaged populations, and small office practices.

This project will design and test a simple and intuitive "quality dashboard" suitable for small office practices that will integrate quality measurement and clinical decision support at the point of care.

AHRQ is very pleased to be collaborating with the Office of the National Coordinator of Health IT on the funding of a report to review and analyze the best clinical evidence on use of health IT by the underserved, elderly and disabled. The findings of this analysis will give us information we need to ensure that these populations reap the benefits of health IT.

States also play a critical role in all aspects of health care delivery. To that end, in FY2007, we also have funded a $3 million contract with Research Triangle Institute to provide technical assistance to up to 20 states on best use of health IT to improve the quality of healthcare for Medicaid and SCHIP beneficiaries.

Technical assistance is very critical to the successful adoption and implementation of health IT. To assure that as many Americans as possible benefit from our research, we have created a National Resource Center for Health IT.

The Resource Center leverages our investments in health IT by offering help where it's needed most in real world clinical settings that may feel ill-equipped to meet the implementation challenge. It facilitates expert and peer-to-peer collaborative learning and fosters the growth of online communities that are planning, implementing, and researching health IT.

AHRQ has also used the Resource Center to assist States that are initiating statewide clinical data sharing. We have convened small, round-table working

meetings of experts to share detailed expertise with States as they determine governance and technical architecture of their data-sharing organizations. We have met with many states, including New York, Wyoming, Montana, Delaware, Maryland, and Georgia.

The Resource Center provides a Web portal with capabilities to convene practitioners, encourage collaboration, and disseminate best practices. The portal gathers communities of practices with similar interests and concerns to share and learn. The Resource Center also supports a special portal for the nation's community health centers, providers in the Medicare health IT initiative, and the Indian Health Service, as they work to adopt health IT.

Lessons Learned

Mr. Chairman, I would like to conclude by offering a few brief observations based upon our work in health IT.

First, high quality health IT alone cannot improve our health care system unless it is integrated into the very fabric of care by incorporating systems into our individual clinical practices, hospitals and other settings.

Second, for most health care settings, health IT is not likely to create "out-of-the-box" solutions. Effective use of health IT begins with a careful examination of the health care setting and then uses the power of IT to enhance effectiveness and efficiency.

Third, accelerating the pace of health IT adoption and implementation, given the level of economic investment that would be required, requires the sharing of both knowledge and experience through additional opportunities for voluntary peer-to-peer learning.

Finally, the development of interoperable health IT can accelerate the pace of innovation and the speed with which patients will benefit from new medical breakthroughs. The inherent delays in our current system for assessing the effectiveness of new drugs, devices, and procedures could decrease dramatically with widespread use of health IT and advance our common goal of evidence-based medicine.

Conclusion

Mr. Chairman, thank you for the opportunity to update you on the progress we are making in the area of health IT, particularly for underserved populations. I am confident that working together, we can ensure that all American receive high-quality, safe health care services.

Mr. TOWNS. Thank you.

Let me first thank all three of you for your testimony. Again, I apologize for our lateness. There were votes on the floor and, you know, you have to vote around here. You know, if you don't vote, they talk about you so that delayed us. So I wanted to just sort of apologize for that.

Let me begin with some questions. You know, I'm concerned that the communities that need health care, better health care, are generally the communities that will probably last be connected. I mean, these are the communities that will sort of be left out.

What can we do to try and make certain that the communities that have been neglected for so long are not neglected this time around? What can we do to prevent that from happening?

Ms. AUSTEIN CASNOFF. Well, certainly that is the population that we target, and those are the providers who we work with. Obviously, the majority of the patients we serve are uninsured. Over two-thirds are minority populations, so HRSA's mission is very much geared toward addressing the needs and in providing the highest quality care to those populations.

We do believe, as my peers today have talked about and as I've talked about, that HIT is a very powerful tool to help move that agenda forward; and I think you will hear as well from the next panel some very specific examples, including one of our grantees who is moving that forward and who is using HIT to accelerate the pace of quality care in those kinds of communities. That's specifically what our grants are targeted to do.

Mr. TOWNS. Any other comments?

Dr. KOLODNER. Mr. Chairman, as you know, we do have this national awareness of the need to move forward in health IT. And, really, there have been fairly early efforts to move forward, and there have been attempts to do this over the last 15 years. I would say that the activities that have occurred in the last 3 years, actually, have made more progress than in the decade or two before that.

What we need to do, as I'd mentioned, is to make sure that in every aspect that we're looking at, whether that's the electronic health record or the funding for resources there or the network and how it is addressed or privacy and security policies and in understanding that there are difficult cultural biases and preferences, that we need to take into account, to make sure, that as we do each of these activities that we involve the community, that we involve those who are members of the medically underserved communities or those who are taking care of them.

Mr. TOWNS. Do you want to add anything, Dr. Clancy?

Dr. CLANCY. The only thing I'd add is, when I think about some of the really dramatic successes we've seen, they include a number of underserved communities; and I think our collective challenge in working together and with you is to make sure that we can scale this up as rapidly as possible. It is absolutely not a given that we have to have a digital divide and that we can't bring everyone along together.

So, in New York City, you know, the Health and Hospitals Corp. has been using a registry for the past few years, which is the specific application or functionality of an electronic health record to

track people with diabetes; and it makes a big difference. You can't do that on paper.

So that's the kind of advance that I think we can insist on and will continue to do so.

Mr. TOWNS. How about establishing an HIT empowerment zone, a health empowerment zone?

You know, I'm looking at these empowerment zones around the country and in other areas that have really done some remarkable things. You know, I was in Harlem just recently, a place that was just written off. They now have an empowerment zone there, and it's the place to be now. You know, people are fighting to get in there, and they're saying that the empowerment zone really made the difference.

So when I look at areas that have all of these health disparities, what about the possibility of creating an empowerment zone to deal with the health issues in these areas? Because the traditional fashion—you know, for some reason, they have just not gotten service, and so I just think that if we continue down the road—and you mentioned in terms of 20 years. See, those communities might be 40 years; they might be no years, you know. So I'm just wondering, what is your reaction to a possible empowerment zone that would take this information and would come in and would make certain that they get everything and get it first and then move forward?

Dr. CLANCY. Well, I guess, Mr. Chairman, I'm not exactly sure what an "empowerment zone" is. We'd like to followup with you on that.

Let me say that I think one terrific aspect of the work that Dr. Kolodner's office has launched, particularly in the Nationwide Health Information Network, is the potential to connect public health with clinical care. We know that we've seen as a result of reporting on quality of care that we are starting to see improvements overall and a reduction in disparities for those activities that take place in a clinician's practice—so were the right tests ordered?—and so forth.

Where we're seeing slower improvements are in those areas that require chronic, ongoing care to achieve, for example, the optimal control of diabetes, the control of risk factors for heart disease and so forth. We believe that in order to actually advance those areas of quality, we are going to need good connections between clinicians' practices and resources in the community, and I think health IT could be very powerful there. And I think that's one of the potential, powerful applications of the Nationwide Health Information Network; it's that kind of connectivity that you need.

Mr. TOWNS. Right.

Dr. Kolodner, is there a written policy office that ties the implementation of health IT and grants to the reduction of health disparities? Is there a written policy?

Dr. KOLODNER. There is not a specific written policy.

What we have done is, as I've mentioned, in each of the activities that we've undertaken, we have specifically written in language. For example, on the grant contract agreement that we put out for the AHIC successor, we specifically wrote that a consumer sector would need to address the needs of healthy populations as well as those of vulnerable, disadvantaged and chronically ill populations.

In the NHIN network contracts that we put out, when we put out the first contract language, we said that to be considered as an eligible health information exchange the applicants would need to include different types of provider organizations, two of which must include independent physician practices and safety net providers.

So, while we don't have a single specific policy written in the office that says what we're going to do, we actually have been embedding it in all of the activities that we've undertaken.

Mr. TOWNS. You know, let me ask, is there any coordination of these programs? I'm just concerned about that. I mean, do agencies talk to each other about what's going on and about what needs to go on?

You know, I was just listening to the comments made earlier by Dr. Christensen when she was talking about it in terms of disparities and in terms of the numbers. Are the agencies talking to each other as we move forward?

Dr. KOLODNER. Yes. Actually, if you had asked me that question 3 or 4 years ago, I think you would have found kind of spotty collaboration. What we have, in fact, been doing, especially in the last few years, is increasing that.

I think one of the reasons that you might have a question about that is we probably haven't done as good a job of communicating the activities that we have been doing, but we have, for example, a Health IT Policy Council that is across the Federal agencies and departments, and we have a Federal health architecture group that involves 26 different agencies and departments. So we actually do have collaboration going on, and we connect the appropriate levels and the appropriate types of people in each of the departments and agencies. And, as I've mentioned, not only across the Federal sector but also with our activities with AHRQ and with others, we're actually facilitating collaboration across the States and between the Federal and the State entities.

So we are doing our very best. There are a lot of things that are going on. I'm sure there's opportunity for improvement, but I think we actually have been doing a great deal of the collaboration in the last couple of years.

Ms. AUSTEIN CASNOFF. If I may, collaboration is absolutely key to what we do. We spend a very large part of our energy in working with other agencies and in finding partners to help the safety net providers.

For example, next week, we're having our first-ever HRSA-HIT grantee meeting with over 600 attendees—the title is Success through Collaboration and we are very pleased that AHRQ is represented there—the National Coordinator, every Federal agency as well as public and private sector organizations.

So we believe it is absolutely critical to not only HRSA's activities but particularly to our grantees, and we are trying to educate our grantees about collaboration with potentially nontraditional partners as well, working with States, working with the Governors and their legislatures, working with their Medicaid agencies. So we absolutely emphasize that as critical to the movement of HIT in the safety net community.

Mr. TOWNS. At this time, I yield to the ranking member, Congressman Bilbray.

Mr. BILBRAY. Thank you.

Dr. Clancy, you made a reference that 50 percent of your funds are going to rural, 50 percent.

Dr. CLANCY. Yes.

Mr. BILBRAY. Off the top of your head, generally, what would that be in comparison to the general population? 10 percent?

Dr. CLANCY. Do you mean what proportion of the U.S. population is rural?

Mr. BILBRAY. Yes.

Dr. CLANCY. About 25 percent.

Mr. BILBRAY. You know, I grew up in a working class neighborhood where, without the Navy hospital, you had the clinic, and that's about it; you had the neighborhood. With the underserved community, it was so easy for us to use race and to use ethnic background, but, overall, the common denominator in my neighborhood was that we were working class people who were below the average income. That's pretty consistent. The economic status is the largest determining factor with the underserved. Is that fair to say?

Dr. CLANCY. What I can tell you is, from our annual report on health care disparities, we see big gaps associated with individuals' race and ethnicity, and we also see very large gaps for poor compared to high-income Americans.

Mr. BILBRAY. But don't those ethnic groups tend to fall into the same category as the ethnic? I mean, I find it hard to believe that a lot of our Californians who live in Hollywood and who happen to be African American are not going to be falling into the underserved population in their neighborhoods. You know, the poor tend to be underserved no matter who you are. Do we move up into the middle class and upper middle class where the minorities are getting hit pretty hard with it?

Dr. CLANCY. Both race or ethnicity and income turn out to be important and independent predictors of getting even poorer quality of care than everyone else. They are, as you note, often closely associated, but they are independent. So there are members of racial and ethnic minorities who have done much better, in terms of income, who still experience disparities.

Mr. BILBRAY. But the community base tends to be served, generally, substandardly in both areas?

Dr. CLANCY. Yes.

Mr. BILBRAY. The VA had a success story with Hurricane Katrina in recovering the records. Why were you able to be so much more effective at recovering records than the private sector in New Orleans?

Be careful. You've got to remember that my wife is from New Orleans, so I lived through that. We had a house hit by Katrina.

Dr. KOLODNER. For about 20 years, the VA started investing in health IT, and it was an effort that was led by the frontline clinicians, not just a top-down type of process. So the issue of top-down/bottom-up, for example, is something I do not see as an either/or. It has to be at both ends. Leadership has to say that we want to do it, but the real innovation and creativity and motivation is going to come from the frontline commissions. So the VA had, over that

period of time, been able to put in an information system that was extensively used.

In many places, such as New Orleans, it was essentially paperless. When the power went out in New Orleans and the veterans were trapped in the VA hospital, they did have emergency power, and the electronic health record actually continued to run up until the time that the last person was evacuated. And they were able to take that information and within 24 hours have it loaded so that wherever those people went, their information was there and available. And I think that's the kind of experience that confirms the value of having the information electronically and the tremendous improvement in the continuity of care not only in crises, but in other times as well, and improving the quality of care that electronic health records allow.

Mr. BILBRAY. Doctor, the private sector for decades now has been trying to get away from paper records and trying to go to electronic, and they haven't been doing it because of some lofty vision of fairness. They've basically been doing it because they feel it's cost-effective.

Is that fair enough to say that we should be able to implement an IT system that, in the long run, will be more cost-effective than maintaining the paper structure we have today?

Dr. KOLODNER. Yes, I think that would be very fair.

Mr. BILBRAY. The question will be then, where are we going with the VA? Can the VA lead the Federal family by setting an example for the rest of the Nation and lead through example rather than through mandate?

Dr. KOLODNER. Well, we are working—with the collaboration I mentioned, we actually have the VA, the Department of Defense and the Human Health Service all at the table and helping with the national health IT agenda, both connecting into the Nationwide Health Information Network as well as at the table, advancing the standards and embracing the standards themselves.

I think one of the things that those agencies have had as an advantage is that there's a perfect alignment between the funding and the incorporation of health IT. Right now, one of the challenges we have is, with the disparate funding mechanisms we have and with some of the perverse incentives there, that what we are working to do is to get not only solutions in place, but we are working to align those adoption incentives so that we can move forward.

Mr. BILBRAY. You know, sadly, so often those who would be the best served are the most scared of new technology. I mean, the real scare tactics out there are people being scared of new technology being used. It astonishes me the people who will talk about and be worried about privacy, and then they'll have a cell phone on their hip or in their purse and they'll have a credit card in their wallet. Any one of us who uses either one of those devices can be extensively tracked even when the phone is turned off.

I always like making my constituents feel really comfortable with that.

What are we doing about security with the IT issue? Any one of you can answer that, but I know the VA has been pounded on this for a while.

Dr. KOLODNER. The VA has been pounded on it. Although, if you look at the instances, the electronic health record that is used for the delivery of care isn't where the breaches have occurred. We know, as we roll out the national health IT agenda, that the security and the privacy of that information is absolutely fundamental. I would not put my information on a system that's not secure and that's not honoring the privacy in the way that I might want it. So we're building that into the foundation.

As to the certification of the products—of the electronic health records—for example, security is one key factor for that certification criteria. With the Nationwide Health Information Network, the security is a key part, and what we actually have done in the trial implementations of the nine contracts that we've just let is we've built in consumer choice as a requirement for participating, where the individuals get to say whether or not they want their information to flow over the network at all or how they might want it to flow.

So we believe that those are critical capabilities. We are still learning how to balance those and how to make sure that we honor those without actually causing an increased chance of giving them bad care. So those are the kinds of things that we need to pursue.

Mr. BILBRAY. But isn't it true that with cooperation and with the biometric confirmation that IT has the potential, if done properly, to substantially increase the security and privacy with documentation as opposed to the existing system where you have clerks going through it and you have paper needing to be shredded and that kind of issue?

Dr. KOLODNER. When done properly, health IT actually is much, much better than the paper record.

Mr. BILBRAY. Ladies, do you have any comments to either one of those issues?

Dr. CLANCY. I agree.

Mr. BILBRAY. Thank you very much.

I yield back, Mr. Chairman.

Mr. TOWNS. Thank you very much, Congressman Bilbray.

Congresswoman Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. I thank you and the ranking member for allowing us to join you in this hearing.

I would just like to say, on the health empowerment zones, I know Dr. Clancy has heard me talk about them, the part of H.R. 3014 that have been part of our minority health bill going back two Congresses. I think it's a very good concept, and it goes beyond what you may know as REACH, the REACH Program, to allow communities to have priority access for programs at any agency that can help them meet their health care goals. So, in 3014, you'll see a little of what a "health empowerment zone" is.

Dr. Clancy, I guess I'll start with you. We've been working together for a long time, so you probably can anticipate my first question, which is, are any grants going to territories or are they precluded from having some of these grants, the $166 million worth of grants that are going to 41 States?

Dr. CLANCY. I was just checking with my experts here who are closer to the actual detail. We do have a collaboration with Puerto

Rico. This was part of the collaboration we did with ONC, which looked at information security and privacy policies and actually——

Mrs. CHRISTENSEN. The territories are eligible and can apply competitively?

Dr. CLANCY. Yes. Yes.

Mrs. CHRISTENSEN. With regard to community health centers, how many community health centers do we have in the country?

Ms. AUSTEIN CASNOFF. I believe there are over 1,000.

Mrs. CHRISTENSEN. Was that "18" number for community health centers that have gotten grants? Are those all that have gotten—I can go back to your testimony, Dr. Casnoff: Eighteen health centers were awarded high-impact EHR grants in 2007.

My question really is, since these are so central to the delivery of health care in underserved communities, is there a long-term plan to have all of them hooked up to HIT, all of them electronically, to have all of their medical activities electronic?

Ms. AUSTEIN CASNOFF. Well, we are still exploring how to get to complete coverage for all of the health centers. Obviously, they need to be part of the broader movement toward electronic records.

What we are doing is, in a sense, we are seeding; we are demonstrating; we are getting started and are helping each of our networks' grantees move to more and more health centers. So we are continuing to expand the number of health centers that are getting HIT support, and we believe very strongly they need to do it together and not necessarily as individual health centers. So we think they can learn from each other, benefit, reduce the risk of purchasing. Each of our grants requires these networks to take on new health centers and not continue to fund the same ones, so we are moving in that direction.

Mrs. CHRISTENSEN. As the different agencies under Health and Human Services collaborate, do you try to make sure that—because HRSA has grants and Dr. Clancy's agency has grants and there are other grants in the department, do you try to coordinate so that they are fairly spread across the country, so that one State isn't getting one from the agency for health care quality and research grants and also getting yours? Are you spreading it around in your collaboration?

Dr. KOLODNER. Many of the grants and contracts are a competitive process; and so, depending on whether it's a contract or a grant, we may be actually locked into what the ranking of the applicant is. But we do, in fact, sit down and look at where those different activities are occurring so that we can get as broad a spectrum as possible.

Mrs. CHRISTENSEN. Well, our communities don't necessarily have a lot of grant-writing expertise. I wonder how you accommodate for communities that have high need but don't really get the high grades on the grant applications.

Ms. AUSTEIN CASNOFF. That was a very large priority of Dr. Duke's, the Administrator of HRSA, which was to make sure those communities that, in a sense, were left behind in the grant process received grants. So there was a whole special competition this year for those areas that have never received a health center grant before, and we also work very closely—we have something called "planning grants," because we heard from the communities that

not everybody was ready to move into a more sophisticated HIT, so we actually did a special competition of relatively small grants to get people started. We certainly recognize that not everyone is at the same point.

Mrs. CHRISTENSEN. Dr. Kolodner, you said in your testimony that the agency has taken specific steps to include medically underserved populations as you transition to the AHIC successor. Could you tell us something about the steps that you've been taking?

Dr. KOLODNER. OK. That's what I mentioned a little bit earlier.

The process that we're doing right now is—we actually put out a cooperative agreement type of grant. The applicants sent in their applications by the end of September, and we are in the process of selecting, but the messaging that we sent out to anybody who was considering that application was, as I mentioned, the need to take into account and to include a broad spectrum of consumers, including those who are from the vulnerable populations.

In addition, because it's a cooperative agreement, we will be working with the awardee to make sure that they, in fact, have at the table, as part of the participating group, members from a variety of rural, underserved and medically vulnerable populations.

Mrs. CHRISTENSEN. Go ahead.

Ms. AUSTEIN CASNOFF. I was just going to add that any time there is a public notice as Dr. Kolodner is referring to, we get that out specifically to our HRSA grantees to make sure that they're aware of these public comment opportunities and to offer them the opportunity to make sure that they do respond.

Dr. CLANCY. One other point. I'm sorry. When you were asking about how we try to create a coherent portfolio and to make sure that we're reaching out, one of the ways that we do that—as a matter of fiscal responsibility, there are very specific checks and balances—for example, to make sure that we're not funding the same person in four different agencies to do the same work. In addition to that, you heard Cheryl say that she served as a reviewer for our grants. We also use set-aside mechanisms.

So, this year, in a portfolio of $21 million of grants that we were going to make, we said we are going to set aside a few million dollars. Actually, we ended up investing more in underserved communities. We had about twice as much as we had set aside, which I thought was actually a very good sign. So there is a fair amount of outreach. I think we could do more, but we are working very hard.

Mrs. CHRISTENSEN. Just as I'm going through—I'll hold on any other questions I might have for right now.

I wanted to just point out that some of you are familiar with the minority AIDS initiative and the fact that when funds were to be targeted to indigenous communities and faith-based groups, a lot of other groups came in and started to change the board around. They hired a new executive director and presented themselves as minority organizations.

So as you reach out to make sure that minorities are sitting at the table, I just want to make sure that you're aware of that and that you try to get organizations or groups that are really from the community.

Mr. TOWNS. Thank you very much.

Congressman Clay.

Mr. CLAY. Thank you, Mr. Chairman.

Let me start off with some questions for the entire panel.

Is there any consideration given to reducing health disparities in either your grant deliverables or your grant strategy? And this is along the same line of questioning as Dr. Christensen. In other words, what health-policy objectives are you attempting to meet, in terms of your agencies' overall goals?

Ms. AUSTEIN CASNOFF. If I may begin, we actually asked anyone applying for money this year to have a baseline set of core quality measures. HRSA's moving toward a consistent set of measures, and we have built some of those specifically into our grants. And then we will be monitoring; they will be required to report on those as well.

So we absolutely are committed to quality measurement, because, again, HIT is not the end. It's improving the quality of care in a very quantitative, measurable way.

Mr. CLAY. OK.

Dr. Clancy.

Dr. CLANCY. Because we have the opportunity, which I would like to thank you all for, to report annually to all of you on both quality and disparities in care, what that means is that, for the first time in this country, we actually have a consistent set of metrics, and we can report our progress in terms of how we are doing.

And for each group, in some areas we are doing better, in other areas we're about the same, and in some areas we're doing worse. We use that very specifically to frame a lot of priorities for our initiatives.

So, by way of example, our recent disparities report found some pretty glaring problems for Hispanic elders. So that has resulted in a collaboration with the Administration on Aging specifically targeting preventative services for Hispanic elders, because the rates were so strikingly different.

So we've got the framework to be able to do that, and my colleagues will tell you that we're not shy about sharing these results.

Mr. CLAY. Very good.

Anything to add, Doctor?

Dr. KOLODNER. Well, the activity of our office is actually fairly small, in terms of the grant. It's really trying to get the infrastructure in place. But, as I've mentioned, it is important that we make sure that infrastructure be informed by the needs of all of the communities. And we have done the very best that we know how to get that input and to make sure that those communities are involved. We will continue to work in that direction.

Mr. CLAY. Thank you for that.

Another panel-wide question: The implementation of health IT can be expensive, in terms of large-scale enterprise-type solutions. Have you looked into smaller-scale technologies like smart cards, cellular phones, to interconnect community health facilities?

Ms. AUSTEIN CASNOFF. One of the things we heard from our community, again, when we put out a Federal Register notice, was it was not just about electronic health records, as you say, so we created something called the innovations grant. And we had, in a

sense, low-hanging fruit and heavy lifting. And it was just as you said, for our health centers serving the populations in need, what best serves their needs?

And you will hear on the next panel from one of the recipients of that, about how personal health records or kiosks or e-prescribing or linking oral health or mental health to medical records. So it is not always the biggest solution. Sometimes it is those intermediate solutions or building on something that is already in place.

So that's absolutely a priority for our awards.

Dr. CLANCY. I mean, I'm sure you're aware that in the health care industry, generally, there is a lot of innovation going on, in terms of using cell phones and other technologies to reach people for disease management and other interventions. We have funded a fair amount of work in this area.

In addition to that, we now have a clearinghouse where people can share these innovations. And we are reaching out very broadly so that people know about this, so they know about potential promising practices that will help them.

So it is not the full enterprise solution or paper, you know, that there is steps on the way.

Mr. CLAY. Doctor.

Dr. KOLODNER. Well, the idea of having standards is that it actually breaks you free of a particular technology solution so that, really, innovation can occur. And by making sure that the standards are there and not proprietary but are really open, I think it fosters a tremendous amount of creativity and movement forward for just the type of opportunities you are talking about.

Mr. CLAY. Thank you.

Mr. Chairman, is the clock malfunctioning? That 5 minutes went awfully quick. Oh, it's 3 minutes. I'm sorry.

Mr. TOWNS. Yes, yes, but if you need another half a minute, I'd be delighted to give it to you.

Mr. CLAY. Thank you. I'm touched.

Just real quickly from all of you, are you using small or disadvantaged business vendors to supply your grantees with any technological capability?

Ms. AUSTEIN CASNOFF. Well, we award grants to our health-center networks, and then they have to follow proper procedures to do competitive purchasing. We do not get involved at all in their selection of products. But they do have to follow Government rules in terms of competitive purchasing.

Mr. CLAY. But you do monitor who they award the contracts to?

Ms. AUSTEIN CASNOFF. Correct.

Mr. CLAY. And do you know if they use small or disadvantaged-owned business?

Ms. AUSTEIN CASNOFF. I am not aware of that, but we can certainly get that information for you.

Mr. CLAY. Would you provide this committee with that, please?

Ms. AUSTEIN CASNOFF. Sure. OK.

Mr. CLAY. Thank you. I yield back.

Mr. TOWNS. Yeah, on that note, let me just say that—do other agencies outside of HHS have health IT grants?

Dr. KOLODNER. I think the grants to the communities—USDA has some grants. I don't know that their communities—they do

have grants for electronic health records. FCC has some things; in fact, they have a grant program that I think they will be announcing the results of shortly, that are medical broadband connectivity to rural and underserved areas. And that is not just rural, but also inner-cities.

There are others that do have related technologies but not usually for the kinds of health IT that HHS entities fund.

Mr. TOWNS. All right. How can we get a list of these grants? Is there any way that we can—I will definitely be delighted to hold the record open to get it—a list of all of these grants, because I think the question raised by my colleague from Missouri, in reference to minority vendors, you know, I think that is something that we need to really look into.

Dr. KOLODNER. I think we have a partial list. I can go see whether we can refresh that and get that back to you.

Mr. TOWNS. I appreciate that. Thank you so much.

Any other questions?

Let me thank all three of you for your testimony. I really feel that this is a very important issue. I think that this is a way that we can address some of the concerns that are out there. And I appreciate your honesty and the fact that there is a disparity in a major kind of way, and we feel that through this process, maybe we can correct some of these things. But in order to do it, you will have to be flexible and to make certain that the areas that are not served are served. And I think that's key. You know, we don't want to leave them out again.

So thank you so much for coming. I look forward to working with you in the days and months ahead.

And you will hear more about this empowerment zone. You know, we think that has a lot of potential; we think that will help us with the disparities. And, of course, we will be working on it.

And I want to thank Dr. Christensen for her efforts in this area. I want to thank Congressman Clay and my colleague, Congressman Bilbray.

And I say about this committee, you know, in the Congress, we have a lot of people that do not work together and do not work in a bipartisan way. But I tell you now, this committee is a bipartisan committee, and we work together.

Thank you so much.

Mr. BILBRAY. Because we fear the chairman; that's why. [Laughter.]

Mr. TOWNS. Thank you so much.

[Witnesses sworn.]

Mr. TOWNS. Let the record reflect that all five have answered in the affirmative.

So I want to start with you, Ms. Marchibroda, and then sort of just move right down the line.

STATEMENTS OF JANET M. MARCHIBRODA, CEO, EHEALTH INITIATIVE; DR. WINSTON PRICE, CHAIR, HEALTH IT AND TRANSPARENCY ADVISORY BOARD, STATE OF GEORGIA; LORI EVANS, DEPUTY COMMISSIONER FOR HEALTH IT TRANSFORMATION, STATE OF NEW YORK; DR. FARZAD MOSTASHARI, ASSISTANT COMMISSIONER, DEPARTMENT OF HEALTH AND MENTAL HYGIENE, CITY OF NEW YORK; AND DR. NEIL CALMAN, PRESIDENT, INSTITUTE FOR URBAN FAMILY HEALTH

STATEMENT OF JANET MARCHIBRODA

Ms. MARCHIBRODA. Good afternoon, Chairman Towns, Ranking Member Bilbray, honorable subcommittee members, Dr. Christensen, distinguished panelists and guests.

My name is Janet Marchibroda, and I am the chief executive officer of the eHealth Initiative. It is an honor to offer my testimony before you today on Federal, State and local efforts to transform health and health care using health information technology.

Chairman Towns, I greatly appreciate your invitation to address this subcommittee, and I commend you for your leadership in furthering the use of health IT to improve health outcomes, enhance access to care for medically underserved communities, and reduce health disparities. We at the eHealth Initiative look forward to working with you and the Health IT Empowerment Caucus.

The eHealth Initiative [eHI], is a nonprofit independent organization whose mission is to improve the quality, safety and efficiency of health care using information and information technology. We are a diverse group representing every sector of health care, both nationally and locally. We serve as a key bridge between national policy and local initiatives through our work in States and communities, and actually helped 20 States in our country develop road maps for using health IT and are working with a number of regions to drive sustainability of health information exchange.

As my written testimony indicates, concerns about quality, safety and disparities in care and rising health care costs have driven the Federal Government and national and local leaders alike to look for solutions to these challenges.

Because of the highly fragmented nature of our health care system, clinicians often don't have the information they need to better serve patients, those that are responsible for population health also don't have that information, and then, most importantly, patients can't easily engage in their own health and health care, view their own health records or choose to share their health information across clinicians who treat them.

And so, a lot is going on at the Federal level—that is in my written testimony—as well as the State level, and it's very interesting. A number of States are now moving forward with great vigor around moving the health IT agenda. While there was no legislation prior to 2005, actually in 2005 and 2006, 38 States introduced 121 bills related to health IT, and 36 were passed in half of our country's States.

Since January 1 of this year, 217 bills have been introduced across all 50 States in the United States related to health IT, and

also Governors are playing a significant role, with 20 Executive orders having been issued.

In addition, if we go one more level down, there are a number of community-based initiatives—and we counted 165 back in 2006—that are bringing multiple stakeholders together to mobilize data to improve health care quality and safety.

But, despite all of this activity, adoption has been slow for a number of reasons. There is a lack of standards adoption that would enable interoperability. There is a misalignment of incentives that often drives volume and fragmentation as opposed to sharing information. There are some concerns about privacy and confidentiality, and not to mention the significant workflow issues within the small physician practice.

We put together, working with 200 organizations from every sector of health care, the "eHealth Initiative Blueprint: Building Consensus for Common Action," which is a shared vision and a set of common principles, strategies and actions for improving health through information technology.

We were able to achieve consensus on a number of issues, but there were two areas where more work, more dialog is needed. We got to consensus on principles, but in the areas around policies for information-sharing, and specifically financing, more work is needed, and a public-private sector dialog and partnership will be needed in order to move that work forward.

You asked us, top-down or bottom-up? Are there too many cooks in the kitchen? And which approach will work best? We believe that leadership needs to come from both but needs to be coordinated.

Clearly, a need for Federal leadership for moving this agenda, particularly around adopting standards for interoperability, getting harmonization in adopting, providing guidance on policies related to information-sharing, and then, of course, stimulating the private-sector investment by providing necessary seed funding and aligning incentives.

At the same time, much work is also needed at the State and local level, and we are actually not going to get there just with the top-down approach. And I will be very brief, as we watch the time.

We did some research, and we released it back in June 2007. And what did it tell us? It said there are no incentives for sharing information, or actually disincentives across the country for doctors and hospitals and plans to share information, given our current payment system. So those that have been successful have been able to do so because they've built social capital, a radius of trust among folks that don't ordinarily work together, in order to move that forward. And you've got to do that locally, where health care is delivered. And you really need it in order to address those difficult policies for information-sharing. How do we address the privacy issues?

The other thing is just logistical. If you look, and our survey shows, that the clinical data that you need to exchange to deliver health care, most of it, a lot of it, resides locally, within the doctor's office, within the hospital, within local pharmacies. So, as a result, the Nationwide Health Information Network will need to be built from the ground up, but also linked with national networks, because there are many actors working at the national level.

So, in closing, some suggested actions for national and Federal leadership.

First thing, we need to drive standards adoption. We need to harmonize and drive adoption for interoperability. And this is critical. The Federal Government has made significant progress in the area of standards so far. We believe that the transition of the AHIC over the next several months will support the continuation of this work.

We believe that this transition, however, will require an independent convener that engages every sector of health care in an inclusive, transparent and balanced process that is designed to listen, engage, synthesize and deliver a common path forward.

Second, the Federal Government should continue to lead and expand upon its efforts to develop a framework for privacy and security, leveraging things like the HISPC as well as the FACA committee under AHIC 1.0. We need to focus on aligning incentives, of course, and that is a complicated problem that we'll need to address, and a public-private sector dialog is needed.

But we think, in addition, much progress can be made today through a public-private partnership that can provide guidance on and stimulate shared action for how the field might move forward on some short-term actions or business cases for the use of information, whether it is around quality, drug safety or consumer access for information.

The Federal Government is playing a leadership role in addressing disparities, but opportunities exist for more leadership in this area. Health IT offers great promise for helping clinicians deliver equitable care through evidence-based decision support, chronic care management tools and population health functions.

But targeted resources must be provided to those clinicians who serve minority and other underserved communities to ensure they are not left behind in the drive to accelerate health IT adoption. The Federal Government can play a strong role in ensuring that the providers have the resources they need, whether it's grants, loans or hands-on help, to support this process.

In addition, the Federal Government——

Mr. TOWNS. If you could sum up. Yeah, the lighting is not working.

Ms. MARCHIBRODA. OK. Should I stop?

Mr. TOWNS. Sum up. Just sum up.

Ms. MARCHIBRODA. OK, I'll sum up.

So around the areas of disparities, there are a number of areas that need more Federal involvement in order to move this work forward.

Finally, and we heard earlier, providing technical assistance is very important and particularly States and communities, as you deal with sustainability, we need to focus on that area.

Thank you for the opportunity, and I look forward to answering any questions you may have.

[The prepared statement of Ms. Marchibroda follows:]

HEALTH INITIATIVE

Testimony of Janet M. Marchibroda

Chief Executive Officer

eHealth Initiative

Before the

U.S. House of Representatives

Committee on Oversight and Government Reform

Subcommittee on Government Management, Organization and Procurement

November 1, 2007

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U.S. House of Representatives
Committee on Oversight and Government Reform

Statement of Janet M. Marchibroda, Chief Executive Officer, eHealth Initiative

Testimony Before the Subcommittee on Government Management, Organization and Procurement of the House Committee on Oversight and Government Reform

November 1, 2007

Good afternoon Chairman Towns, Ranking Member Bilbray, Honorable Committee Members, distinguished panelists and guests. It is an honor to offer my testimony before you today on federal, state and local efforts to transform healthcare through health information technology (IT) and health information exchange, and discuss how agencies and stakeholders can coordinate to meet the needs of our nation's most vulnerable populations.

Chairman Towns, I greatly appreciate your invitation to address this Committee, and I commend you for your leadership in furthering the use of health information technology to improve health outcomes, enhance access to care for medically underserved communities and reduce health disparities. We at the eHealth Initiative look forward to working with you.

The eHealth Initiative (eHI) is a non-profit, independent organization whose mission is to improve the quality, safety and efficiency of healthcare through information and information technology. eHI engages multiple stakeholders, including clinicians, consumer and patient groups, employers, health plans, healthcare IT suppliers, hospitals and other providers, laboratories, pharmaceutical and medical device manufacturers, pharmacies, public health, and public sector agencies, as well as a growing coalition of more than 200 state, regional and community-based collaboratives to develop and drive the implementation of a common set of principles, policies and best practices for mobilizing information electronically to improve health and healthcare in a way that is responsible, sustainable, responsive to each stakeholder's needs, and which builds and maintains the public's trust.

eHI also serves as a bridge between national policy and local initiatives through our work in states and communities, where we have helped nearly 20 states develop plans for transforming their own healthcare systems through health IT, and where we have helped communities research and discover how to build sustainable health information exchange from the ground up.

The Need for Coordinated Action in Healthcare

Concerns about quality, safety, and rising costs in healthcare have driven the federal government and national and local leaders alike to look for solutions to these challenges. Among these challenges, U.S. adults receive about half of recommended health care services.[1] Despite

[1] McGlynn EA, Asch SM, Adams J, et al. "The Quality of Health Care Delivered to Adults in the United States". N Engl J Med 2003;348:2635-2645.

documented benefits of timely preventive care, barely half of adults (49 percent) receive preventive and screening tests according to guidelines.[2] And poor quality translates into higher costs. The current gap between national average rates of diabetes and blood pressure control and rates achieved by the top ten percent of health plans translates into an estimated 20,000 to 40,000 preventable deaths and $1 to $2 billion in avoidable medical costs.[3]

In addition, chronic disease is a growing and costly problem in the United States. More than 125 million Americans had at least one chronic care condition in 2000, and this number is expected to grow to 157 million by the year 2020.[4] People with chronic conditions drive a majority of healthcare spending in the U.S., accounting for 78 percent of all health care spending in 1998.[5] Seventy-six percent of all hospital admissions are attributable to people with chronic conditions. And people with chronic conditions account for 88 percent of all prescriptions filled and 72 percent of all physician visits.[6] In a country where healthcare spending is 16 percent of the gross domestic product, and much higher than other industrialized countries, the United States--according to many leading employers--is losing its competitiveness and ability to compete globally.[7]

Finally, the Agency for Healthcare Research and Quality's 2006 National Healthcare Disparities Report indicates that disparities in care remain prevalent--with some disparities diminishing while others are increasing; and that opportunities for reducing disparities remain.[8]

The Commonwealth Fund's recent survey of healthcare opinion leaders released in July 2007 showed that 67 % of health care opinion leaders thought the acceleration of health IT would be effective in improving quality and safety in healthcare.[9] Concerns about America's health and healthcare are not only shared by healthcare opinion leaders, but also by consumers. According to a 2006 Kaiser Family Foundation survey, over half (54 percent) of American adults are dissatisfied with the quality of healthcare and almost a third (31 percent) are very dissatisfied.[10] In addition, over 81 percent of Americans are dissatisfied with the cost of health care in the U.S., with a majority (56 percent) very dissatisfied.[11]

Because of the highly fragmented nature of the U.S. healthcare system, information about the patient is stored in a variety of locations largely in paper-based forms and therefore cannot easily be accessed. As a result, clinicians often do not have comprehensive information about the

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[2] The Commonwealth Fund. *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*, New York: The Commonwealth Fund. 2006.
[3] The Commonwealth Fund. *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*, New York: The Commonwealth Fund. 2006.
[4] Wu S. Green A. *Projection of Chronic Illness Prevalence and Cost Inflation.* RAND Health, Santa Monica, California: RAND Corporation;
2000.
[5] Medical Expenditure Panel Survey, 1998.
[6] Ibid.
[7] Reinhardt UE, Hussey PS, Anderson GF. 2004. "US Health Care Spending in an International Context." *Health Affairs*. 23(3): 10-25.
[8] National Healthcare Disparities Report, 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/nhdr06/nhdr06.htm
[9] Commonwealth Fund Health Care Opinion Leaders Survey, July 2007.
[10] 2006 Kaiser Family Foundation "Health Care in America" Survey.
[11] Ibid.

patient when and where it is needed most—at the point of care—and those responsible for managing and improving the health of populations do not have all the information they need to measure progress, identify disparities and facilitate improvement. Businesses cannot measure the effectiveness of clinicians or health systems in delivering safe, equitable, high-quality care. Most importantly, patients cannot easily engage in their own health and care, view their own health records, or choose to share their health information across the clinicians who treat them.

Increasingly, leaders both within the public and private sectors are focused on breaking down barriers to higher quality, safer, more efficient healthcare through the introduction of several new strategies including those related to the adoption of health IT given its critical and demonstrated role in improving health and healthcare. And with this increased focus, we have seen a number of policy changes both at the federal and state levels.

Federal Leadership

At the federal level, the Department of Health and Human Services (DHHS) Office of the National Coordinator for Health Information Technology (ONC) is providing a significant amount of leadership and coordination within the federal government around health IT. Since its inception in 2004, ONC has initiated several activities designed to provide support for the adoption of health IT, including contracts that support standards harmonization, certification of health IT products, and the assessment of business rules and policies related to privacy and confidentiality across states.

On August 2006, President George W. Bush issued an executive order calling for healthcare programs administered or sponsored by the federal government to utilize health IT systems and products that meet recognized interoperability standards.[12] In addition, several grant programs and technical assistance activities designed to support health IT adoption have been initiated by several federal agencies including the Agency for Healthcare Research and Quality—and particularly its National Resource Center for Health IT, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Department of Defense, the Department of Veterans Affairs Administration, and the Health Resources and Services Administration.

Congress has also played a considerable role in supporting the adoption of health IT, with several bills having been introduced over the last several years that address key barriers to health IT adoption, including standards for interoperability, funding, and authorization of bodies to provide coordination and technical assistance. Most recently, in June 2007, the Senate Committee on Health, Education, Labor and Pensions approved the *Wired for Health Care Quality Act of 2007* (S. 1693) which includes several provisions related to the role of government, funding, standards, and the alignment of quality with health IT. Congresswoman Anna Eshoo recently introduced a companion bill to the Wired Act in the House, of which you are a cosponsor, Mr. Chairman. And we understand you may develop a health IT bill that focuses on how health IT can address disparities. Again, I commend your leadership, and we stand ready to work with you.

[12] The White House. *Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs.* http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html August 22, 2006.

State and Local Level Activity Continues to Rise

A number of states are also moving forward in parallel with federal efforts to develop and implement policies and plans that promote health IT and health information exchange. Recently, we have seen a significant increase in state-level legislative action regarding health IT and quality improvement. While there was virtually no legislation at the state level related to health IT prior to 2005, in 2005 and 2006 thirty-eight states introduced 121 bills specifically focused on health IT, and of those, 36 bills were passed into law in 24 states.[13] In 2007 so far, 217 bills have been introduced across 50 states that refer to the adoption or implementation of health IT, nineteen of which have been signed into law in sixteen different states.[14]

Along with the increase in the overall quantity of bills being introduced and passed on the state level, we also see a welcome shift in the focus of these bills. State legislation is becoming increasingly sophisticated, calling for a focus on improving the quality of care through the use of health IT, rather than focusing on health IT alone. Several of these bills also authorize funding of state initiatives, or establish exploratory and investigative task forces to facilitate state progress.

U.S. governors are also playing a critical role in moving forward. To date, 20 executive orders have been issued by governors in 15 states, which are designed to drive improvements in health and healthcare through the use of IT--eight executive orders in 2007 alone.[15]

The number of collaborative health information exchange initiatives at the state, regional and community levels has grown considerably over the last three years. According to eHealth Initiative's *Third Annual Survey of Health Information Exchange at the State, Regional and Community Levels*, at least 165 initiatives existed in July 2006, located in 49 states, the District of Columbia and Puerto Rico.[16] Early findings from the 2007 survey results indicate that, while a handful of initiatives have closed their operations, there are at least 16 new health information exchange initiatives. Review of the early findings from the 2007 survey also indicate a slight increase in the number of *operational* health information exchange initiatives above the 26 identified in 2006.

Despite all of this activity at the national and local levels, the adoption of health IT has been slow due to a number of well-documented factors, including:

- The lack of standards adoption that would enable interoperability of health IT systems across the care system
- The misalignment of incentives that often drives volume and fragmentation and does not reward the use of information to deliver better healthcare
- Concerns about privacy and confidentiality of electronic information

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[13] eHealth Initiative, *States Getting Connected: State Policy Makers Drive Improvements in Healthcare Quality and Safety Through IT*. Washington, D.C.: eHealth Initiative; August 2006.

[14] eHI State Legislation Tracker. www.ehealthinitiative.org. Accessed October 2007.

[15] Ibid.

[16] eHealth Initiative. *Improving the Quality of Healthcare through Health Information Exchange: Selected Findings from eHealth Initiative's Third Annual Survey of Health Information Exchange Activities at the State, Regional and Local Levels.* Washington, D.C.: eHealth Initiative; September 2006.

- The significant work flow change required by providers to transform healthcare delivery through the use of health IT

A Common Path Forward

Our discussions with stakeholders across the healthcare system at the national and local levels reveal that more clarity is needed regarding the incremental steps that must be taken to improve healthcare quality, safety and efficiency through information and information technology. With all of the change, and the multitude of activities taking place at the national, state, and local levels, healthcare leaders find that it is often hard to keep track and make sense of what is happening, and understand the steps that should be taken to improve healthcare quality, safety and efficiency through information technology.

In addition, because the healthcare system is so fragmented, collaboration across the multiple stakeholders in healthcare is crucial to defining and implementing solutions that are not only patient-centric, but will also work within the system. Responding to this challenge, eHealth Initiative's leadership in March 2007 launched a collaborative process designed to offer practical guidance on how to improve health and healthcare using health IT and health information exchange.

The *eHealth Initiative Blueprint: Building Consensus for Common Action* (eHI Blueprint) is a shared vision, and a set of common principles, strategies and actions for improving health and healthcare through health IT and health information exchange. The eHI Blueprint is designed to offer guidance to national, state and local leaders—both within the public and private sectors—and across every sector of healthcare. It was developed by a broad, transparent, collaborative, multi-stakeholder process involving nearly 200 organizations including clinicians, consumer groups, employers, health plans, health IT suppliers, hospitals and other providers, laboratories, pharmacies, pharmaceutical manufacturers, public health agencies, and state and regional leaders.

The eHI Blueprint offers a shared vision of a high-performing healthcare system, where all those engaged in the care of the patient are linked together in secure and interoperable environments, and where the decentralized flow of clinical health information directly enables the most comprehensive, patient-centered, safe, efficient, effective, timely and equitable delivery of care where and when it is needed most – at the point of care.[17]

The eHI Blueprint frames an incremental path forward across five areas critical to improving health and healthcare: engaging consumers; transforming care delivery; improving population health; aligning financial and other incentives; and managing privacy, security, and confidentiality. While broad-based consensus was reached on principles and several strategies and actions across these five areas, the eHI Blueprint also identified areas where more national dialogue is needed—including specific strategies related to financing as well as policies for information sharing. Such dialogue will require federal leadership and a national public-private

[17] Institute of Medicine. Committee for Quality in Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

sector dialogue, involving the many diverse stakeholders in healthcare—including those operating both at the national and local levels.

Top Down or Bottom Up?

This hearing asks us – are their too many cooks in the kitchen? And which approach will work best -- top-down or bottom-up? We believe that leadership needs to come from both the national level and the state and local levels, working in a coordinated fashion.

Clearly there is need for federal leadership for moving this agenda forward, particularly as it relates to driving the harmonization and adoption of technical standards for interoperability; providing guidance on policies related to privacy and security; and stimulating private sector investment through the provision of necessary seed funding and the alignment of incentives.

At the same time, increasingly, health care leaders and policymakers alike are realizing the importance of collaboration at the regional and community levels in driving improvements in health care quality, safety and efficiency. In a recent report entitled *It Takes a Region: Creating a Framework to Improve Chronic Disease Care*, Dr. Ed Wagner and colleagues state that "in the absence of substantial national health care reform, regional quality improvement efforts appear to offer the best hope for transforming American healthcare."[18]

eHealth Initiative's research findings on value and sustainability in health information exchange also reveal the importance of local collaboration to facilitate health IT adoption and the mobilization of information electronically between health care organizations. Supported by a set of experts in economics, finance and health care, and lessons learned from learning laboratories in ten regionally-based health information exchange efforts, the eHealth Initiative Foundation with funding support from the Health Resources and Services Administration, learned that sustainability of health information exchange is indeed possible, but hampered by the embedded infrastructure resulting from many years of a third-party, fee-for-service reimbursement system that has resulted in a fragmented delivery system which creates little demand for, and in fact, much resistance to the sharing of information across health care organizations.[19]

As a result, those that have been successful in spite of these forces, have done so because among other things, they have built—at the state and local levels--"social capital" or a "radius of trust" that enables multiple stakeholders with divergent interests to come together around a common good—improvement of health and health care for the individuals which reside within a community.[20] Social capital has enabled many local efforts in the U.S. to build the trust necessary to come to agreement on and then implement policies for information sharing that address privacy and confidentiality concerns and develop business models that deliver value to local stakeholders who need to bear the cost of the exchange--despite pressures to silo data given misalignment in the current payment system.

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[18] Wagner E., Austin B, Coleman C.. *It Takes a Region: Creating a Framework to Improve Chronic Disease Care.*

[19] eHealth Initiative. *Health Information Exchange: From Start-up to Sustainability.* Developed by the eHealth Initiative Foundation with support from the Department of Health and Human Services Health Resources and Services Administration. Washington, D.C. May 2007.

[20] Ibid.

In addition, through eHI's survey research it has been noted that much of the clinical data required for healthcare delivery and improvement resides within local (vs. national) institutions--such as hospitals, local laboratories, pharmacies and physician practices.[21] As a result, the "nationwide health information network" will need to be built from "the ground up", through the linkage of organizations locally through health information exchange networks, and the linkage of local efforts with both national networks as well as each other, through a "network of networks", utilizing standards for interoperability developed nationally.

Recent funding initiatives sponsored by the federal government also signal recognition of the importance of regional and community collaboration, including the DHHS Secretary's October 5, 2007 announcement of contracts totaling $22.5 million to nine state and local health information exchanges to begin "trial implementations of the Nationwide Health Information Network."[22] In December 2007, the Centers for Disease Control and Prevention is expected to announce contracts to support public health surveillance by state and local entities, that will complement the NHIN awards.[23]

There are many national actors in health care, including national health plans, national labs, national (and global) employers, hospital chains that operate nationally, and even the federal government--including Medicare, the Department of Defense and the Department of Veterans Affairs. These national players are trying to figure out how to deal with the multitude of local efforts. The natural tension between national and local efforts is not new, and one which has been experienced in nearly every sector of the economy.

Getting to an improved system that informs care delivery and improves the health of the American population requires both, and we need to figure out how to build a bridge between national and local efforts through common interfaces and policies. That's one of our priorities at the eHealth Initiative, as we work with all of the diverse stakeholders in healthcare to help build a healthcare system that delivers the right care to *every* American, every time.

Suggested Actions for National Leadership

There are several areas where federal leadership can make an important contribution toward transforming the quality, safety and efficiency of our nation's healthcare system through information and information technology.

- **Driving Standards Adoption:** First, the harmonization and adoption of national standards for interoperability are critical to facilitate the information sharing needed to drive improvements in the quality, safety and efficiency of care. The federal government has made significant progress in this area, and the transition of the American Health

[21] eHealth Initiative. Improving the Quality of Healthcare through Health Information Exchange: Selected Findings from eHealth Initiative's Third Annual Survey of Health Information Exchange Activities at the State, Regional and Local Levels. Washington, D.C.: eHealth Initiative; September 2006.

[22] http://www.hhs.gov/news/press/2007pres/10/pr20071005a.html. HHS Awards Contracts for Trial Implementations of the Nationwide Health Information Network, October 5, 2007.

[23] Centers for Disease Control and Prevention, RFP No 2007-N-09275, *Accelerating Public Health Situational Awareness through Health Information Exchanges*, http://www.fbo.gov/servlet/Documents/R/1675039/309666, May 21, 2007.

Information Community (AHIC) by DHHS over the next several months will support the continuation of this important work. We believe the transition will require an independent convener that engages every sector of healthcare—including those who work both at the national and local levels--in an inclusive, transparent, and balanced process, that is designed to listen, engage and synthesize diverse perspectives to develop a path forward for health IT interoperability that is focused, sustainable, and achieves results related to standards harmonization and standards adoption.

- **Addressing Privacy and Security Policies**: The federal government should continue to lead and expand upon its efforts to develop a framework for privacy and security, leveraging the work of the current AHIC and drawing upon the work of the Health Information Security and Privacy Collaboration (HISPC), another federally funded effort which has conducted research and engaged leaders in 34 states around privacy and security policy.

- **Aligning Incentives:** As noted in eHI's June 2007 report on value and sustainability for health information exchange, both national and local efforts focused on health IT adoption and health information exchange suffer from a reimbursement system that largely encourages both volume and fragmentation in healthcare. As a result, there are no incentives—and in fact, disincentives for, clinicians, hospitals and other providers, labs, and payers to share information.[24] Leadership is needed—across both the public and private sectors to address the longer-term, complex, financial sustainability issues related to health IT interoperability which stem from America's current payment system. Enhancements to payment policy are needed that reward not only higher quality, more efficient healthcare, but also offer in the earlier years other incentives that will support the foundational health IT underpinnings needed to get to better outcomes and federal leadership is required to move this work forward.

  In addition, much progress can be made today through a public-private partnership that can provide guidance on—and stimulate action for--how the field might move forward on *near-term opportunities* for the creation of a set of business cases for the use of electronic clinical information—for example, focusing on areas such as healthcare quality, drug safety, and consumer access to health information.

- **Addressing Disparities:** The federal government is already playing a leadership role in addressing disparities, but opportunities exist for more leadership in the area of using health IT as a tool to close the differential gaps.

  Health IT offers great promise for helping clinicians deliver equitable care through evidence-based decision support, chronic care management tools and population health functions. But targeted resources must be provided to those clinicians who serve minority and other underserved communities, to ensure they are not left behind in the

[24] eHealth Initiative. *Health Information Exchange: From Start-up to Sustainability.* Developed by the eHealth Initiative Foundation with support from the Department of Health and Human Services Health Resources and Services Administration. Washington, D.C. May 2007.

drive to accelerate health IT adoption. Creating a gap between those with IT and those without will only serve to exacerbate the existing disparities in care, which is unacceptable. The federal government can play a strong role in ensuring that providers have the resources they need—grants, loans, or hands-on help in implementation—to effectively use health IT in patient care.

In addition, the federal government has a tremendous opportunity to provide leadership in the area of engaging patients in their own health and healthcare, especially consumers within vulnerable populations. Health information tools can create a new standard of care in which delivering information, self-care tools and decision aids to the patient are as integral to high quality care as providing tests, medications and treatments.

These tools should be universally available to consumers regardless of whether or not they have health insurance; they should serve consumers' varied needs, be integrated in the delivery of care and conveniently available outside of care delivery settings. These tools should also be designed explicitly to meet the needs of diverse groups including the economically and geographically underserved, disabled, older, and culturally diverse populations. The federal government can provide leadership specifically in developing tools that meet the needs of these diverse groups, while the private market is maturing.

- **Providing Technical Assistance:** The eHealth Initiative Foundation's research on value and sustainability also made it clear that the next 24-36 months is a critical time on the ground, in terms of the success of health information exchange initiatives designed to mobilize clinical information electronically to support improvements in healthcare quality, safety and efficiency.[25] Widespread failures will set this effort back by many years, and the federal government has an opportunity to provide leadership and support to these important community initiatives.

  In addition to the work being conducted by the Office of the National Coordinator to test prototypes for a nationwide health information network, communities need tools and technical assistant to support their becoming financially sustainable. To achieve sustainability, these communities need "hands-on help" in developing and applying successful business models, which both the 2006 and 2007 eHealth Initiative Survey results tell us is their number one challenge.[26] The Department of Health and Human Services has played a federal leadership role in supporting this work, and we hope that continued efforts will help to ensure success.

Finally, the federal government cannot do this work alone. Public-private partnerships--operating both at the national and local levels--are needed to gain consensus, provide leadership and

[25] eHealth Initiative. *Health Information Exchange: From Start-up to Sustainability.* Developed by the eHealth Initiative Foundation with support from the Department of Health and Human Services Health Resources and Services Administration. Washington, D.C. May 2007.

[26] eHealth Initiative. Improving the Quality of Healthcare through Health Information Exchange: Selected Findings from eHealth Initiative's Third Annual Survey of Health Information Exchange Activities at the State, Regional and Local Levels. Washington, D.C.: eHealth Initiative; September 2006. Preliminary 2007 Survey Results.

provide a common path forward that is workable, sustainable, and will result in significant improvements in the quality, safety and efficiency of care.

Summary

In summary, it could not be a more important time to drive the necessary changes that are needed both nationally and locally to drive improvements in our healthcare system through information and information technology. Great progress has been made, but more work is needed to drive towards our vision of a high-performing healthcare system enabled by information and information technology. This is hard work, requiring both leadership and collaboration across every sector in healthcare who need to work together—hand in hand with federal and state government, to develop and apply common principles and policies about how we'll get this important work done.

We have a tremendous opportunity to build upon the work that has already been done related to the technical aspects of health IT interoperability and more national dialogue and action is needed—across both the public and private sectors, related to both financing and policies for information sharing. But we most work together, and we must continue to focus on our goal, which is to improve the quality, safety and efficiency of healthcare for all Americans. The use of interoperable, standards-based health information technology plays a critical and foundation role in achieving this goal.

Again, thank you for this opportunity and I look forward to answering any questions you may have.

M. TOWNS. Thank you very much.
Dr. Price.

STATEMENT OF WINSTON PRICE

Dr. PRICE. Thank you very much, and I hope you're using the same hearing timing technology.

Mr. Chairman, members of this committee, Members of the House of Representatives, ladies and gentlemen, good afternoon.

I am Dr. Winston Price, a board-certified pediatrician working both in New York and Georgia. I am also a past president of the National Medical Association and the current chair of the Georgia Health Information Technology and Transparency Board. On behalf of the NMA and the Georgia HIT Board, I would like to thank you for the privilege of testifying before you at this time on this vital subject.

Mr. Towns and your staff deserves special mention in light of your role in the preparation of this important hearing.

Throughout the 112-year history of the National Medical Association, we have been a leading voice in the struggle toward eliminating health disparities that affect not only our members but also the millions of minority patients that we serve. As we embrace the innovations of the 21st century, we remain committed to the notion that all Americans should have access to health care of the highest quality. It is in this context that I have framed my remarks.

As the Nation addresses this subject, we must ask ourselves, are vulnerable populations at the crossroads of a health care evolution, or are they in someone's cross-hairs during a health care revolution?

I think we can all agree that health care has evolved. The United States leads the world in health care innovation, as noted, for example, by the many Nobel Prizes Americans continue to win in medicine. The whole world seems to want to come to American hospitals, especially our teaching hospitals, for cutting-edge treatments and cures. Our pharmacy industry is the world's most innovative and profitable.

But be that as it may, our health outcomes do not speak to that same degree of advantages. Unfortunately—and you've heard from the honorable Dr. Christensen, so I won't belabor that issue again—but America's vulnerable populations do not display the same high quality that we see in terms of the innovations that bespeak our health care system.

So is it a revolution? Well, many of us are now convinced that America's health care is in need of a revolution. If health care innovators are the leading revolutionaries, then the concerns of the Nation's underserved populations must be their vox populi that informs their manifesto.

Our strategy for ensuring that this revolution efficiently addresses the needs of all Americans is that we must understand the heavy weight as impacted by each of the following five factors and I will be very brief with those.

Standards: And you heard the description about the importance of standards in moving this health care HIT agenda forward.

Electronic health records: And you will hear from the other members of this panel, so I won't go into detail about that. But let me

emphasize the fact that electronic health records is a key component of this HIT initiative. We have lessons learned from Katrina, but I want you to not lose sight of the more than a half-million children in foster care who suffer from a perennial Katrina every day. These unfortunate individuals, similarly like the individuals in Katrina, are separated from their family historians who could fill in the health care history gaps and they, many of them, received fragmented, episodic and oftentimes substandard care without the benefit of available and continuous medical record.

Let me delve into pay-for-performance, very briefly, as the third category. Now, many facets of determining the return on investment for HIT is centering around the fact that it's going to improve the quality of health care for Americans. But I must impress upon you the fact that these initiatives, while well-intended under the guise of improving quality, aim many times to position themselves in such a way to redefine methodologies for physician reimbursement. We must ask ourselves, how will pay-for-performance affect physicians' practice patterns as they relate to sicker minority groups? And given the sicker caseload of minority physicians, how will pay-for-performance affect the viability of these physicians?

Now, we certainly believe that health disparity speaks for itself, but we know that the main reason for minority physicians not getting involved with health information technology is the fact of funding. Indeed, the Medical Records Institute's survey in 2006, reported that the top two reasons for not engaging in health information technology was lack of adequate funding and lack of support by the medical staff.

Process and outcomes is certainly important, as well.

And because time is up, I'm going to summarize in the last 30 seconds that we have between Brooklyn folks.

And that is, in Georgia, where I chair the Health Information Technology Transparency Board, we recognize the importance of addressing a number of the issues that we talked about earlier. We have instituted a $1 million demonstration pilot project that we targeted specifically to rural communities and some of the issues that you raised earlier, in terms of making sure that minority vendors are involved in the engagement in those particular grants, are things that we look at very consciously.

And, recently, we were awarded a $3.9 million grant from CMS to look at the development of a transparency Web site. A transparency Web site to bring the quality and cost to the consumer are two of the cornerstones of Secretary Leavitt's initiatives to make sure we move that health care agenda.

So I'm just going to tell you the broad categories. I promise I'm only going to read the categories of the AMA recommendations to move this forward: bridge the digital divide; amend the charter of the American Health Information Community to make sure that there is adequate representation by the minority community; create HIT empowerment zones, something that you've been discussing already; implement a Medicare and Medicaid demonstration project to identify payment methodologies that encourage participation and make sure the underserved communities are part of the mix; and, last, to coordinate the Federal data-collection process.

Mr. Chair, I want to thank you for the opportunity to speak with you on this particularly important topic and we stand ready, at the National Medical Association, to assist you in your movement forward. And I commend you on the selection of your committee members.

Thank you.

[The prepared statement of Dr. Price follows:]

NMA Statement to the Subcommittee on Government Management, Organization and Procurement

Committee on Oversight and Government Reform

U.S. House of Representatives

Statement

of the

National Medical Association

to the

Subcommittee on Government Management, Organization and Procurement

Committee on Oversight and Government Reform

U.S. House of Representatives

RE: Vulnerable Populations/Vulnerable Physicians & Health Information Technology:

Are they at the Crossroads of a Healthcare Evolution or in Someone's Crosshairs During a Healthcare Revolution

Presented by Winston Price, MD, FAAP, FACPE

November 1, 2007

I want to thank you on behalf of the physicians in the National Medical Association (NMA), the Georgia Health Information Technology & Transparency Board and the millions of minority citizens impacted by the changing landscape as a result of HIT initiatives. I appreciate the opportunity to testify before you today regarding HIT as this technology has so much potential to improve healthcare and reduce health disparities yet like nuclear energy if not properly harnessed could bring devastating harm to many people in its path./ I would especially like to express our thanks to Representatives Henry Waxman (D-CA) & Edolphus Towns (D-NY) for their continued leadership on this issue.

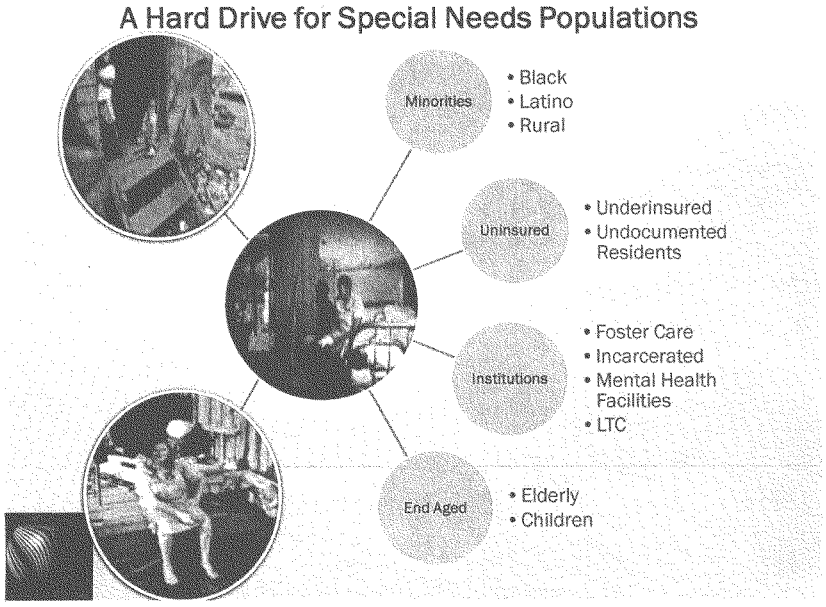
I am Dr. Winston Price, a board certified pediatrician working in both NY and Georgia. I am a past president of the National Medical Association and current chair of the Georgia Health Information Technology & Transparency Board. Regarding Georgia I will reference factual information on current HIT initiatives and its demographic statistics but the recommendations and conclusions are in regards to the NMA and vulnerable populations in general. Mr. Chair, as you are aware, Health Information Technology holds the promise toward maximizing efficiency, reducing medical errors, facilitating consumer involvement in healthcare decisions and assuring adequate disaster readiness for all Americans. But for many physicians and for a significant number of US citizens the hope of participating in this rapid change in healthcare delivery will escape them due to a mal-distribution of fiscal, administrative and technical resources in America pertaining to HIT. In order to

allow certain at risk communities to participate in the HIT evolution on par with more affluent areas of our nation there needs to be additional resources available to prevent the growing "digital divide" in HIT.

OVERVIEW

In order for HIT initiatives to serve as a key benefit for both the minority community and the healthcare professionals serving them they must assure that they can effectively accumulate data, share appropriate data and analyze that data. More importantly they must be able to create the protocols that determine what critical data must be assessed where none exists currently on the healthcare experience of Black consumers, Black health professionals and the healthcare industry in general for vulnerable populations. These key data points and their significance can impact on the critical indicators of health outcomes that potentially help better define the "Best Practices" toward improving the health of Black America. With the ability to obtain, analyze, share & coordinate this valuable information we can move ever closer toward understanding & eliminating the causes of health disparities.

The programs and strategies aimed at the elimination of health disparities must be soundly guided by real time evidence and this evidence must also include the intended population that it is trying to serve. A major deficiency in a vast portion of the currently available datasets used to create clinical guidelines and reimbursement methodologies is that it under-represents the Black population and other at risk communities in quantity and geographic mix. These datasets also poorly define many socioeconomic and lifestyle factors that affects the outcomes on health for these communities. As such we must take a *hard drive* at including the vulnerable, at-risk populations (VARP) in the HIT funding and implementation strategies. These VARP include, but are not limited to, minorities, the uninsured, the institutionalized, the rural communities, and the extreme aged (both young and old). The experience of minority physicians and other professionals caring for this population are largely under documented.



The predictive modeling schema that results from data-mining of experiential information is a growing area in many other industries and has helped to expedite many companies level of efficiency while reducing waste and errors. In order for America's HIT initiatives to fully benefit from this burgeoning and revolutionary aspect of data analysis, toward eliminating health disparities, it must develop and implement a sound HIT strategy for those communities and affected professionals specifically. In other words, it must use the right data to get the critical answers for at-risk communities to improve their outcomes as well. The HIT programs aimed at achieving that goal must also be appropriately funded and structured for long term success.

P4P Quality Initiatives May Worsen Health for At-Risk Populations

- Pay-for-Performance (P4P) Task Force of the NMA

▪ While many facets of determining the ROI that HIT could bring toward improving the state of health for Blacks center on cost reduction and increased efficiency much of the current debate and agendas focuses on the impact of P4P initiatives. These initiatives, while well intended under the guise of improving quality, aim to position themselves in such a way as to re-define methodologies for physician reimbursement. The importance to the NMA in this matter is to assure that P4P (or so-called "playing for dollars") does not worsen the status of health for Black America. The NMA Task Force on P4P has been creating greater awareness by educating our members, the healthcare regulators, the healthcare payors, the legislature and the community at large as to the potential negative aspects of P4P. The NMA White Paper on P4P addresses the potential bias, even if unintended, that many P4P schema place on minority physicians and those health professionals caring for these at-risk communities.

▪ In any case, practice-based HIT is no longer just a strong recommendation because in this P4P scenario it becomes a key survival tool. It will be required and one of the driving factors will be the increasing presence of P4P payment schema. The NMA will need to be at the forefront of not only the P4P debate but supportive of the implementation of HIT for its member physicians. The reasons, as mentioned, are both qualitative toward improving outcomes and quantitative toward its economic impact on the cost of doing business and compensation. Consumer pressure will also be a driving force too as nearly three out of four Americans believe strongly that electronic medical records can make the difference between life and death in emergencies. Many HIT-related programs are being used to improve quality of care and reduce costs, with some states targeting specific aspects of care such as the overuse of emergency department services, reducing medication errors and assuring consumers have personalized health records (PHR) The later component of HIT assists consumers in having personal information to use with health transparency data to make informed decisions about selecting healthcare services. It also provides transportable health information as part of a sound disaster readiness program.

▪ As P4P becomes a more prevalent reality in the course of business for today's physician, he or she must face the daunting pressure to add health information technology (HIT) in the practice. These waves of change swell as a physician is challenged with declining revenue, increasing malpractice liabilities and a more demanding patient population. These changes are of particular concern to the physicians represented by the NMA and those caring for at-risk populations. It appears that P4P, as currently implemented, may further reduce the disproportionate reimbursements for NMA physicians due to a more economically-challenged and disease-intensive patient population. With their revenue streams already becoming more restrictive, our colleagues must also now bear the expense of integrating HIT solutions into their practice.

▪ As consumers, physicians have already been challenged at home with trying to maintain secure computers, networking their households, and integrating internet-based communications into their lives. The challenge has been significant, enough so, that many still have not advanced beyond basic word-processing and email, even though those costs are moderate and with little risk. Now, they are expected to do the same with their offices at great cost and even greater risk with failure threatening their livelihood. Such hesitation among many of our physicians and local health systems is with merit. During previous years, the push for "technology" in physician's offices resulted in quickly out-dated hardware, incompatible systems, and programs ill-suited for practice management that drained more resources than "enhanced" physician practices anticipated. In fact, a 2005 study conducted by the Medical Group Management Association, found that little more than 10 percent of the nation's physicians had adopted electronic medical

technology. In larger hospitals, only about 35 percent of doctors have adopted the technology. Current movement forward in many sectors has remained slow and plodding because of, among other reasons, lack of technological standards, implementation costs, support resources and legal hurdles.

- Currently however, as a move to increase the adoption of HIT in physician practices, regulations have been relaxed to enable hospitals to donate technology to community physicians, and Congress passed legislation to make permanent a federal office that promotes health IT. Besides the qualitative reasons mentioned earlier for NMA members to begin adopting HIT, there are some economic reasons. First, government and industry feels this move is so important that they are willing to offer financial carrots. For the first time the Centers for Medicare & Medicaid Services (CMS) has announced grants providing states with $150 million in 2007 and 2008 to increase quality and efficiency of patient care through HIT. In addition, California has committed $240 million towards HIT and New York's commitment totaled $105 million in Phase 1 with an additional $350 million in Phase 3 of their initiative. Many other states have or are considering similar proposals. NMA is developing strategies to work with its members so that they to may benefit from such "largesse" during this window of opportunity.

- Although grants and government support along with the aura of improved quality of care are adequate reasons to move physician practices towards HIT-based solutions, the ultimate driving factor for many physicians still will be P4P or similar quality improvement program (QIP)activities. As noted in Healthcare Financial Management (Freeman, 2005) P4P programs are largely responsible for the success of the Nationwide Health Information Network (NHIN) and Regional Health Information Organizations (RHIO); two entities that are tasked by the federal government to oversee HIT. Many P4P programs require that physicians submit clinical data so it can be determined if they achieved the program's outcome targets. Some P4P programs also offer incentives when physicians use an EHR. Physicians who participate in a P4P program without an EHR must manually extract the required clinical data for reporting which is time consuming, staff intensive and costly. They also do not benefit from the automatically generated alerts and reminders, so called, decision support tools, that help them achieve their quality targets. P4P may well be the currently single biggest motivator driving physicians to adopting an EHR.

- This certainly impacts NMA physicians even more because more than half of the states were operating Medicaid pay-for-performance programs in the middle of 2006 and nearly all will have them within five years, according to a new study. This is a population that we disproportionately treat in our patient mix. Furthermore Brian Robinson, states in GovernmentHealthIT http://govhealthit.com/article98211-04-12-07-Web that more than 70 percent of the planned new programs will start within the next two years. Most of these will shift in emphasis from managed or primary care to environments that stress chronic-disease management. This will happen even while primary care remains the focus of most Medicaid pay-for-performance programs, the study states.

- Furthermore a study published by the Commonwealth Fund (by Kathryn Kuhmerker, a former director of Medicaid in New York state, and Thomas Hartman, vice president for health care quality improvement for IPRO, a health care quality assessment and improvement organization) state that HIT will be a focus for many of these programs. They added that several programs opted for a paying-for-participation approach rather than just for performance, in an effort to encourage providers to adopt electronic health records, electronic prescribing and other technologies. In addition, HIT "also has the potential to reduce data collection costs in [pay-for-performance]

programs, which should allow [pay-for-performance] programs to expand into less-traditional venues," they said.

- Another example is the Silicon Valley Pay-for-Performance Consortium, a collaborative effort started by Cisco®, Intel Corporation and Oracle along with several large California physician organizations (IPOs) to accelerate the use of technology for quality health care.

- Through this consortium, after receiving NCQA PPC recognition, consortium members qualified to earn financial rewards for instituting new health information technology systems designed to improve the patient experience and outcomes. Utilizing nationally recognized quality of care standards helped ensure all seven POs were in alignment, and also helped them qualify for other Pay-for- Performance programs.

- NMA must not only work to make P4P an equitable and well-developed program that meets the needs of its members and patient population, it must also be at the forefront of educating and implementing health information technology among its physicians. Currently there is an inadequate environment willing to offset the costs, a burden that unduly falls on our members. The implementation of and effective reimbursement from P4P programs may however demand the presence of an EHR. Without such efforts to facilitate acquisition, implementation and maintenance of an EHR, not only could NMA physicians be at risk of reduction in reimbursements from P4P in of itself, but also by the mere fact of not having the tools in place to institute P4P. As time progresses HIT will also be used not only to measure "quantity of care" but also to define "quality" of care and thus slow adopters, the physicians in poor communities, may be further handicapped. He or she may neither have the "evidence" of the level of care that is being provided to their patients but may see their patient base eroded as consumers move increasingly to a data-driven and technology-based health delivery environment.

AT-RISK POPULATIONS and HEALTH DISPARITIES

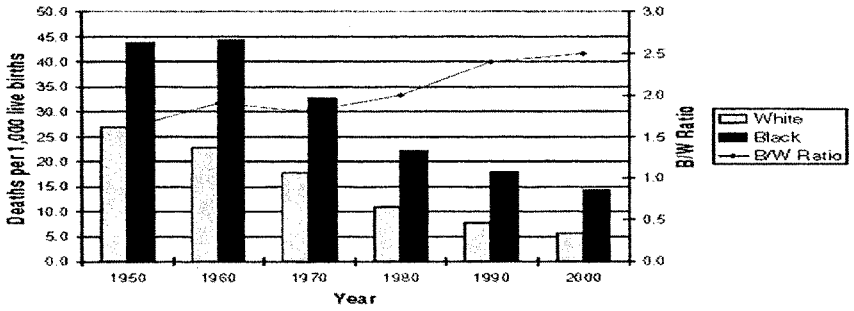
Even a cursory comparison of black and white populations shows that these groups bring substantially different health profiles to the clinical encounter. Significant racial disparities exist in health status, health system quality and access, healthcare utilization and patient compliance

Black Americans lead the nation in 12 of the top 15 leading causes of death, including heart disease, cancer, diabetes, and kidney disease. Racial disparities in health status persist across the entire human lifespan. At the start of life: Black infant mortality is two and a half times higher than that of white babies. And at the end of life: White men outlive black men by 7 years; and white women outlive black women by a half-decade.

When you quantify the human toll of health disparities, the results paint a clear and troubling picture. Depending on which causes of mortality you include in the equation, there are 85,000 to 130,000 excess deaths among blacks each year. The term "excess deaths" refers to the number of deaths that would not have occurred if blacks shared the same mortality rate as whites.

Although there has been an appreciable decline in infant mortality for both races, the racial gap remains striking, and the gap is actually widening. In fact, the racial gap in infant mortality was wider in 2000 than it was a half-century earlier in 1950.

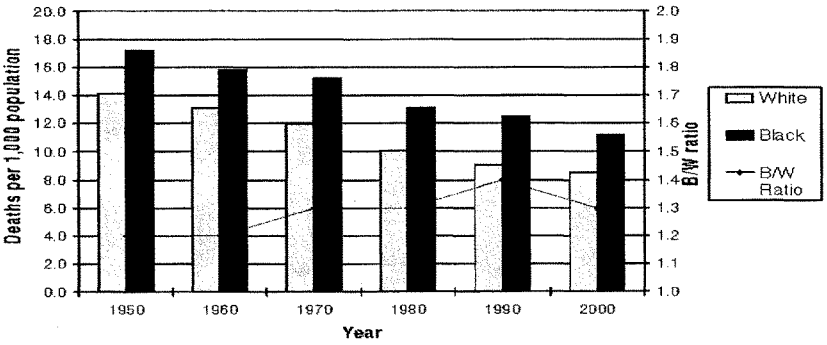
Infant Mortality Rates, 1950-2000



Williams, DR. 2003. Racial/Ethnic Disparities in Health.
http://www.macses.ucsf.edu/News/williams.pdf. Accessed March 29, 2006

When we look at mortality for "all causes," here again, we see the distinctive health status gap between whites and blacks. As with infant mortality disparities, we see the overall widening effect. And here again, the racial gap in overall mortality was higher in 2000 than it was in 1950.

Mortality Rates All Causes by Race, 1950c-2000



Williams, DR. 2003. Racial/Ethnic Disparities in Health.
http://www.macses.ucsf.edu/News/williams.pdf. Accessed March 29, 2006

When minorities do have healthcare coverage, there are still deep disparities in healthcare delivery which results in worse health and higher morbidity for minority patients. In March 2002, a 15-member committee from the Institute of Medicine (IOM) released its 600-page report titled, "Unequal Treatment." The committee's 18-month investigation found that racial disparity in healthcare was "remarkably consistent" across a 10-year corpus of literature. This pattern occurred in every investigated disease area, including cardiovascular disease, HIV, diabetes, and end stage renal disease. And the pattern persisted even after researchers took into account such factors as insurance, disease severity, and compliance with doctor's treatment plan. The IOM committee showed that these inequities result in significantly higher death rates for minority patients. Lastly, there are racial and ethnic disparities in healthcare utilization and medical compliance. Racial and ethnic minorities are more likely to avoid or delay seeking care. And they are less likely to comply with medical care.

These patterns also result in poorer health status, including greater mortality. Racial and ethnic disparities exist in:

- health status
- healthcare quality
- healthcare access (insurance)
- healthcare utilization & compliance

- We must also take into account physician practice patterns and patient perceptions of physician care.
- First, minority doctors are more likely to serve minority populations. This means that minority doctors are more likely to have the disparate population profile described earlier.
- Second, patients prefer physicians who share their racial or ethnic background.
- Patients tend to rate their physicians' communication style higher in race-concordant relationships.
- And minority patients report higher levels of healthcare satisfaction when receiving care from minority physicians.
- These patterns paint a clear picture about the uniquely beneficial clinical encounter between minority patients and providers.
- This is why the IOM committee that reported on health disparities in 2002, and the Sullivan Commission that examined healthcare diversity in 2004, both called for an increase in the proportion of minority healthcare providers.
- This all means that policy initiatives, like some P4P programs and ill-planned HIT mandates may threaten the viability of minority and rural providers. These measures are counterintuitive to improving minority health and must be approached with caution.
- And when you take these two scenarios together—poorer health status among minority patients, and the uniquely beneficial role of minority providers—you have a bigger picture that evokes a new set of questions:

    - How will Pay-for-Performance affect physician practice patterns as they relate to sicker minority groups?
    - Given the sicker caseload of minority doctors, how will Pay-for-Performance affect the viability of these physicians? And how will it affect the movement toward greater—not less—diversity in the healthcare workforce?
    - What are the implications of all of this for minority access and quality of care?
    - And ultimately, will Pay-for-Performance help or hurt the national effort to eradicate health disparities?
    - The data are not in, and ultimately the success or failure of Pay-for-Performance must be evidence-based.
    - But the concept's efficacy depends on the quality of the evidence by which performance benchmarks are determined.
    - If minority populations are not appropriately factored into the data collection and analyses processes, then the resultant standards will not reflect the actual clinical characteristics of minority patient populations.
    - And if physician practice patterns are not comprehensively factored into the equation, then the resultant standards pose potential danger to healthcare access and care for minority patients.

- The NMA is closely tracking this issue and it is our belief that any quality improvement/performance measurement system must be patient-focused.
- It must have realistic performance standards that reflect population profiles.
- And it must recognize physician practice patterns and the potential impact of policy on diversity and the viability of minority physicians.

POTENTIAL IMPACT OF P4P ON VULNERABLE POPULATIONS

- False quality measures could cause patients to go against their usual and customary choice of physician;

- Patients could face increased costs by potentially having to pay more to see their choice of physician;
- Physicians could be forced into more preventive care;
- Patients could be denied access to vital pharmaceuticals and other therapies on the basis of their assessed value to the P4P system;
- Physicians who serve sicker patients are less likely to report quality improvements that lead to increased rewards, and would therefore be less enthusiastic to work in underserved communities.

POTENTIAL IMPACT OF P4P ON MINORITY PHYSICIANS

- P4P will negatively impact the revenue stream of physicians that are already compensated the least for the populations they serve;
- Patients will get a false sense that they are getting poor quality care based on erroneous measures, thus undermining the doctor-patient relationship;
- P4P could have a deleterious effect on African American economics, given that Black physicians' economic well-being is a useful marker for economic solvency in the Black community;
- P4P could potentially lead to the practice of "cookbook" medicine, where compliance-driven physicians learn to 'check boxes' but jettison the 'art' of medicine;
- The physician/patient relationship could fall prey to the patients' geographic location and/or the patient pool of which they are a part.

NMA SOLUTIONS CONCERNS:

The 'evidence base' by which performance is measured should be compiled across diverse populations; Clinical data are probably more reliable predictors of quality improvement than are claims data; 'Bad' outcome does not equal 'bad' doctor and culturally competent providers should be included in the design and implementation of all P4P frameworks. Also P4P frameworks and the SGR cannot coexist [SGR, the Sustainable Growth Rate, is the current mechanism for reimbursement of physicians who serve the Medicare population]; Therefore, P4P reporting requirements should remain voluntary at this stage; Health information technology (HIT) is vital to the long-term viability of P4P – therefore, a financial commitment at the national level is *sine qua non to* insuring that solo and small-practice providers are able to install the necessary HIT infrastructure.

Mr. Chair, as a case in point, let me share with you one example of how funding at the federal level can miss maximizing adoption of HIT in vulnerable populations. The proposed legislation HR 3963 was introduces as part of the supplemental SCHIP funding. This bi-partisan bill shows the laudable efforts and sensitivity of the federal government to allocate funding for HIT programs but the structure of the bill recommends $225 million for quality improvement initiatives but only $5 million for demonstration projects, aimed at EHR pilots that would encourage the use of technology in the care of children. The problem that potentially exists in this bill is that many minority and rural physicians would not qualify or compete favorably for the larger granting offer. These physicians and their communities need HIT implementation, HIT training and HIT support funding to assist them in EHR, e-prescribing , health information exchange and transparency website adoption.

This strategy to facilitate and provide economic support to small, rural and vulnerable physician groups is consistent with Goal 1 of CCHIT's strategic plan namely:

- **Goal 1: Inform Clinical Practice**

- Strategy 1. Incentivize EHR adoption
- Strategy 2. Reduce risk of EHR investment through standardization
- Strategy 3. Promote EHR diffusion in rural and underserved areas

We must therefore continue to be vigilant in breaking down the barriers to adoption of HIT which have been steady for the period from 2002-2006. These barriers according to the Medical Record Institute's (MRI) *Eighth Annual Survey of EHR Trends and Usage* in 2006 were as follows:

- **Lack of adequate funding or resources 55.5%**
- **Lack of support by medical staff 31.7%**
- **Inability to find an EHR solution or components at an affordable cost 29.4%**
- **Difficulty in evaluating EHR solutions or components 23.6%**
- **Unable to find an EHR solution that meets our application or technical requirements 23.6%**
- **Difficulty in finding an EHR solution that is not fragmented among vendors or IT platforms 23.2%**
- **Difficulty in creating a migration plan from paper to electronic health records 22.9%**
- **Difficulty in building a strong business case (ROI) 21.0%**

THE GEORGIA EXPERIENCE: ONE STATE ON THE MOVE

The goal of the Georgia Department of Community Health, under the leadership of Commissioner Rhonda Medows, is threefold.

1- To assure ***Access*** to affordable, quality health care in its communities.

2- To promote ***Healthy*** behaviors and improved health outcomes.

3- To assure ***Responsible*** health planning and use of health care resources.

Georgia's population in 2006 was 9,146,732 with 1,986,700 of those residents enrolled in Medicaid at a cost of $6,840,869,446 billion. The alarming reality in the state's demographics pattern is that 1,676,990 of those residents are identified as Poor i.e.-Below Federal Poverty Level (FPL) and the citizens categorized as Near-Poor i.e.-100-199% of the FPL consisted of another 1,640,766 people living in the state. The breakdown of the Georgia population for individuals living in poverty is summarized below and figure 1.

Children (0-18)	2,530,127	28 % of total residents
Poor Children	648,692	26 % of total children
Adults (19-64)	5,818,229	64 % of total residents
Poor Adults	910,359	16 % of total adults
Elderly (65+)	798,376	9 % of total residents
Poor Elderly	117,938	15 % of total elderly

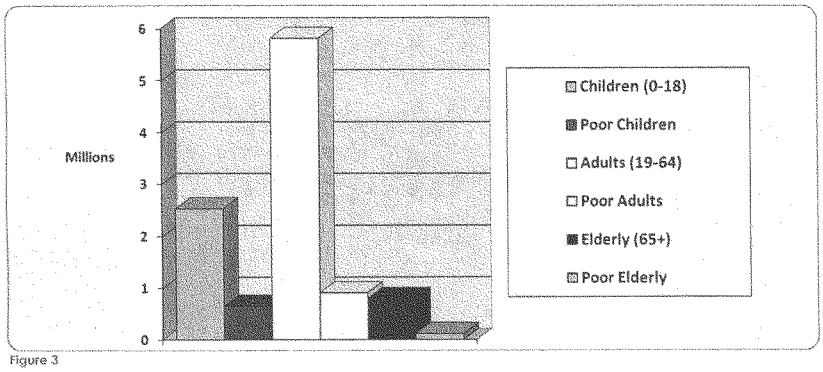


Figure 3

Distribution by Race/Ethnicity			
White	5,375,708	59	% of total residents
Black	2,679,383	29	% of total residents
Hispanic	759,498	8	% of total residents
Non-Citizen	664,618	7	% of total residents

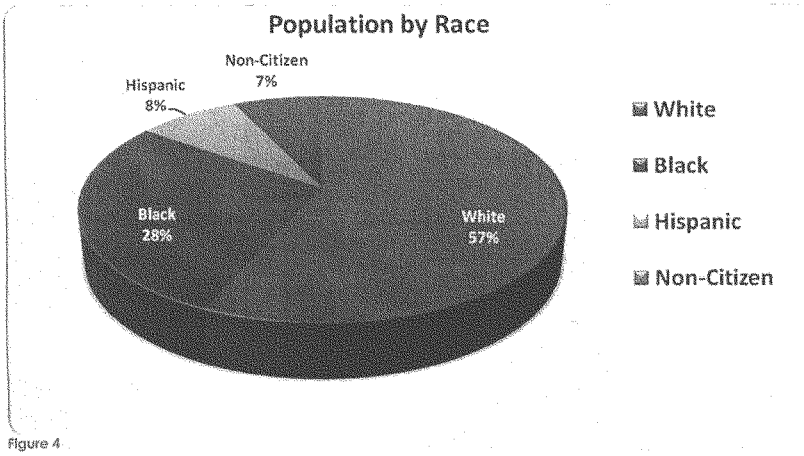


Figure 4

Health Insurance Coverage of the Nonelderly, 2005-2006

Medicaid 1,109,064 Children 745,084 Adults 363,980

Uninsured 1,644,815 Children 313,465 Adults 1,331,350

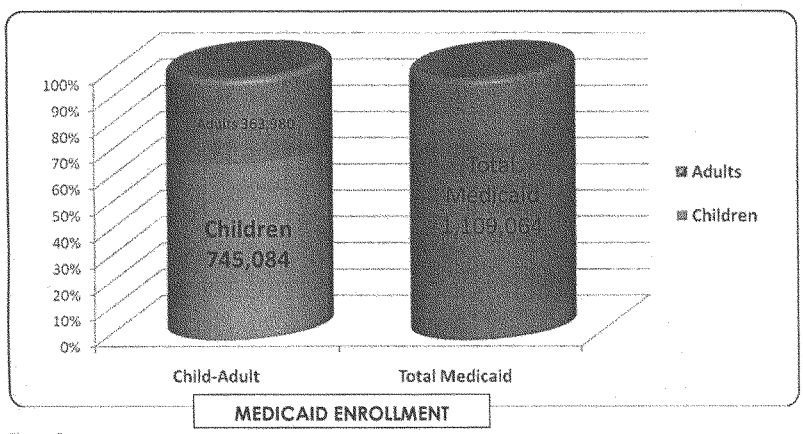


Figure 5

Poor: Below Federal Poverty Level (FPL) 572,812 35 % of uninsured

Near-Poor: 100-199% of the FPL 489,712 30 % of uninsured

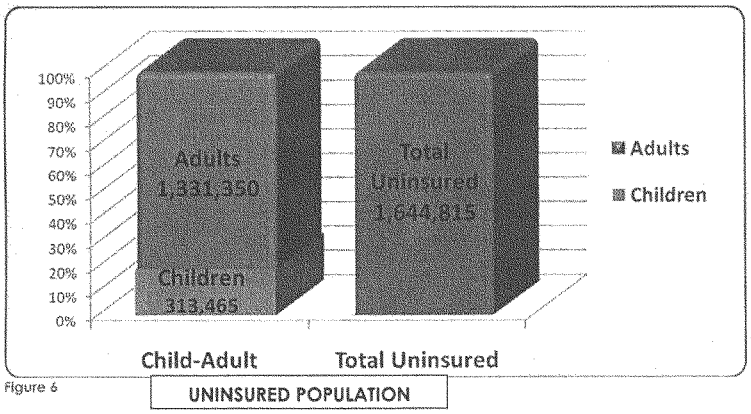


Figure 6

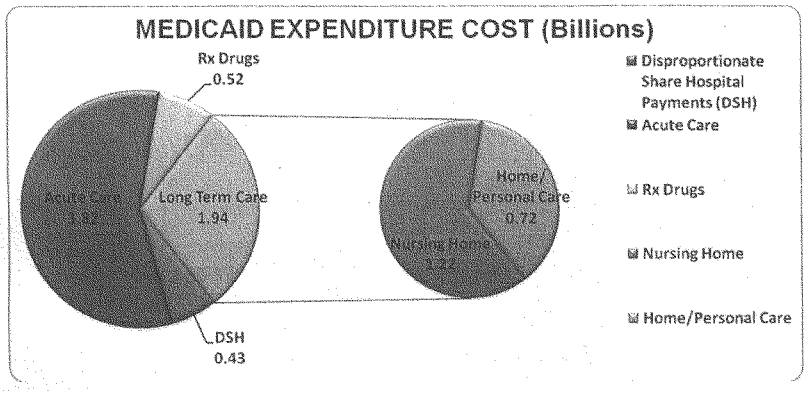


Figure 7

Medicaid Expenditures
Total Medicaid Spending, FY2006 $6,840,869,446 Billion Including DSH

Disproportionate Share Hospital Payments (DSH) accounted for $424,627,514 million or 6.2 % of total spending;
Acute Care costs were $4,343,902,324 billion or 63.5 % of total spending of which
Rx Drugs costs carved some $522,087,319 million or 12.0 % of the acute care spending.

In the current graying of America Georgia has its share of responsibilities and therefore liabilities which incurred for Long Term Care (LTC)expenditures a staggering $2,072,339,608 billion which represented a full 30.3 % of total spending. The bulk of this expense was spread across nursing home care totaling some $1,223,538,302 billion or 59.0 % of LTC spending and another $718,957,094 million for home/personal care which made up 34.7 % of LTC spending. (Fig. 7, 8)

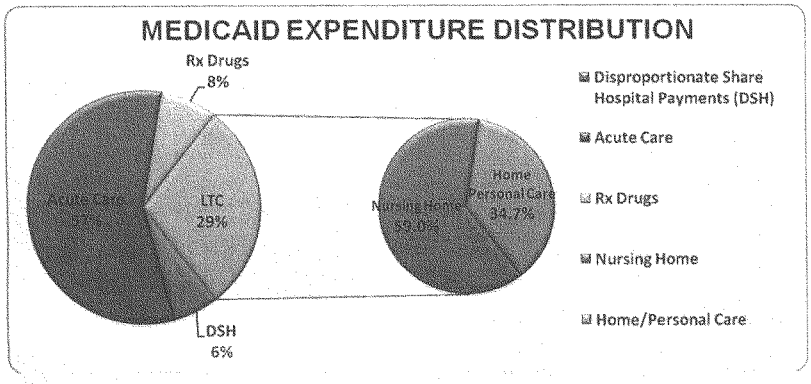


Figure 8

- Georgia is one of the many states that make up the so called "stroke belt" in the Southeast, and as such it experiences some of the Nation's worse indicators of poor health outcomes. These fall into the categories of disproportionate incidence of obesity, diabetes, hypertension, CVD, infant mortality, cancer and HIV /AIDS. Minority, indigent, rural and uninsured populations tend to compose a large segment of those affected by these maladies. A significant proportion of these conditions and chronic diseases could be avoided, eliminated or better managed with improved preventive health screening, more effective disease management and more efficient use of resources to help in consumer education which facilitates them making better informed health decisions. So Georgia has a lot to gain in terms of improving efficiency, reducing medical errors and giving consumers better access to healthcare information to assist in those informed medical decisions.

- To that end, on October 17, 2006, Governor Sonny Perdue issued an executive order creating the Health Information Technology and Transparency (HITT) Advisory Board. The Board advises DCH on the best practices for encouraging the use of electronic health records and establishing a statewide strategy to enable health information to be readily available and transparent. DCH goals for HIT in Georgia are to enable the understandable, universal, timely and secure communication of health information across the public and private sectors for the benefit of today's health care consumer. Better coordinated care means:

- Improve health care quality and safety
- Increase clinical and administrative efficiency
- Improve detection of natural and man-made population threats

- Enable research
- Provide cost savings

The two initiatives of the HIT Board are outlined below:

Health Information Technology & Transparency Advisory Board

Health Information Exchange

Goal:

- Facilitate the implementation of health information exchange statewide

Deliverable(s):

1. Create a state matching fund pilot program to promote health information exchange: Plan for 2-3 pilot sites.
    - a. Matching grant funding to support partnerships between groups of providers and/or payors, local communities – both public and private sector entities

2. Serve as a source of state and federal regulatory information regarding health information exchange, privacy and security issues, etc

Resources:

1. HITT Advisory Council – HIE Committee

2. DCH Designated Staff (IT Division)

3. Dedicated Project Manager

4. Ad hoc members as requested

Health Care Transparency Web Site

Goal:

- Develop a consumer focused Web site that provides to consumers health care quality and cost information.

Deliverables:

1. Develop and implement the transparency Web site

    a. Obtain consumer input, (direct input, focus groups, etc). Create a site that is consumer focused and consumer friendly

    b. Base the Web site info on current and accurate data that is kept updated on a timely basis:

    c. Data sources: Data maintained by DCH, other state agencies, and stakeholder organizations, as well as data information provided by health care providers and insurers

    d. Build/buy the web platform needed to support the Web site

    e. Procure the Web site creation, programming, and maintenance services needed: (RFI for information, RFP for procurement)

Resources

1. HITT Advisory Council – Transparency Committee
2. DCH Designated Staff (Health Planning Unit with IT support)
3. Dedicated Project Manager
4. Ad hoc members as requested

Since the HITT Board's inception they have initiated a $1 Million demonstration pilot project for the State of Georgia, funded by the state budget, as part of the Health Information Exchange initiative. They also recently were awarded a $3.9 Million grant from CMS for the development of its Health Care Transparency Web Site initiative for the state of Georgia.

In addition Georgia operates The **Georgia Health Partnership** (GHP) which is a state-of-the-art electronic health care administration system that gives patients, doctors, pharmacists and other providers easy, secure and efficient access to health care information. The new system began operating April 1, 2003 for the Medicaid and PeachCare for Kids programs. This portal allows Medicaid health care providers to electronically submit claims to the MMIS System. The Georgia Health Partnership has improved turn-around times for claims, eligibility verification, and enrollment requests for Medicaid. The MMIS system also interfaces with the Georgia Department of Human Resources by sharing data collected for the Georgia Registry for Immunization Transactions and Services (GRITS). With adequate federal support this invaluable system can be expanded to serve a larger population in Georgia as well as enhanced to provide even more functionality.

The goals of the portal site are simple:

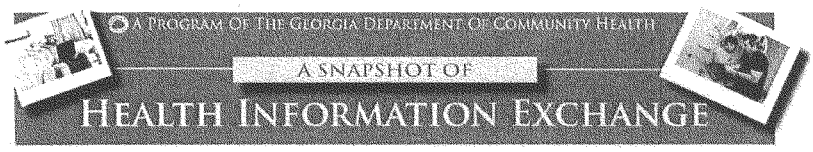
- Increase access to health care information for members
- Reduce paperwork and increase efficiency for providers and administrators
- Improve services for people served by Medicaid and the state's health plans

This electronic environment will allow administrators to easily manage data and improve turnaround times for claims payments, eligibility verifications and enrollment requests. The new system will improve the department's ability to develop disease management programs, identify emerging trends, and determine policies about treatment and prescription coverage.

The **DCH Initiatives** for HITT over the next two years are outlined below and they are laudable goals but they must be supported by a significant federal fiscal commitment to assure its timely success for what has been described to you as a very vulnerable community:

FY 2007	**FY 2008**
• **Medicaid Transformation**	• **Medicaid Transformation** • **Financial Integrity**
• **Integrity of our Programs & Safety Net**	• **Health Improvement** • **Solutions for the Uninsured**
• **Consumerism**	• **Medicaid Program Integrity** • **Workforce Development**
• **Health Improvement & Resolving Disparities**	• **PeachCare for Kids™ Program Stability**

	• **SHBP Evolution**
• **Uninsured: Community Solutions**	• **Consumer Service and Communication** • **Health Care Consumerism**



Overview

President George W. Bush launched an initiative in 2004 to reform health care through the improved adoption of health information technology and empowerment of consumers through information. In support of President Bush's initiative, Governor Sonny Perdue issued two Executive Orders relating to Health Information Technology and Transparency (HITT):

1. Signed in October 2006, the first created the HITT Advisory Board to facilitate and encourage the use of electronic health records and to establish a statewide health information exchange strategy and to promote marketplace transparency
2. The second, signed in February 2007, encouraged marketplace transparency by providing cost and quality data to consumers, and application of industry best practices that facilitate the use of electronic health records

The Board members, which are representative of various heaviders and businesses, will advise the Georgia Department of Community Health (DCH) in applying industry best practices for facilitating and encouraging the use of electronic health records and establishing a statewide strategy that will enable health information to be available across the full continuum of care.

The Vision

Health information technology promises to help transform health care in Georgia by lowering costs, reducing medical errors and improving quality of care. Georgia providers will have access to the clinical information they need to make informed decisions about patient care when and where they need it. Georgia citizens will have access to the information they need to make decisions about their own care based on cost and quality.

The Process

The HITT Advisory Board is working to develop a strategy to enable health information technology to be available across the full continuum of care. The strategy encompasses encouraging the development of interoperable and secure health information across different provider and payer groups.

The HITT Advisory Board and DCH worked together to develop evaluation criteria used to determine pilots eligible for funding through the Georgia Health Information Exchange (HIE) Pilot Program. Providers, payers or local health communities may submit pilot proposals. Potential pilots would include the use of:

* **Electronic health records** to improve the safety and quality of health care and reduce the costs
* **e-prescribing** to reduce medication errors and the cost of medication by helping to ensure formularies are used as prescribing decisions are made
* **Health information exchange** to provide clinical information when and where it is needed for health care decisions

Applicants must submit a mandatory Letter of Intent to apply by August 31, 2007. Completed applications must be delivered to DCH by 4:00 PM., EST on or before September 28, 2007.

For more information about the Georgia Health Information Exchange Pilot Program, visit www.dch.georgia.gov.

Mr. TOWNS. Thank you very much, Dr. Price.
Ms. Evans.

STATEMENT OF LORI EVANS

Ms. EVANS. Good afternoon, Mr. Chairman, Ranking Member Bilbray, Dr. Christensen. Thank you very much for inviting me here today.

My name is Lori Evans. I am deputy commissioner at the New York State Department of Health, responsible for our new Office of Health Information Technology Transformation. I also had the fortune of helping launch the first national health IT office with Dr. David Braylor, so I am especially excited about the topic of the hearing today.

And I'm also thrilled to have two co-cooks with me, Doctors Mostashari and Calman, who you will be hearing from as well.

In New York, we are currently investing approximately $150 million in health information technology to support our progress in improving health care quality, affordability and outcomes for all New Yorkers.

The most important aspects of health IT is not software and computers; it is clinicians being able to make better treatment decisions and coordinating care more effectively. It's about nurses and pharmacists delivering safer therapies, and consumers and patients making better choices from different health care options. It's the way people connect together across a fragmented delivery system, from community health centers to physician offices, hospitals to skilled nursing facilities, and even to the consumer's home. It's the way information is retrieved and used to realize value from health information technology.

Reforming our health care system will require many things, which are under way in New York such as universal coverage, such as long-term care and hospital restructuring and many other things and it must also include vastly improved availability in use of health information. Our success in New York and our success across the country will be defined by whether or not we use information to improve patient care and to reduce health care costs and to support different ways of paying for health care in different models of delivering care, especially in our most underserved areas.

In my written testimony, I provided a high level of discussion of our approach in New York related to the funds that we have the good fortune of spending. And there are really three foundations that we are trying to realize in New York, that we are trying to set in New York. And one is the technical, one the clinical, and one is organizational.

And the technical foundation is about enabling the technical interoperability and transformation of today's largely paper-based system to an electronic interconnected system and being able to measure and report on quality in population health information.

The clinical foundation is about clinical adoption to attract the sufficient demands for health IT from clinicians and the supply of it from the industry. So we ensure that the health IT tools increase the likelihood of success and are able to deliver value to those that are using them and to result in patient care improvements.

And the organizational foundation is also crucial. It's about governance and public trust and how health care clinicians can use health information technology to succeed in patient care improvements, and for them to know that there their issues will be resolved in a reasonable way.

The successful adoption of health information technology must emerge from these three intertwined capabilities. For example, interoperability is as much a function of trust as technology or clinical participation, and it is achieved through policy and governance.

Regional health information organizations become very important in this context. RHIOs working with other RHIOs, the Government and others, are about creating this collaborative, multi-stakeholder environment that assures effective interoperability and quality in population health improvement.

Another critical component of the organizational foundation is an organization called the New York eHealth Collaborative. That is a public-private statewide partnership in New York that is helping to drive a lot of our work there.

Turning to the role of health information technology in improving health outcomes and decreasing health disparities, I think this agenda really starts with access to care. But I think this is also where access to insurance and access to information go hand-in-glove, because simply having health insurance is no guarantee that there will be access to the right high-quality care at the right time by the right clinician.

This requires a health care system that is restructured to create a patient-centered model that emphasizes primary and preventive care. In New York, we believe these reforms start with the Medicaid program. This requires changing our reimbursement system from a system that rewards volumes of services to a system that recognizes quality and improved outcomes and encourages the delivery of preventive care. Creating this quality-based or outcomes-based reimbursement system will require the widespread adoption of health information technology, and that is the foundation that we are trying to lay through our grant program.

Integrating prevention and quality measurement enabled by health information technology offers tremendous potential in addressing and eliminating health disparities caused by a lack of prevention and access to the most effective health interventions.

Regarding the interplay of Federal and State government—and I wish our Federal colleagues were still here—I think the interplay is crucial to advance the socially optimal level and type of health information technology adoption we need in New York and across the United States. We don't have too many cooks. We have too few cooks. We need a solidification in funding of a coordinated structure and process comprised of Federal and State leadership, as well as the health care community. And I think the three panelists from New York today really symbolize that quite nicely.

Mr. TOWNS. Could you sum up?

Ms. EVANS. Sum up.

In the Congress, you know, we think that the lack of funding has been significant. And to just have as bit of fun with the analogy today, I think we have been served a small plate of lima beans. We need many cooks contributing to a well-defined meal plan with all

food groups and proper nutritional levels. This, with the proper funding, will lead to a feast of health information that will feed the Nation's health reform efforts.

Thank you.

[The prepared statement of Ms. Evans follows:]

Statement of

LORI M. EVANS

DEPUTY COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INFORMATION TECHNOLOGY TRANSFORMATION

before

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT MANAGEMENT, ORGANIZAITON AND PROCUREMENT

on

"Too Many Cooks? Coordinating Federal and State Health IT"

November 1, 2007

Statement of
LORI M. EVANS
DEPUTY COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INFORMATION TECHNOLOGY TRANSFORMATION
November 1, 2007

Chairman Towns, distinguished Subcommittee members, thank you for inviting me today to discuss health information technology (health IT), and specifically: (1) New York's Healthcare Efficiency and Affordability Law (HEAL) health IT investment program to support improvements in quality, affordability and outcomes for all New Yorkers; (2) the role of health it in improving health outcomes and decreasing disparities; and (3) the interplay between the Federal and State health IT agendas, including the impact of federal resources and standards on the State's health IT programs.

BACKGROUND

As you know, the U.S. health care system has a long and distinguished history of innovation. At the same time, health care faces major challenges. Health care spending continues to rise and concerns persist about preventable errors, uneven health care quality, uncoordinated care and poor communications among providers. These problems - high costs, medical errors, variable quality, administrative inefficiencies and lack of coordination - are closely connected to inadequate use of health information technology (health IT) as an integral part of the medical care delivery system. Health IT plays a significant role in our progress to improve the quality, safety and efficiency of healthcare.

The most important aspect of health IT is not software and computers - it is clinicians being able to make better treatment decisions and coordination of care, nurses and pharmacists delivering safer therapies and consumers making better choices from their options.

It is the way people connect together across a fragmented delivery system - from community health centers to physician offices; hospitals to skilled nursing facilities and even to the consumer's home. It is the way information is retrieved and used to realize the expected value from health IT and support prevention and quality-based reimbursement reform including new models of care delivery.

Statement of
LORI M. EVANS
DEPUTY COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INFORMATION TECHNOLOGY TRANSFORMATION
November 1, 2007

Over the past few years, the federal and state governments and the health care community leadership have made progress in setting the stage for supporting the transformation of health care delivery through the use of health IT. Much work remains.

Currently, the Office of the National Coordinator for Health Information Technology is managing multi-year landmark health IT initiatives that, together, provide a foundation for the development of a nationwide health information network (NHIN). Multiple federal agencies are also undertaking initiatives to support health information exchange and adoption. Quality and population health tools required for physician performance and patient outcomes measurement and reporting to improve health care quality and reduce costs are being developed. The federal executive agencies' interest in health IT is matched by a strong and growing Congressional interest.

Increasingly, states are leading the development of health IT policy by coordinating multi-stakeholder approaches to health information exchange and quality tools, addressing patient privacy and confidentiality funding and promotion of the adoption and effective use of interoperable EHRs. At least 35 states have issued health IT gubernatorial executive orders, proposed budget appropriations, commissioned planning efforts, established executive-level offices and/or introduced legislation.

Communities across the country are also shaping the emerging health IT landscape through Regional Health Information Organizations (RHIOs) to enable interoperability, quality measurement and reporting, and population health improvement initiatives. RHIOs are providing real-world laboratories for analyzing the technology, governance, clinical, business and legal issues raised by interoperable health information exchange.

Statement of
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DEPUTY COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INFORMATION TECHNOLOGY TRANSFORMATION
November 1, 2007

There are also well over 100 financial incentive and pay-for-performance programs underway in the private sector developing health IT quality tools. They are designing incentive payments for clinicians along with a spectrum of prevention, process and quality-based outcomes. While still in early development stages, health information exchange projects and quality improvement tools supporting pay-for-performance initiatives are providing lessons regarding the importance of the organizational, financial, technical and clinical aspects of health IT.

1. NEW YORK'S HEAL NY HEALTH IT INVESTMENT

The innovation that has made New York's medical care among the best in the world has not been applied to its health information systems. With this in mind, New York has made supporting the transformation of health care through health information technology a priority. Health IT plays a significant role in New York's progress to improve the quality, safety and efficiency of healthcare. The Department of Health (DOH) will lead the State's effort to achieve the common goal of using health IT to unlock new opportunities in the practice of medicine. We envision a health care system in New York supported by health IT where:

- The health care system is oriented around the patient, with strong privacy protections, ensuring the privacy and security of patients' individually identified health information , and supporting the right of New Yorkers to have great control over and secure access to their personal health information;
- Clinical information is in the hands of clinicians so that it guides medical decisions and care coordination;
- Medical information follows the consumer so they are at the center of their care;
- Quality initiatives requiring health IT tools result in robust accountability based on the information needed to assess patient outcomes;
- Clinical information is accurately collected in a timely manner for population health reporting, clinical trials and for other research purposes;

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- Clinical research and care delivery are linked together to measure and monitor longitudinal outcomes; and,
- New Yorkers are prepared for health care emergencies through the development of the capacity to communicate with their clinicians and receive and exchange health care information, such as medications.

The newly created Office of Health Information Technology Transformation (OHITT) within the NYS Department of Health is charged with coordinating the realization of this vision in order to support improvements in health care quality, affordability and outcomes for all New Yorkers through vastly improved availability and use of health information.

This vastly improved availability and use of health information will inform and give us options to think about how to pay for and deliver health care differently - in ways that promote prevention, award good outcomes and improve patient care.

Over the past year DOH has started to advance widespread adoption of health information technology with investment from the Health Care Efficiency and Affordability Law (HEAL) NY health IT investment. The current investment of $159 million ($53M awarded and $106 in process) is setting three foundations - technical, clinical and organizational - to support our progress in improving the quality, safety and efficiency of health care. These foundations must be combined and co-evolved so they can be coordinated and addressed together in order to realize benefits from health information. It's how beneficial health information is in improving quality, reducing health care costs and improving health outcomes that will define the success of New York's health IT program.

The three foundations are:

- Technical: Technology to enable technical interoperability and the transformation of today's largely paper-based system to an electronic, interconnected system.
- Clinical: Clinician adoption to attract sufficient demand for, and supply of, health IT tools to increase the likelihood of success and delivery of benefits to patients and providers.
- Organizational: Governance that establishes trust by assuring health care professionals that most of their participation and use of health IT will succeed, provide efficiency gains and patient care improvements, and issues will be resolved reasonably.

The successful adoption of health IT must emerge from these three intertwined capabilities. For example, interoperability is as much a function of trust as technology or clinical participation, and is achieved through policy and governance.

Organizational Foundation

Regional Health Information Organizations are important in this context. RHIOs, working with other RHIOs, government and other organizations must create a collaborative, multi-stakeholder environment that assures effective interoperability and quality and population health measurement and reporting through governance, policies and standards. RHIOs are not technology organizations, do not develop software or provide technical integration services. They are not proprietary physical health information exchange networks. Rather, RHIOs partner with qualified health information service providers (HISP) or vendors competing in the marketplace for these services. They ensure clinical goals drive technical implementation and that open, or non-proprietary health information exchange protocols and services, are developed, implemented and available to all providers and payors.

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Within New York State, The New York eHealth Collaborative (NYeC) also becomes an important component of the organizational foundation. As a statewide, multi-stakeholder public-private partnership to support collaboration and common technical approaches starting with the HEAL NY Health IT projects, NYeC was designed to represent and incorporate the various stakeholders involved in health IT. NYeC has formalized a governance structure and established collaborative processes designed to maximize stakeholder involvement. It supports the development of consensus on the overall health information and quality improvement strategy for NYS.

Technical Foundation

New York is advancing three key building blocks which comprise New York's health information infrastructure, as follows:

Statewide Health Information Network for New Yorkers (SHIN-NY) - a collaboration of networks to interconnect clinicians to exchange patient information regardless of where the patient receives care in order to deliver the appropriate treatment at the right time in a coordinated, patient-centered manner. The SHIN-NY will utilize the Internet and consist of specialized software protocols and services, including security tools and a suite of standards. It will be a part of the emerging Nationwide Health Information Network (NHIN).

Clinical Informatics Services (CIS) - Community-based health IT tools which aggregate, analyze, measure and report data in a standardized and valid manner for uses including quality and population health initiatives that is available to all payors, providers and public health officials.

Information Tools – EHR for clinicians and personal health tools for New Yorkers providing: (i) clinicians with information tools when and where they need them to guide

medical decisions, (ii) New Yorkers with greater control over and access to their health information, and (iii) Public Health Officials with the ability to survey, report, and respond to population health events.

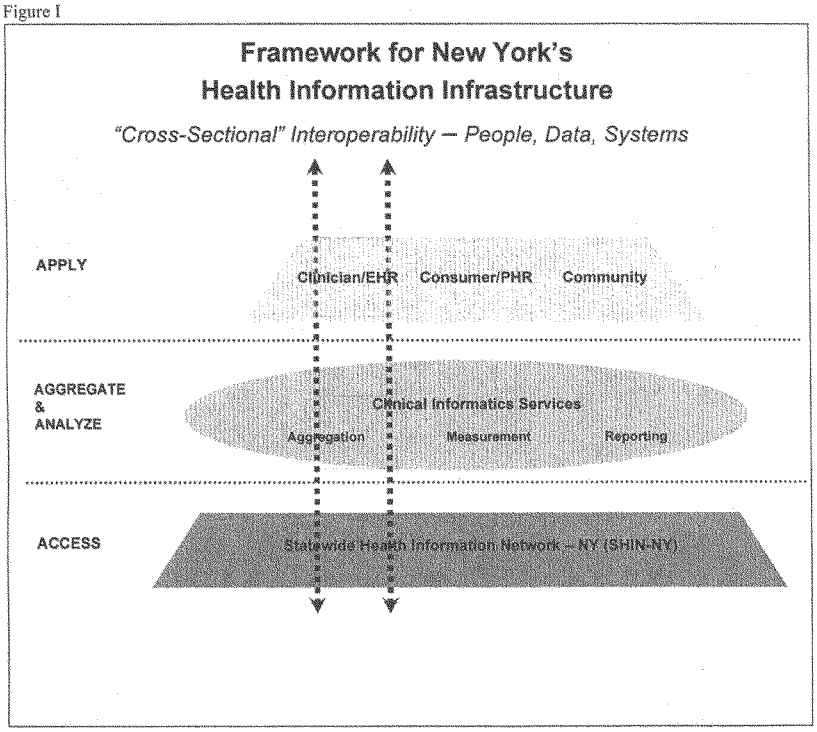
The challenge of advancing these building blocks is made more difficult in that the elements of successful health IT adoption-demand, supply and the infrastructure and capacity-exist only in part or not at all.

We are therefore advancing a "cross-sectional interoperability" approach, which is implementing all three technical building blocks (SHIN-NY, CIS, information tools) in limited and incremental amounts in order to accomplish:

- Benefits right from the start for clinicians and providers
- Support community-based adoption whereby health IT tools must be readily available and integrated into the practices of a population of users to realize benefit internal to the people over time.
- Integrate demand and supply through the infrastructure so that efforts start immediately to educate providers about the benefits until there is enough experience and visibility to sustain usage.

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Figure I



A complete cross section can be designed to provide real benefit quickly. In this way, a clinician can begin to derive benefits from these 'cross-sections' without having to wait for an entire health information exchange component to be completed and available via

the SHIN-NY. Like any infrastructure project, limited efforts can provide value by integrating demand and supply through early development.

Clinical Foundation

This is about clinician adoption and that electronic health records (EHRs), for example, are essential but not enough to ensure effective use of information and improved health for New Yorkers. An environment must be created and substantial efforts made to utilize the information so that clinicians learn how to recognize the benefits from the vastly improved availability of health information.

This is where CHITAs (Community Health Information Technology Adoption Collaborations) play an invaluable role. A CHITA is a community collaboration of ambulatory care clinicians and clinically affiliated providers whose mission is to advance adoption and effective use of health IT tools, especially EHRs, for clinicians at the point of care. Accomplishing a CHITA's goal (effective adoption and use of health IT) resulting in patient care improvements can be achieved through a workflow re-design and process and quality interventions and improvement.

2. HEALTH IT'S ROLE IN IMPROVING HEALTH OUTCOMES AND DECREASING DISPARITIES

Universal health insurance offers tremendous potential to reduce health disparities caused by lack of access to health care services. But, as the Kaiser Permanente Institute on Health Policy reported earlier this year, simply having health insurance is no guarantee to access of necessary or high-quality health care. So, at the same time New York is working to provide universal health insurance coverage to its residents, it is looking at ways to improve the quality of the health care being purchased.

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As Governor Spitzer has stated from the beginning, New York's healthcare system must be restructured to create a patient-centered model that emphasizes primary and preventive care to help keep New Yorkers healthy and prevent serious complications from chronic diseases. We believe these reforms must start with New York's Medicaid Program.

With over $47 billion dollars in total spending, New York's Medicaid program is the single largest payer of health care services in the state. It underwrites almost one-third of all health care costs. If we want to improve the health of New Yorkers and reduce health disparities, the state's $47 billion-dollar Medicaid reimbursement system must be removed from a system that rewards volume of services and favors inpatient care to a system that recognizes quality, improved outcomes and encourages the delivery of preventive care.

Creating this quality-based reimbursement system will require the widespread adoption of health information technology. Patient medical histories, clinical data and decision-making support tools must be available at all points of delivery. The information needs to be provided in the aggregate for determining outcomes measurement and reporting among multiple clinicians, providers, and payers.

This effort will require regional collaborations of providers who serve Medicaid patients be inter-connected by health IT for a quick information exchange regardless of where the patient receives services. The purpose is to improve the quality of care rendered.

The patient's healthcare providers would be able to promptly, electronically, access nationally recommended preventive services and guidelines so that the practitioner can compare the recommended care with the patient's electronic medical history to identify gaps.

Integrating these quality measures into the Medicaid reimbursement system offers tremendous potential in addressing and eliminating serious health disparities caused by a lack of prevention and access to the most effective health interventions.

3. INTERPLAY OF FEDERAL AND STATE GOVERNMENT AND IMPACT OF FEDERAL RESOURCES AND STANDARDS ON NY'S HEALTH IT PROGRAM

Interaction between the federal and state governments is crucial to advance the socially optimal level and type of health IT adoption in the U.S. There are crucial roles and actions at both levels which must be aligned and coordinated. It is the primary reason that the Office of the National Coordinator of Health Information Technology was established. The federal and state governments should lead and are expected to benefit from health information technology in nearly all of its mutual roles: as a purchaser and payor of care, an operator of care delivery networks, a procurer of care, a funder of health care research and as a policy-maker and regulator of the health care market.

To date, the federal role has suffered from a significant lack of funding. Notwithstanding, important advances have been made such as effecting the Certification Commission of Healthcare Information Technology and the Health Information Technology Standards Panel. These bodies have great potential, but are still in their infancy and need strategic direction and funding to fulfill their promise. As we make investments in New York, working with federal initiatives is a priority. A key question at this stage in the health IT movement is the sequencing, pace and consistency of development, not about federal control and monolithic policy. Innovation at the state and regional levels needs to be encouraged. It's not about too many cooks, but solidification and funding of a federal structure. It greatly concerns state-level innovation and implementation approaches that balance a bottom up approach based on market

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conditions and state level governance and operational approaches that create a national standard harmony, product certification and policy coordination. Standards alone are insufficient to accomplish widespread interoperable EHR adoption. Two standards-compliant EHRs cannot share information without a network that is specialized to handle the detailed and open protocols needed for secure information exchange.

Integration of federal and state health IT programs

Numerous federal and state agencies are developing and deploying health data collection mechanisms to support their programs. These include, but are not limited to, data for quality monitoring, health status reporting, public health monitoring, bioterrorism surveillance, clinical trials and post adverse event and drug event reporting. Many agencies require similar information to be reported by the health care community. However, nearly all the agencies are developing stand-alone data collection silos that require physicians, hospitals, laboratories and pharmacies to report the same information to the many agencies in different formats. In addition to spreading precious government resources across redundant activities, these impose substantial burdens on the health care community and interfere with the general adoption of interoperable solutions.

The money invested by the federal and state governments should be used to develop systems that collect health information from the health care community, bringing both levels of government into leadership roles that foster interoperability using a single, interoperable infrastructure for data gathering where possible. Using a single infrastructure is particularly important to minimize the reporting burden on providers and provider systems.

Emerging health IT networks funded by different agencies and programs should be integrated to the degree possible. Health care provider experience has shown that the fewer times data are collected, the more efficient, complete, valid, timely and useable it is. It is recognized that individual programs have specialized needs that would have to be

addressed. The resulting system specific to those programs would be both more effective at data collection, more cost-effective in using government funds and less burdensome to the health care community. If done correctly, federal and state integration could be a strong catalyst for community-wide interoperability as well. Rationalizing the federal and state investment in health IT could provide significant funding for a health information exchange network that is mutually shared by both the federal government and the health care community.

Mr. TOWNS. That is why we are having this hearing, trying to get you a balanced diet.

Ms. EVANS. Thank you.

Mr. TOWNS. Dr. Mostashari.

STATEMENT OF FARZAD MOSTASHARI

Dr. MOSTASHARI. Good afternoon, Chairman Towns and Ranking Member Bilbray. I am Dr. Farzad Mostashari. I am assistant commissioner in charge of the Primary Care Information Project at the New York City Department of Health and Mental Hygiene.

We heard that our current health care system does not deliver health efficacy, efficiency or equity. Our system is rife with redundant, unnecessary and sometimes harmful interventions, while evidence-based, life-preserving measures are delivered only about half the time. Health disparities are not addressed, or even exacerbated by unequal delivery of services.

We, at all levels of government, as purchasers of health care and as guardians of the health and safety of the public, now have a responsibility and an opportunity to create a new landscape for health care.

Extension of electronic health records and establishment of policy and standards for health information exchange are critical building blocks, but they are not sufficient. A recent study in the Archives of Medicine found that patient encounters conducted with electronic medical records, as currently designed and implemented, had the same low quality of chronic disease management and preventive care as those conducted with paper records.

This may seem paradoxical but should not come as a surprise. Consumers, purchasers and payers do not have the information needed to recognize and incentivize providers who deliver better prevention. So our reimbursement system rewards providers who deliver more services, not prevention. It therefore follows that the health care IT market and physician office workflows are also not oriented toward prevention in chronic disease management.

In order to break this logjam, we need to simultaneously support a restructuring of health IT, office workflows and reimbursement systems. Once established, these new structures will be mutually reinforcing, and market forces can finally be aligned to deliver improved health and value.

We believe that we have created a local model for this transforation through the New York City Primary Care Information Project. Anchored by a city commitment of $27 million and approximately 40 staff members, we are implementing electronic health records for over half of all high-volume Medicaid providers in the city; establishing standards-based data transmission between practices in laboratories, pharmacies, health plans and hospitals; integrating prevention into EHR software and practice workflows and enabling pay-for-prevention. Let me briefly describe each of these interdependent pieces.

We are assisting more than 1,500 New York City primary care providers to adopt prevention-oriented EHR systems over the next 2 years. This includes all 29 of the city's federally qualified health center networks. This group alone comprises 648 providers and half

a million patients, 50 percent of whom are on Medicaid and 20 percent of whom are uninsured.

We are also focusing on Medicaid providers among solo and small practices, which provide most of the primary care in this country but don't have the financial, technical and quality-improvement resources of larger practices and the lowest rates of EHR adoption.

Bringing interoperability and health information exchange to this community of safety-net providers has required a great deal of effort on our part. As the Institute of Medicine's recent report describes, the absence of a strategic plan and the lack of clear decisionmaking processes have hindered national progress on interoperability. They also suggest process and a commitment to evaluation and updating of standards based on experience in the field.

In our experience in the field, these Federal efforts have had a measurable impact in some areas, but well-established and agreed-upon standards are still not widely implemented. The absence of policy guidance has resulted in slow standards developments in some priority areas and the risk of overly hasty standards-setting in other areas, including quality reporting in biosurveillance.

The impact of the planned transformation of the American health information community is unknown, but in our opinion, it is unlikely that an industry-led entity will be able to provide the credible policy leadership to this process, as has been done in New York through the work of the State Department of Health and the New York eHealth Collaborative.

The policy leadership requirement extends to EHR functionality as well as interoperability. Several features critical for improving prevention are not consistently or effectively implemented in products meeting Certification Commission for Health Information Technology's standards. These include structured data collection for a minimal set of required clinical items, like smoking status; registry tools for examining entire patient panels and generating lists of patients for recall or anticipatory care; automated clinical quality measurement, including the ability to view and analyze health disparities in every measure; and real-time, bilateral connections to the public health system for immunization and disease reporting.

Unfortunately, practices are also not structured to effectively deliver or monitor preventive care. As part of our community initiative, we are working with safety-net providers to maximize the productivity of support staff, the completeness of necessary documentation, improve patient satisfaction. In some cases, we need to design new workflows.

We believe that interoperable EHRs with registry functions implemented by practices that focus on quality of care can finally produce reliable metrics of actual clinical outcomes. And this platform can be the basis for pilot physician recognition and paper-prevention incentive programs.

In conclusion, although I would like to gratefully acknowledge the support we have received from CDC and ARC for research and evaluation, New York City's Primary Care Information Project is an example of a community-led project with local innovation and resources.

Healing our health care system using interoperable health information technology will require the resources and energy of all of

us at the Federal, State and local levels. There is a need for a common policy framework at the national level, but we cannot afford overly prescriptive or premature policies or standards that would thwart State and local innovation and stifle local investments.

We, and other communities like ours, could realize a great public benefit from Federal legislation that provided funding and a comprehensive policy framework for EHR extension, health information exchange, and quality-based recognition incentive programs if such legislation included an explicit and pervasive emphasis on prevention, a concern for disadvantaged communities, support for community-based projects as the action arm for these activities, and a commitment to fund and support the rigorous evaluation and optimization of these initiatives.

Thank you for the opportunity to testify. I'll be happy to answer questions.

[The prepared statement of Dr. Mostashari follows:]

TESTIMONY

of

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Assistant Commissioner,
Primary Care Information Project
New York City Department of Health and Mental Hygiene

before the

U.S. Congress

Committee on Oversight and Government Reform
Subcommittee on Government Management,
Organization and Procurement

Hearing on

"Too Many Cooks?
Coordinating Federal and State Health IT"

Washington, D.C.
November 1, 2007

Good afternoon, Chairman Towns, Ranking Member Bilbray, and Members of the Subcommittee. Thank you for the opportunity to testify on the important subject of health information and technology.

My name is Farzad Mostashari, I am Assistant Commissioner in charge of the Primary Care Information Project at the New York City Department of Health and Mental Hygiene.

The invitation to these hearings mentioned this Subcommittee's oversight of federalism and the efforts of federal, state, and local governments. Let me start by stating that while there is legitimate debate over the relative roles of these different levels of government, there is no question that government has an important role to play. The current health care landscape does not deliver health, efficiency, or equity: The system is rife with redundant, unnecessary, and sometimes harmful interventions, while evidence-based life-saving measures are delivered only about half of the time. Health disparities are not addressed, or are even exacerbated, by unequal delivery of services. We, at all levels of government, as purchasers of health care, and as guardians of the health and safety of the public, have a responsibility and an opportunity to create a new policy landscape for healthcare.

There is no question that paper-based systems are a part of the problem, and that interoperable health information technology (HIT) must be a part of the solution. More than three decades of carefully planned and executed research studies in academic research centers and integrated delivery networks have demonstrated the potential of quality, safety, and efficiency gains with electronic health record (EHR) systems. The Institute of Medicine has supported the extension of electronic health records as a key strategy in addressing the quality chasm, the President has called for all Americans to have electronic records by 2014, there is bipartisan support for legislation that would increase access to interoperable health record systems, and many states have launched ambitious "e-health" initiatives.

However, a note of caution is required. While extension of electronic health records and establishment of standards and structures for interoperability and health information exchange are critical building blocks, they are not sufficient. A recent study in the Archives of Medicine found that patient encounters conducted with electronic medical records, as currently designed and implemented, had the same low rate of adherence to best practice guidelines and the same low quality of chronic disease management and preventive care as primary care visits conducted with paper records. This may seem paradoxical, but should not come as a surprise. The healthcare IT market has not produced systems that focus on prevention and chronic disease management; physician office workflows and processes are still not oriented towards prevention and chronic disease management, and our reimbursement system still rewards health care services delivered, not prevention. Any effort (or legislation) that hopes to yield a net public benefit from investments in HIT must address not only electronic health record extension and interoperability but also prevention and chronic disease management, and do so in a

way that does not leave behind medically-underserved communities. In New York City, we believe that we have created a model that accomplishes this.

The NYC Primary Care Information Project

The NYC Primary Care Information Project (PCIP) seeks to improve population health in disadvantaged communities through the use of interoperable HIT. The initiative was anchored by a City commitment of $27 million and approximately 40 staff members to support the project. Our strategy and organization includes three components, a community electronic health record extension network, communitywide health information exchange, and a quality reporting and quality improvement network.

Community EHR Extension

The first part of our strategy involves providing prevention-oriented EHRs to primary care providers who care for the medically-underserved.

Our initial focus was community health centers. With focused funding from the Robert Wood Johnson Foundation, we helped create a Primary Care Health Information Technology Consortium comprising all 29 of the City's federally qualitative health center networks. Our goal is that all of them will have prevention-oriented EHRs by 2009. That's 648 FTE providers; it's about half a million patients, 50 percent of whom are on Medicaid and 20 percent of whom are uninsured. In support of this consortium of safety net providers, we were able to successfully advocate for $3.2 million in New York State funding to purchase and implement EHR software or, for those who have already implemented a system, to incorporate population health and preventive care functionality within them. The consortium has also successfully advocated for $2 million from the New York City Council for health center infrastructure, and $600,000 for workforce retraining.

We next looked towards solo and small practices, which provide 80 percent of primary care in this country, but which do not have the financial, technical, and quality improvement resources of larger practices, academic medical centers, and integrated delivery networks. Consequently, these practices have the lowest rate of EHR adoption in the nation (recently estimated at less than five percent) and face the greatest challenges in being able to provide high-quality evidence-based care. We are looking to other organizations to help convene and support small providers as they try to adopt electronic health records—the medical societies, the quality improvement organizations, the hospitals and some health plans.

One of the main things that we are doing is outreach and education. We have developed a City Health Information bulletin which describes the basics — what is an EHR, what are some functionalities of an EHR, privacy and security issues, the economics and potential financial benefits, challenges to implementation, a readiness assessment, information about the Primary Care Information Project, and Continuing Medical Education credit. We have also developed a public health detailing campaign, with an EHR action kit with

educational materials for providers, other practice staff and patients, and have conducted hundreds of onsite visits to practices in the south Bronx, central and east Harlem and central Brooklyn. This material is available on our website at www.nyc.gov/pcip.

We will assist more than 1,500 New York City primary care providers to adopt a prevention-oriented EHR system in the next two years. The first practices to start up on the EHR did so this month. Once we are fully operational, we will assist 100 providers a month to implement the system. Here is the basic outline of our operational approach to EHR extension to these practices:

Following rigorous and competitive procurement, the City has registered a $20 million contract with a commercial EHR vendor, enhanced its preventive care functionality, and granted licenses to community practices that care for medically-underserved populations and that have made the necessary in-kind and cash commitments.

We sent out a Request For Proposals based on Certification Commission for Health Information Technology criteria and received a strong vendor response. All the large ambulatory EHR vendors bid on our project. We did five finalist demos -- five days of taking them through their paces and asking the tough questions --and then conducted financial and organizational due diligence.

The software we selected employs a one-system solution incorporating the practice management system (scheduling and billing), medical charting and electronic prescribing, querying and reporting functionalities and patient portal functionality. Most importantly, it has modern architecture—it is flexible, modular, and configurable.

To be eligible for our program, practices must provide primary care. They must care for underserved and vulnerable populations (at least 30 percent of encounters for Medicaid or uninsured patients). They must participate in our public health goals, including automated confidential public health and quality reporting. They must take part in the quality improvement activities, including the decision support tools.

The City is granting these eligible practices a package of software and services. This includes unlimited perpetual licenses to the New York City build of the EHR and practice management software, which has the decision supports and the linkages to NYC systems. The package includes two years of maintenance and support; onsite training (the vendor is setting up a NYC office to be available to our participants); data interfaces to all large commercial laboratories; quality improvement technical assistance onsite and online. It also includes predictable and relatively low maintenance and support costs in the range of $1,650 per year.

The implementation is managed by the vendor. Our staff help with organizational IT and practice readiness and provide needed support to the practices' project management, implementation, and quality improvement efforts. Given our ability to leverage the scale of the project, the cost to the City for each provider is approximately $12,000 for every

individual clinician in vendor costs, and approximately $3,000 per clinician in DOHMH staffing required to support practice readiness, implementation, and evaluation.

In return, the practices have to bear in-kind costs of hardware and network infrastructure, and productivity loss during training, start-up and evaluation. They must assume all the ongoing costs of maintenance and support after the two-year testing period. Finally, practices must commit $4,000 in cash per provider to a quality improvement fund that will finance post-implementation quality efforts.

Community Health Information Exchange and Interoperability

Interoperability standards and health information exchange have been the focus of the initial work of the Office of the National Coordinator and most of the state-funded eHealth initiatives. How much of a difference have these efforts made on the ground?

In our experience, these efforts have had a measurable impact in some areas, but well-established and agreed-upon standards are still not widely implemented, and standards development is proceeding slowly in priority areas and maybe too hastily in other areas. Let me give you some concrete examples:

Where standards and exchange have worked well:

- We have successfully used industry standards (NCPDP Script 8.1) in working with New York State Department of Health to establish a query-and-response service that provides 90-day medication fill histories from the State's Medicaid claims warehouse to providers at the point of care. The messaging standard and implementation guide significantly reduced the time and resources needed to establish and test this connection, and makes it much more easily scaled to other providers.

Where established standards are not implemented, or priority standards not yet established:

- In our community EHR project, we would like providers to be able to integrate electronic results from multiple laboratories. This would require that the laboratories use standard ("LOINC") codes for their laboratory results, or at the very least, commit to providing an accurate and updated mapping of their proprietary dictionaries to this standard. This has been difficult and slow to accomplish, even for a project of our size, scale, and technological readiness.
- We would like to integrate medication fill histories from pharmacies or payors with the provider's own prescribing history, and enable providers to move from one medication (and allergy) database to another. This still requires drug-by-drug manual review.
- There are no standards for representing key items on a problem list, like "ruled out" or workup-negative diagnoses, persistent versus intermittent asthma, or accurately representing smoking status ("current," "former," "never," missing).

- There is no vocabulary standard in the U.S. for collecting "reason for visit" (aka "chief complaint") for primary care encounters.
- There is no service-oriented (query and response) messaging standard for patient-centered health information exchange documents that could be used by a medical provider to query multiple Regional Health Information Organizations, or by a consumer to request his or her medical summary from multiple organizations.

Where standards development may be proceeding too hastily:

- Standard-setting for quality of care measurement and biosurveillance may enshrine a reporting and analysis architecture derived from experience with and orientation toward data mining of quality or public health data warehouses, rather than considering the transformational potential of EHR-derived automated clinical quality measurement and public health reporting.

As the Institute of Medicine's (IOM's) recent letter report ("Opportunities for Coordination and Clarity to Advance the National Health Information Agenda") clearly describes, the absence of a strategic plan and the lack of clear decision-making processes have hindered progress on interoperability. The IOM also suggests a process and a commitment to evaluation and updating of standards based on experience in the field. The work of the New York State Department of Health in establishing a statewide health information network should provide both short-term value to health information exchange activities in the New York, and valuable input and experience for national standards-setting organizations to build on.

A particularly important priority for concordance between policy and standards is protecting privacy and security. A framework for implementing privacy through technology as well as policy, such as that delineated by the Markle Foundation's Connecting for Health Common Framework, would fill a critical national gap.

The impact of the planned transformation of the American Health Information Community is unknown, but in our opinion, it is unlikely that a purely private and industry-led body will be able to provide credible policy leadership to this process.

Community Quality Improvement Network

As mentioned in my introduction, in order to achieve community health and a public good from interoperable EHRs, the software products need to change, physician office practice processes need to be redesigned, and provider and practice benchmarking needs to be improved, so that meaningful recognition and incentive programs can be established. In that process, there needs to be an intense focus on priority preventive care and chronic disease management issues that have the greatest impact on the health of the community, and each of these areas (technology, practice, reimbursement) needs to support the others in mutually interdependent fashion.

EHRs Need to Change

Electronic medical records as currently implemented do not improve the quality of care or prevention. The following features are critical to realizing the potential of EHRs, but are not effectively or consistently implemented in products that are currently certified as meeting Certification Commission for Health Information Technology standards.

1. Structured Data Collection: For effective development of quality measurement and decision support tools, required data elements must be collected in a standardized manner across the community. This requires using common drug, laboratory and procedure codes; using standard definitions and responses for a minimal set of required medical history items (e.g. smoking status); and ensuring that the required data are consistently and accurately collected.

2. Registry functions: It is absolutely critical that practices have the tools and training to look at entire patient panels and to generate lists of patients for recall (e.g. on a recalled medication) or anticipatory care (e.g. coming due for a test). An ideal registry manages populations with chronic disease and assists providers with an outreach and service infrastructure (e.g. sending letters or e-mail).
3. Quality measurement: A set of clinical quality measures that comprehensively but parsimoniously addresses priority health issues (like blood pressure, diabetes, lipid control, immunizations, and screening for cancer, HIV, depression, and alcohol/substance abuse) must be predefined and easily reportable, and afford the ability to view and analyze health disparities by race/ethnicity and income/insurance status.
4. Decision support tools: For each of the priority issues measured, patient-specific, automated decision support tools (e.g. treatment reminders, adverse drug event warnings) at the point of care help providers and their staff to adhere to clinical best practices, follow preventive care guidelines, and avoid harmful errors.

Our work in this area draws on the experience and resources of the CDC-funded NYC Center of Excellence in Public Health Informatics, a collaboration among the Department of Health and Mental Hygiene, the Columbia University Department of Biomedical Informatics, and the Institute for Family Health, a fully paperless community health center network in NYC, and the winner of this year's Davies Award of Excellence in Public Health.

In the Primary Care Information Project, we have embarked on a joint development project with our "best of breed" Certification Commission for Health Information Technology certified EHR vendor to improve and deepen their products capability in these domains, and to demonstrate the functionalities and impact of a model electronic health record for community health.

We are now beginning to work with NYC providers using other EHR products, and their vendors, to extend these functionalities to other systems as well.

Practices Need to Change

Business and clinical care process changes are needed to realize EHR-enabled quality improvement.

1. Changing workflows: Practices should take the opportunity to rethink workflows instead of "paving the cow paths," i.e., merely digitizing current inefficient processes. By mapping out common workflows (e.g. scheduling, rooming and examination, referrals, prescriptions, immunizations, billing and checkout) practices can examine and improve existing processes to maximize the productivity of support staff (e.g. standing orders), patient and staff satisfaction, and completeness of necessary documentation.
2. New workflows: Taking advantage of EHR functions may require creating new workflows and staff functions. Examples include designing processes for care management of panels of patients with a chronic condition, using clinical and administrative feedback reports, and electronic patient communications.
3. Patient-centered care: Practices will need to look at their processes from the patient's viewpoint – how can patients be supported through education, goal setting, self-management, medication adherence, etc.?
4. Privacy policies and procedures: Practices must establish privacy policies and procedures to ensure that patients' health information remains secure. This includes restricted access to only appropriate users, passwords, and staff education and workflows that support effective documentation of consent and privacy.
5. Billing: EHRs can enable improved preventive care and chronic disease management, but practices have to carefully review the reimbursement policies and incentive programs for which they are eligible in order to maximize the return on investment in providing high quality care.
6. Staff and budget implications: Practices will need to hire or retrain staff to meet new needs (e.g. scanning, computerized documentation, panel management) and ensure access to professional IT support, and be prepared to make a significant time investment to successfully implement the EHR system.

We have established a Quality Improvement Technical Assistance Fund, using the $4,000 per provider cash contributions from practices implementing the EHRs, and supplemented it with PCIP staff in order to provide comprehensive support for practice redesign and quality improvement that includes onsite assessments and a collaborative readiness model, and these practices will hopefully evolve into an ongoing learning community.

Reimbursement Needs to Change

Financial incentives for medical providers are misaligned. Solo and small primary care practices are squeezed by stagnant reimbursement rates and rising costs, and are finding it difficult if not impossible to meet their increasingly complex professional duties while seeing enough patients to pay the bills, much less engage in quality improvement activities.

Implementing and maintaining health records, changing workflows, conducting population disease management, screening for, and dealing with the consequences of, depression, alcohol and substance abuse or HIV, and providing high-quality preventive care and chronic disease management require additional resources. Under our current service-based reimbursement system, activities that deliver improved health are usually poorly reimbursed, un-reimbursed, or even decreasingly reimbursed.

However, current quality measurement methods and data proposed by purchasers and health plans (including CMS) rely on the use of aggregated administrative claims data for quality measurement, and physicians are reluctant to accept greater reimbursement tied to "pay for performance" arrangements using this data.

We believe that if quality measurements are going to be used for significant incentives or recognition programs, the data has to be better. EHR-based quality measurement has a huge role to play. Interoperable EHRs with population health functionalities, implemented by practices that focus on appropriate use of the EHR-enabled quality measurement and decision support tools, can finally produce reliable metrics of actual clinical outcomes (e.g. blood pressure control).

Most significantly, however, these tools also give practices the tools they need to improve their performance on the basis of these metrics, and, hence, the health of their patients. Rather than receiving a report card which tells them about their failures after the fact, clinicians will receive a reminder saying "person needs a flu shot, click here to order" while seeing the patient[1].

We are working with New York State Department of Health, the NY eHealth Collaborative, the NY Business Group on Health, Bridges to Excellence, selected health plans, and our Quality Improvement Organization, to create a distributed model for automated collection and aggregation of clinical quality measurement data from EHR-enabled providers that would be used as the basis for physician benchmarking, recognition programs, and a "pay for prevention" incentive structure. The additional revenue generated from the recognition and incentive programs would then sustain the EHR implementation and practice redesign work necessary to produce the quality reports and quality improvement efforts.

[1] We have been awarded a research grant from the Agency for Healthcare Research and Quality to evaluate the impact of this type of EHR-derived quality measurement on provider satisfaction with performance measurement.

Concluding Remarks: "Top-down" or "Bottom-up"?

New York City's Primary Care Information Project is an example of a community-led project with local innovation and resources that has received limited federal funding (for research and evaluation) comprising less than 10 percent of overall project costs. We have struggled to realize true interoperability, and while we have realized some definite benefits from national standards development and certification activities, we are still frustrated by the slow rate of progress in national standard setting in some areas, and fearful of the adverse impact of premature standards-setting in others.

Community EHR extension projects like ours can remove several critical barriers to achieving quality gains through EHRs, particularly in solo and small medical practices where most primary care is delivered and in community health centers, which are the backbone of our health systems safety net. These gains include:

1. Helping practices understand the risks and benefits of EHR adoption.
2. Reducing complexity and risk of EHR product selection.
3. Decreasing initial cost of EHR adoption.
4. Standardizing and facilitating network and IT infrastructure and IT support.
5. Facilitating interoperability, including access to electronic laboratory results.
6. Bringing scale to quality improvement collaborations and learning communities.
7. Helping practices qualify for recognition and quality incentive programs.

We and other communities like ours could realize a great public benefit from federal legislation that provided funding and a comprehensive framework for EHR extension, health information exchange, and quality measurement — if such legislation included an explicit and pervasive emphasis on prevention and chronic disease management; a concern for disadvantaged communities and the underserved; support for community-based projects as the "action arm," for these activities; and a full commitment to fund and support the rigorous evaluation and optimization of these initiatives.

Thank you for the opportunity to testify on the role of health information technology in improving population health and reducing health disparities. I would be happy to answer questions from members of the Subcommittee.

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Mr. TOWNS. Thank you very much.
Dr. Calman.

STATEMENT OF NEIL S. CALMAN

Dr. CALMAN. Chairman Towns, thank you for inviting me to provide testimony on this very critical issue of health information technology and health information exchange. I am going to focus my remarks very specifically on issues related to the care of those who are traditionally underserved by our current health care system: the poor, the uninsured, the homeless, new immigrants, people of color, folks whose primary language is other than English, those who are covered by Medicaid, in many cases, and other vulnerable groups.

I am a family physician still practicing in the Bronx and Manhattan for the past 31 years. I am also president and cofounder of the Institute for Family Health. We are a Reach community; we are a federally qualified health center. We operate 29 practices in New York City and up in the mid Hudson Valley. We were founded in 1983 with the specific goal of serving the underserved.

We serve 75,000 patients at our sites; 67 percent are black or Hispanic; 12 percent are uninsured; 40 percent receive Medicaid; 65 percent are below 200 percent of the Federal policy level; and 18 percent require services in a language other than English.

In 2006, we had a thousand patients served who were homeless and more than 600 with HIV/AIDS.

The institute is similar to over a thousand other community health centers in this country. What is different about us is that, in 2002, we made the investment to become one of the first community health center networks to implement a fully integrated electronic medical record and practice management system throughout our entire network.

This has allowed us to enhance our services, significantly improving patient care through improved record keeping, tracking systems, alerts to providers at the point of care, visit summaries, which we give to our patients after each visit, and a vast library of health educational material that are available in multiple languages.

The motivation for this project, interestingly, came out of our work with REACH and our work with over 40 diverse organizations including 20 faith-based organizations whom we work with to try to eliminate racial disparities in diabetes and cardiovascular disease. We were recently named a National Center of Excellence in Health Disparities.

I want to give you four very specific examples of how health information technology works in this safety net.

First of all, alerts to providers, to our providers reminding them to give pneumonia vaccine to patients over 65 brought the number of vaccine dosages that we give a month from 23 to 395 a month.

An alert which asks nurses to ask a two question depression screening questionnaire brought our rate of depression screening from 4 percent to over 90 percent within 4 months of implementing this technology.

Talking about recall systems, there was a recent study which showed that 7 percent of all people taking a blood pressure medi-

cine called ace inhibitors, if they take it in the first trimester of pregnancy, will give birth to a baby with severe cardiac or respiratory birth defects. Within a day of the study being released, we identified 225 people in our practice who were taking this medication, women of child bearing age, and reached out to every single one of them to warn them that if they were going to become pregnant, that they needed to stop the medication.

These kinds of activities were completely unable to be done before the implementation of health information technology.

We also provide data to the New York City Department of Health and Mental Hygiene every day on the symptoms and findings in our patients in the city.

This resulted in putting our information into their syndromic surveillance system of identifying the onset of the flu epidemic in 2004, 13 days before the data from any of their other data sources.

There are dozens of other examples of how health information technology and information exchange in service to our most vulnerable and needy populations is a worthwhile investment.

I would like to end with some very specific recommendations for this as we move forward.

We have to ensure that all legislation and funding that supports the implementation of electronic health records targets the patients at highest risk in our society. All of the developments must have organized ways for community participation in planning and execution. This is something that, to date, has been sorely lacking.

We need to make sure that providers in the health care safety net are included as primary targets for funding.

Two, we need to make sure that in health information exchange networks that community health centers and other safety net providers are required to be participants in these networks and in order to participate in them, they need electronic health records. So you can't participate in health information exchange if you don't have the core fundamentals of electronic health records in your system.

Three, we need to fund the integration of electronic health records into systems like those run by the city department of health so that we become part of a monitoring system that monitors the care of vulnerable populations, and that can only be done if we aggregate our information and send it to our local health departments.

Four, we have to mandate that all electronic health record systems capture data on race, ethnicity, primary language because otherwise we have no mechanism for determining whether people being cared for in the big academic medical center in New York City are being cared for the same irrespective of race or their insurance coverage.

Five, we have to encourage electronic health record vendors to find mechanisms to help flag people who are eligible for clinical trials. Underrepresented—minorities are vastly underrepresented in clinical trials, and so the data that comes from those trials turns out to be of very limited usefulness in treating those populations.

There are only a few more.

Six, we have to require that EHR certification requires that information that is produced by electronic health records for patient

consumption, such as health education materials, visit summaries, portals that allow patients internet access, all have to be made available in multiple languages and in a fourth grade literacy level.

We have to ensure that all rural areas and all public housing projects are wired, that all rural areas deploy broadband technology and that broadband access is provided in all newly funded public housing, and we need to set a date when all existing public housing needs to have broadband technology; otherwise we are not going to have access in those places.

Finally, we have to require input of communities of color in planning privacy and security requirements. Dr. Price mentioned this before, but privacy and security mean different things in communities of color than they mean for the rest of our society.

There have been enough examples of abuses that people do not trust when information is shared without adequate protections.

We have to provide resources for health information technology in places where the most vulnerable patients are served in prison, in our foster care agencies, in homeless health care sites, migrant health care providers. We have to create a national system for specifically monitoring the impact of health information technology, and I believe one of you asked, but every single grant program should be required to report on the impact of the dollars that are being spent on disparities in the communities that they serve.

I have provided the subcommittee a complete analysis of these issues as well as detailed examples of how our institute has achieved substantial success in some but not all of these areas. And I make myself available to you as you explore this issue further to work with the subcommittee or any Members of Congress who seek to further understand and address the important issues of health information technology in our most vulnerable communities.

Thank you.

[The prepared statement of Dr. Calman follows:]

Institute for Family Health
November 1, 2007

"Health Information Technology: Managing Federal Resources to Reduce Health Disparities"

Subcommittee on Government Management, Organization and Procurement

Testimony of

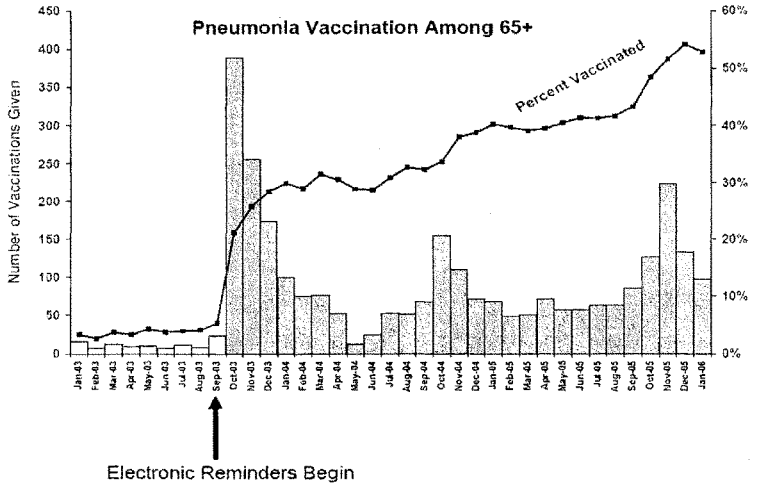
Neil S. Calman MD
President and CEO
The Institute for Family Health

The Institute for Family Health is a federally qualified health center (FQHC) network operating primary care practices in the Bronx, Manhattan and, recently in the Mid-Hudson Valley as well. Founded in 1983, the Institute is dedicated to developing innovative ways to provide primary health services to underserved populations based on the family practice model of care. The Institute operates 16 full-time practices, and eight part-time practices that provide care for the homeless. Several additional clinical programs serve special populations, such as five Ryan White HIV/AIDS programs and two free clinics that provide comprehensive primary care to the uninsured. Of the 75,000 patients served at the Institute's sites, 67% are Black or Hispanic; 12% are uninsured; 40% receive Medicaid; 65% are below 200% of the federal poverty level; and 18% are estimated to require services in a language other than English. In 2006, over 1,000 patients served were homeless and more than 600 had HIV/AIDS. **Patients served by the Institute's centers suffer disproportionately from an array of health problems prevalent in low income neighborhoods, including high rates of asthma, diabetes, hypertension, obesity, depression, mental illness, and substance abuse.**

In 2002, the Institute became one of the first community health center networks in the nation to implement a fully-integrated electronic medical record and practice management system throughout its network of ambulatory clinical sites. The Epic EHR (Epic Systems, Verona, Wisconsin) has allowed the Institute to enhance its services and significantly improve patient care through improved record-keeping, tracking systems, best practice alerts at the point of care, printable visit summaries given to patients at the end of each visit and a vast library of health education materials available to patients in multiple languages.

The motivation to develop this system was due, in part, to work developed by Bronx Health REACH, a CDC-funded project of which I am principal investigator. Bronx Health REACH involves more than 40 diverse organizations committed to eliminating racial disparities in diabetes and cardiovascular disease. Through its preliminary research and the implementation of a community action plan, the Coalition has identified and highlighted vulnerabilities to disparate care faced by people of color: the importance of consistent, preventive care; building trust in our services in the communities we serve; and managing the chronic diseases suffered by our patients through sophisticated technology. **The Institute's leadership recognized that, when placed in the service of underserved communities, EHRs offer tremendous potential to improve health outcomes and to aid in the reduction of racially and ethnically based disparities.**

The EHR system has enhanced the quality of patient care provided at the Institute's sites, demonstrably increasing compliance with preventive care guidelines. Much of this improvement is due to the implementation of clinical decision supports, also known as "best practice alerts" or BPAs, triggered by evidence-based practice guidelines such as annual pap smears, obtaining mammograms at the recommended intervals, flu vaccines, and blood sugar testing for diabetics. Several clear examples of performance improvements in the care of patients with chronic illnesses can be reported in the period following the implementation of BPAs. The implementation of a BPA alerting physicians that pneumoccocal vaccination is recommended for their patients resulted in an 18-fold increase in the rate of pneumococcal vaccines, as shown below. Similarly, a BPA for at-risk diabetic patients resulted in a 55% increase in the rates of referrals for ophthalmology (eye) appointments. The Institute's success in implementing clinical decision supports and using EHR data to improve quality has laid the groundwork for creating a premier laboratory for testing broader public health initiatives to improve community health through primary care interventions.



The Institute has devoted significant resources and time in workflow redesign to advance communitywide health improvements through its collaborative efforts with the New York City Department of Health and Mental Hygiene (NYC DOHMH), one of the world's largest public health agencies. With approximately 6,000 employees and an annual budget of more than $1.5 billion, the Department's programs encompass areas of disease control, environmental health, epidemiology, health care access and improvement, health promotion and disease prevention, and mental hygiene, serving the more than 8 million New York City residents as well as more than 3 million others who work or visit the City each day. The Institute's work in collaborating

with the NYC DOHMH has enabled us to make sure that our patients receive the most up-to-date information about diseases prevalent in the communities we serve as well and, at the same time, informing the health department of the illnesses we are seeing in those communities for their further investigation.

The Institute's goal in establishing an EHR system was not only to improve the quality of patient care at its own practices, but to improve the health of the communities it serves. Federally qualified health centers have an important role to play in, and an obligation to advance, the harnessing of information technology for coordinated, communitywide efforts to improve health.

The following examples illustrate the importance of having and EHR as one tool in addressing health disparities in communities of color in the United States.

Syndromic Surveillance System

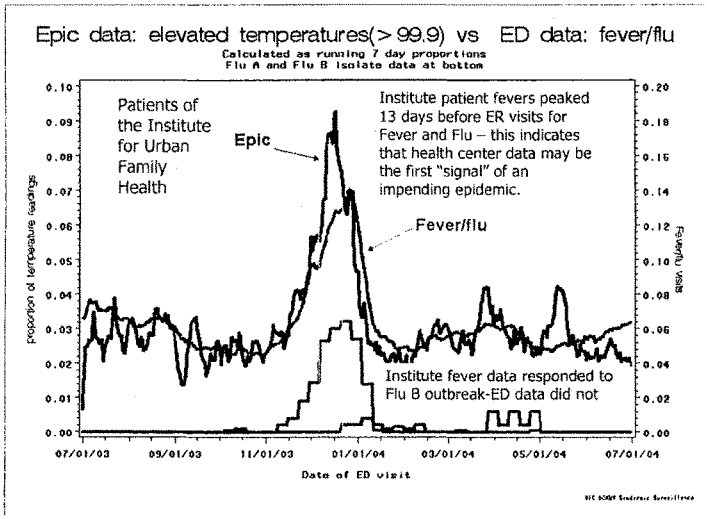
It is a well known but sad fact of public health that most disease outbreaks emerge from low income communities where health care is less available for a variety of reasons, including inadequate insurance coverage, lack of health education, and poor access to primary care. In addition, more people live in overcrowded or substandard housing, and many are homeless. Thus, linking patients in these communities to systems which are developed to monitor emerging disease epidemics is critical. These systems, commonly referred to as syndromic surveillance systems, obtain data from a variety of sources to identify disease outbreaks.

The Institute is the first community health center network in the United States to integrate clinical EHR data with a syndromic surveillance system. The NYC DOHMH system, established in 2002, monitors emergency department visits to detect disease outbreaks early. Chief complaint information is transmitted electronically to the health department daily, where it is analyzed for temporal and spatial aberrations. Respiratory illness, fever, diarrhea, and vomiting are the key syndromes analyzed. Statistically significant changes are investigated to determine their public health importance. Most bioterrorism agents and infectious disease epidemics of concern have a non-specific *prodrome* – a period when mild symptoms occur before the time when patients with more serious symptoms appear in ERs and hospitals. Detection of patients during this prodrome provides health departments with an early warning that may enable them to identify individuals who have been exposed and implement control measures to limit morbidity and mortality.

To enable this type of detection, the Institute has linked ambulatory EHR data from its practice sites to DOHMH's syndromic surveillance system. The Institute implemented the Public Health Information Networking Messaging System (PHIN-MS) – a secure encrypted data transfer mechanism by which daily data abstracts are transmitted to the health department. Every night, data on roughly 600 patient visits are downloaded to DOHMH. The data are compared to data from prior periods in previous years, and geospatially analyzed to detect any "outbreaks" of new symptoms or diseases. Early identification of illness in our practices can help the entire community.

While invisible to the clinical providers, the data integration allows for the identification of disease outbreaks, which are communicated to Institute clinical leadership by staff at DOHMH. Specific information is then communicated to providers through EHR alerts or other means, depending on the information to be conveyed. The Institute documents its response to the DOHMH notification, and provides this to the appropriate DOHMH staff.

The Syndromic Surveillance System integration provides the Institute and DOHMH with the ability to identify and act on new diseases and problems in our communities during a period when mild symptoms occur, prior to patients with more serious symptoms appearing in ERs and hospitals. Working with DOHMH, the Institute analyzed the EHR data to determine what clinical factors could predict both the rise and peak of a potential epidemic before it had surfaced in emergency room data. Ultimately, we determined that gauging measured temperature greater than 100° could enable us to predict the peak flu epidemic almost 10 days before the ER data, and days more before isolates were available to confirm the diagnosis. For example, during the period of March to May 2004, an outbreak of Flu B circulating in NYC was identified in the Institute's EHR temperature data days earlier than in the ER data. This demonstrates that community health centers are sentinels which, with the appropriate technology, can aid in detecting and reporting, and ultimately, preventing the spread of new diseases and problems in our communities.

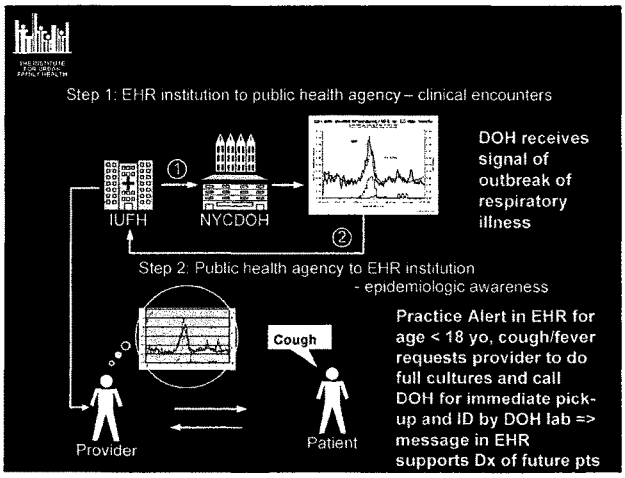


In the summer of 2007, there were two separate cases where epidemiologic alerts were transmitted from the health department, and the Institute immediately built decision supports in the EHR and linked them to documentation and order sets to enable providers to rapidly consider the new information provided by the department.

In the first case, a snack product called Veggie-Booty caused national concern when packages were found to be contaminated with Salmonella and a number of clinical cases were confirmed. As soon as this bulletin was received by the Institute, an alert was introduced into the system that was triggered by a chief complaint of diarrhea. This alert prompted the provider to ask about possible consumption of Veggie-Booty, and recommended appropriate diagnostic and therapeutic interventions if the history was confirmed.

A month or so later, there was an outbreak of Legionella pneumonia in the Parkchester area of the Bronx. An alert was introduced specifically for patients in our Parkchester center which prompted action by the provider in the event a patient in that area presented with respiratory symptoms. Thus the rapid integration of health department information into alerts at the point of care was accomplished successfully.

The bilateral communication with between our community health center network and the NYC DOHMH can be depicted in the diagram below.



Chronic Disease Management and Outcomes Reporting

Some of the greatest challenges facing public health and primary care providers today are the chronic disease "epidemics" such as diabetes, heart disease, and HIV. Computerized clinical decision supports within an EHR system can improve providers' adherence to practice guidelines to address these conditions. In collaboration with the NYC DOHMH, the Institute has developed and implemented a model clinical decision support system at its practice sites that is

organized around New York City's public health priorities outlined in the *Take Care New York (TCNY)* initiative.

Launched in March 2004, *TCNY* set an ambitious agenda to prioritize coordinated actions that can help New York City improve health in ten key areas, each of which causes significant illness and death but is amenable to intervention. NYC DOHMH has estimated the health care burden and amenability to intervention, and established population-level targets for each of these priority intervention areas. The ten *TCNY* goals for patients are:

1. Have a regular doctor or other health care provider.
2. Be tobacco-free.
3. Keep your heart healthy
4. Know your HIV status.
5. Get help for depression.
6. Live free of alcohol and drugs.
7. Get checked for cancer.
8. Get the immunizations that you need.
9. Make your home safe and healthy
10. Have a healthy baby.

The Institute developed a model EHR-based clinical decision support system, built around these public health priorities, that produces, transfers, and applies locally relevant knowledge, applicable to both the target population and the New York City community as a whole. Through the development of this model, the identification of functional requirements for such a system, and an evaluation of its effectiveness, both the personal health care and public health benefit of such a system is being established.

The Institute's EHR-based clinical decision support is a knowledge management system that assists clinicians in problem solving (e.g. diagnosis) and decision making (e.g. treatment planning) in health care settings. Through this initiative, clinical decision supports have been built around New York City's *Take Care New York* initiative to address ten specific health objectives. The Institute's efforts focus on preventive care decision supports which can be accessed and used at the point of care by a clinician interfacing with the EHR. These supports are largely in the form of automated clinical reminders or "best-practice alerts" (BPAs) which can provide patient-specific advice at the time of a patient encounter.

The EHR-based clinical decision support system is used by the Institute's clinical services staff, including all providers, nurses, residents and the quality improvement and practice management teams. There are several levels of utilization within each clinical department which are defined by the role of the staff member. Members of the practice management team have the greatest involvement in the development and implementation of the clinical decision support system. All other members are end users of the system and have an interactive relationship with the system. The Institute provides quarterly reports on the use of *TCNY*-related clinical decision supports to NYC DOHMH, which, in turn, provides feedback to the Institute.

The development of each clinical decision support required needs analysis and design, logic/tool building, validating, implementation, training, and go live production. In addition there are

several post-implementation activities that require on-going support and maintenance, including data analysis and functional evaluation. In order to remain current with all public health standards and policies, the Institute, with guidance and support from the DOHMH, reassessed all clinical decision supports and re-programmed necessary adjustments to the developed software lifecycle and performed many rounds of fine-tuning.

For example, to help patients who actively use tobacco or who may be at high risk for tobacco use, we prompt providers to take a complete tobacco use history and to update this history as appropriate. The system then completes a series of algorithms to determine whether or not to trigger an alert to the provider based on diagnoses, health maintenance topics, gender, or age. The alert received by the provider will prompt him/her to review medications, order procedures, and click a link to obtain current guidelines or other patient education material. In the tobacco use example, patients can be linked directly to a separate health initiative, the New York State Quitline, to obtain assistance and support to stop smoking,

The EHR-based clinical decision support system built around public health priorities has improved adherence to clinical guidelines among Institute providers, including depression and cancer screening. This effort has resulted in the development of a model decision support system, which includes over 40 expert-reviewed clinical measures and provides a foundation for implementing EHR-based, public health-oriented, quality improvement tools throughout New York City. Having recently acquired its own EHR licenses, the NYC DOHMH plans to roll out the model decision support system developed with the Institute at public health clinics and other ambulatory settings across the City. This expansion will enable NYC DOHMH to enhance its ability to measure progress on its *TCNY* objectives, and, with the introduction of related clinical decision supports, to enhance its progress towards improved chronic disease management.

Racial and Ethnic Disparities in Health

While quality improvement efforts in health care have led to substantial improvement in health across racial and ethnic groups, these improvements have not succeeded in closing the gap in health outcomes between certain minority populations and those of white America. Racial and ethnic disparities in health have been widely documented in our community and across the country. Over 80% of the hundreds of studies looking at race and health outcomes confirm that people of color get inferior care and have poorer health status. While minority communities have typically been the last to benefit from advances in medical technology, EHRs hold much potential for improving health care in these communities.

The Institute has launched a critical initiative, based on its organizational experience and interest in eliminating racial and ethnic disparities in health outcomes. The goal of this initiative is to demonstrate the use of an EHR system to identify disparities in health processes and outcomes among its own patients, to explore the root of these disparities, and to implement interventions to address them. This initiative grew out of earlier work to identify the community's perspective on health disparities, and findings that included widespread distrust and fear of the health care system, feeling undervalued and disrespected, difficulty communicating with doctors, concerns about the competency of

community doctors, and the importance of self-advocacy.[1] The Institute's EHR implementation and workflow redesign was conducted with these findings in mind, resulting in features such as flat panel monitors that enable patients to view the EHR screen, and printed visit summaries that highlight key information for patients.[2]

The Institute is furthering this agenda by exploring specific care processes that may contribute to health disparities. We will identify the specific elements in care among practice sites and practitioners that contribute to the highest quality of care and optimal health outcomes for patients at the Institute's health centers, and to determine whether these elements can be replicated at additional practice sites to improve patient outcomes. The Institute's initial efforts in this area focus on disparities among patients with diabetes, one of the most prevalent conditions affecting our patients and the communities we serve. This effort is managed by the Institute's Continuous Quality Improvement (CQI) staff, which reviews data system-wide to identify health disparities and best practices, and communicates them to Institute providers. As best practices for reducing racial and ethnic health disparities are identified, they will be integrated into the EHR's clinical decision support system. End users of the system will be prompted to follow the recommended guidelines. The impact of alerts and other practices resulting from this effort are monitored by the CQI staff.

Together with a project advisory committee, the Institute is establishing measures of optimal health outcomes for diabetic patients and identifying areas of potential intervention that are likely to be sources of variation in diabetes outcomes, and that are actionable in the context of our healthcare system. We are conducting case-control analyses of our data in order to identify areas in which well-controlled and poorly-controlled diabetes patients differ in their interactions with our healthcare system, and analyzing the extent to which these differences correlate with race.

Upon identification of differences in clinical practices, as well as differences in provider or patient behaviors that mediate the relationship between race and diabetes outcomes, the Institute and advisory board selected best practices to be replicated. The two practices which appear to have great promise for improved diabetic control are increasing the frequency of visits early in the treatment of the disease, and increasing the use of nutritionists and health educators to help patient develop a deeper understanding of diabetes and its treatment. Implementation of the best practices involves EHR programming, staff training, and data monitoring and analyses to ensure appropriate application of these interventions and to measure their impact.

By building best practices for addressing racial and ethnic health disparities into its EHR, the Institute is able to implement quality improvement efforts that have an impact not just on overall health care quality, but have the potential to break through "parallel improvements" to truly reduce gaps in disparate health outcomes. This model can be

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[1] Kaplan SA, Calman NS, Golub M, Davis JH, Ruddock C, Billings J. Racial and ethnic disparities in health: a view from the South Bronx. *Journal of Health Care for the Poor and Underserved.* 2006 Feb;17(1):116-27.
[2] Calman, NS, Golub M, Kitson K, Ruddock C. Electronic Health Records: The Use of Technology to Eliminate Racial Disparities in Health Outcomes. In: *Medical Informatics: An Executive Primer.* Health Information and Management Systems Society, Chicago, IL. Kenneth Ong, MD, Editor. January 2007.

replicated by other health care providers to help them address health disparities in their communities.

Public Health Registries

Low income communities in New York City, which are also largely communities of color, often lack a primary care home and receive sporadic care. In order to insure that children are properly immunized and tested for lead poisoning, the Institute has worked with the NYC DOHMH to create the real-time exchange of public health data. Our joint development started with the Citywide Immunization Registry. The Institute purchased and programmed an immunization interface license with Epic in HL7 format allowing the exchange of outgoing immunization information to be received by the registry. This initiative is currently being implemented and is in the technical testing stage.

The Institute is the beta testing site for the initiative to link clinical EHR data with NYC DOHMH's citywide immunization and lead registries, having provided historical batch data for this purpose. The linkage between the two organizations allows for continuous updates to the City's registries, enabling NYC DOHMH to maintain current data in the registry. It also allows the Institute's providers to make online submissions to the registries directly from the patient's EHR, eliminating the need for separate documentation and submission of required registry data.

The creation of linkages between ambulatory care providers and public health registries creates value in several ways. Health care providers experience greater efficiencies in documenting and submitting reportable data, leading to improved reporting and more complete public health data. Two-way integration with EHRs, once fully operational, will enable authorized providers to access immunization and lead test histories from the registry, and can be linked to clinical decision supports. The outcome of this endeavor will allow the Institute and the DOHMH to generate registry information updates and evaluation regularly and with limited errors.

Some General Considerations

Costs and Benefits

The Institute's work on the initiatives implemented in collaboration with DOHMH has been supported with grant funds provided through DOHMH's Primary Care Information Project. The racial and ethnic health disparities initiative is supported by the Commonwealth Fund, building on years of support by the Centers for Disease Control REACH Initiative. Additional staff costs have been covered by the Institute, as addressing community needs is an integral part of its mission.

The value of an EHR system is driven by its functionality. Thus, these initiatives increase the value of our system by enhancing its ability to serve as a tool for improving the health care we deliver to the community, particularly with regard to chronic care, preventive care, and the elimination of health disparities. Once the models have been developed and implemented to incorporate public health data and health priorities, and to address health disparities, they can be modified to address changing needs. These models are replicable applications that can be

translated across EHR products and across communities. Is there a return on our investment in the EPIC EHR and the public health functionality we have built into it?

Improved Provider Productivity?	*Probably* – depending on decision supports keeps providers from reviewing flow charts for all chronic diseases. If no alerts appear, all required health maintenance and secondary preventive procedures are done and up to date.
Improved Efficiency of Support Staff ?	*Yes* - improved messaging, faster communication
Reduction in Support Staff ?	*No* – More outreach staff needed to follow-up on new information on patients not previously available. EHR reports highlight areas of performance weakness in the delivery system that often require new resources to fix.
Improved Outcomes for Patients in Pay-for-performance Plans ?	*Yes* – proven interventions work to improve compliance with some preventive measures– however this has not been a universal experience with all decision supports in all chronic disease areas.
Improved staff retention?	*Unknown* at present – needs to be studied
Improved patient satisfaction?	*Definitely.* Patients note increased involvement in their care, improved access to health information, and increased confidence in their providers.
Increased physician work in patient follow-up and outreach?	*Definitely*– more information means more follow-up is needed. It takes more time and resources to deliver the improved care that EHRs allow us to provide.
Need for new staff for software, hardware, network support?	*Yes*
Need to develop outreach staff for report follow-up?	*Yes* – and staff needs to be bilingual in our population. These are new job functions.
Decrease in health disparities?	*The promise is there.* The proof is not yet in whether we can decrease disparities in outcomes within a center or network, since people of color come in with poorer historical care and at worse levels of disease. EHRs enable us to study this and increase interventions for those at higher risk – which holds great promise for decreasing disparities in care.

System Cost

In an implementation like this, it is almost impossible to identify the costs in a way that would be meaningful for those who would want to engage in such an effort. The actual costs of purchasing the software from Epic, configuring it and developing its functionality in our health center network is approximately $50,000 per provider. The ongoing costs run approximately $9 per patient visit, but about half of that amount is development work that is supported by research and HIT implementation funding in our system.

Beyond the finance however, lies the most important aspect of these projects. They demonstrate the important role that community health care providers can play, both as leaders and participants, in health information technology projects aimed at improving community health and decreasing disparities.

Due to the important roles that patients play on both the Institute's Board of Directors and Project Advisory Committees, the Institute ensures that its patients are represented in the development and assessment of HIT systems and standards. We believe that participation by those at all levels of the health care system is required for an optimal, truly integrated health information system to become a reality.

Privacy Protection

The Institute maintains the privacy and security of data entered into the Epic system through a series of system features, such as password protection, strict control of access to system modules based on users' assigned roles, further restrictions for records containing sensitive information, such as employees who are patients, "break the glass" features requiring justification for record access, and an audit trail tracking user access to records. System access from remote locations is secured through a private frame relay network. There is an industry standard (Watchguard) firewall in place to prevent access to the Institute's network from external sources. Access from external locations, such as providers accessing the system from home, is done via encrypted Virtual Private Network connections.

All data provided for the syndromic surveillance system, EHR-based clinical decision support system, and the city-wide immunization registry is de-identified. The de-identification process includes stripping all identifying information from the feed. An automatically generated internal database identifier is used to link all necessary health information, which is passed through a secure encrypted data transfer mechanism to the DOHMH.

Dissemination of Knowledge

Institute leaders participate actively in local, state, and national forums on the adoption and assessment of electronic health records. I serve on the Executive Committee of New York City's Primary Care Health Information Consortium, a group formed by the NYC DOHMH, the Primary Care Development Corporation, the Community Health Care Association of New York State, and more than 30 community health centers. I also serve on the New York State e-Health Consortium, a statewide group that examines policy regarding the use of HIT and coordinates the

work of over 25 Regional Health Information Organizations (RHIOs), and on the National Quality Forum Ambulatory Care Measures Disparities Subcommittee.

I have presented the Institute's work on using electronic health records to improve public health and reduce health disparities to the National Association of Community Health Centers, the Agency for Healthcare Research and Quality, and the Health Resources and Services Administration.

Finally, the New York City Department of Health and Mental Hygiene, in partnership with the Institute for Family Health and Columbia University's Department of Biomedical Informatics, has received designation as a National Center of Excellence in Public Health Informatics, and I serve as the principal investigator of one of the Center's two major initiatives.

The Institute is committed to the use of health information technology to improve the health of our patients, the communities we serve, and the public, and to insuring that the advances in health care made possible by HIT benefit all members of the community – especially those living in low income, minority, and underserved communities. We are further committed to making the lessons we learn widely available through presentations and publications and ongoing involvement of the community in our future HIT endeavors.

Could Implementing Health Information Technology and Health Information Exchange Worsen Racial, Ethnic, Language and Economic Disparities in Health Care and Health Care Outcomes?

Disparities could worsen if:

- The computer literacy gap gets added to the health literacy gap as an obstacle that people have to overcome;
- Only providers who treat wealthy patients have access to funding to pay for technology implementation and for participation in health information exchanges;
- Safety net providers use resources currently needed for other critical issues to pay for their technology, and therefore have to reduce other needed services;
- Patient portals and email correspondence are used more and more, and this leaves lots of patients out of the system;
- Fear of government access of health records acts as a disincentive for patients who are undocumented to use health services;
- Groups of patients, especially underrepresented minorities who are discriminated against now in the health care system, have real fears about misuse of their health care information;
- Uninsured patients may not have a medical home – so they may not have the same access to someone who can explain why they should participate in the NHIN, may not have a consolidated primary care record, may go to providers who don't have EHRs;

Institute for Family Health
November 1, 2007

Recommendations for Implementing Health Information Technology and Health Information Exchange to Maximize the Potential Benefits in Reducing Racial, Ethnic, Language and Economic Disparities in Health Care and Health Outcomes

The following recommendations are made to assist the legislature in maximizing the opportunities that health information technology provides in helping to reduce disparities in health care practices and health outcomes for people of color.

1. Insure that all legislation that supports the implementation of electronic health records targets those patients at highest risk on our society. This requires that
   a. all developments have organized ways for community participation in their planning and execution; and,
   b. providers in the health care safety net – community health centers and public hospitals – are included as primary targets for finding implementation of health information technology.

2. Insure that all legislation that supports health information exchange (HIE) includes provisions that safety-net providers – specifically community health centers and public hospitals – must be included in HIE networks.
   a. This requires that they first be given the resources to implement electronic health records; and
   b. Specific funding for implementation and maintenance of connectivity to HIE networks for safety net providers who may otherwise be unable to pay for the needed interfaces of their systems with these networks.

3. Fund the integration of all EHRs, especially those in safety net facilities, into local, regional and state health department systems that monitor the disease burden in the community, and help people optimize their preventive health care measures.

4. Mandate that all EHR systems capture data on race, ethnicity, gender and primary language so that providers can examine disparities that exist in treatment within their systems and address them through targeted efforts aimed at high risk populations.

5. Encourage EHR vendors to provide a mechanism for alerting providers to clinical trials which may be relevant to their patients. People of color are underrepresented in many clinical trials in this country and EHRs provide an easy way to identify patients who meet clinical trial criteria so that they may be offered the opportunity to participate. This improves the relevance of clinical findings of these studies to ethnically diverse populations.

6. Create criteria for EHR certification that require that information produced for patient consumption, such as health education materials, visit summaries, and portals that allow patients internet access to their own health information, be made available in multiple languages and at a 4th grade literacy level when needed.

7. Insure that rural areas are funded to deploy broadband technology, and that broadband access is provided in all public housing being built. A timetable should be set to retrofit all existing public housing facilities with broadband capability.

8. Require the input of communities of color in planning privacy and security requirements for health information exchange, and in developing consent procedures for participation in health information exchange. There are well documented, legitimate reasons that issues of privacy, security and consent procedures will play out differently in communities of color. It must be re-established that information provided by patients and entered in their electronic health records, as well as information shared in health information exchange networks, is not subject to government use for purposes of identifying undocumented immigrants.

9. Provide resources for health information technology adoption in prisons, in the foster care system, for homeless health care providers, for migrant health care providers, and for other providers serving vulnerable populations so that these mobile and transient patients can have records that are available wherever they may go.

10. Create a national system for specifically monitoring the impact of health information technology and health information exchange efforts on vulnerable populations, and tie future funding to successes in eliminating disparities in participation in these efforts and ultimately in the care improvements which result.

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Mr. TOWNS. Let me thank all five of you for your statements. I really, really feel you were very helpful in terms of sharing.

Let me just move to you, Dr. Price.

Are there any issues that African American doctors may have adopting this technology, and what can we do to facilitate them if there are able to be helped? What can we do?

Dr. PRICE. Well, I think some of those points were raised by a number of the speakers. Cost is the No. 1 issue in terms of implementation. I think that many of the programs that you heard about from the Federal agencies have all of the right rhetoric and nice touchy-feely sounds about getting into communities, but physicians are facing decreasing reimbursement, increasing liability costs, and the expense of health information technology is just not a priority right now, even though they recognize the benefits, such as Doctor Calman explained.

So I think the best things that can be done are similar to what CMS just announced, getting the systems in as a basic course of business for doing good medical care and in the territories as well to make sure the Virgin Islands and Puerto Rico and Guam are also covered.

Mr. TOWNS. Let me ask this question. I really should have dealt with the Federal agencies on this.

This is an area that I am really concerned about.

You know, now we have physicians that are in private practice and, of course, still single practice and you know, when they expire, nobody comes into that practice. That is a thing of the past.

What happens with those records of those doctors that have been practicing for 40, 45 years, have a room full of records that are now there? What happens? Because in many instances, these are people that have had, you know, serious kinds of operations and all kinds of things, these records are going to be there and nobody wants to be responsible, you know, for them in bringing them. So what do we do with a case like that?

Dr. PRICE. There are technologically possible ways to integrate that by scanning and digital archiving those records, but for the most part, those records sit dormant in damp basements unbeknownst to anyone.

I think as we move forward—I think one of the key issues is that the health care of the future is going to be improved as we get more people to enter their data into electronic health records and also as we improve the issue of personalized health records so individuals can carry their information with them.

Mr. TOWNS. Because in the old days, somebody would come buy the practice.

Dr. PRICE. Someone would buy the practice but wouldn't want to decipher the scribbly notes that are on 3-by–5 index cards.

Mr. TOWNS. I yield to my colleague.

Ms. CHRISTENSEN. Thank you, Mr. Towns.

Thank you all for being here.

Dr. Calman, and maybe you said it in your testimony, if you did, I missed it. Did you have problems getting your patients in the health center and the community that you are serving to accept the electronic medical records?

Dr. CALMAN. Actually, they love it. What we did when we set it up, we based it on the focus groups that we had done with our REACH colleagues, and what we found out was that trust was one of the biggest issues that our community faced. So when we set it up, we used that as sort of a framework for everything from how we designed the exam rooms to how we designed the electronic health records. I'll give you two examples.

We put flat panel monitors in the exam room so the patients can watch when the doctors are recording the visit on the screen. They can also look at their health education materials, diagrams of different health education, things that the doctors can bring up when they are seeing the patient.

We also created what is called an after-visit summary. So far only available in English, but we are now working on ways to see if we can translate it into other languages so that literally at the end of a visit in our center, we hand a patient a copy of everything that was written about them that day, including new lab reports, new X-ray reports and even though people can't necessarily read this, there is something incredibly symbolic when you say to the patient, there is nothing that I have about you, there is nothing that I know about you that I don't feel comfortable sharing with you.

This was more of a transformation for our providers than it was for the patients. The patients were anxious to get their information. The providers were initially reluctant to give it to them. But now have basically complied.

Ms. CHRISTENSEN. Thank you. So the concerns we have that people are going to be afraid for their privacy and everybody knowing their medical history, you were able to overcome this?

Dr. CALMAN. We have taken a slightly different approach in that we believe that before we can share information about patients in a network, whether it is a national network or a State-wide network, patients have to have access to that information themselves. They need to know what is in their record before we go putting it out on the airwaves, and I think that is critically important. So that it will be years before we are all connected, but we have already, for the last 5 years, started to transform that process. And hopefully by this fall—one of the grants we got from HRSA was a grant to implement a patient portal into our electronic health records.

So patients will be able to, either through the Internet or through kiosks in our waiting room, look at their own records with the help of an assistant who will teach them about that, and we are looking at that as a way of both bridging their health literacy issues but also their technology literacy issues as kind of a double win.

Dr. PRICE. I know you are familiar with the discrimination that disproportionately affected African American and Latinos when health information was inadvertently shared, particularly in the light of sickle cell disease and early on in the game with HIV.

I think we are going to need in the medical community to turn back to the legislature to put some real teeth behind the inappropriate gathering of health information by hacking into health systems and sharing or using that information to discriminate. We

don't need that kind of a negative throwback on some of the innovative projects that are going on, like Dr. Calman described, but without those teeth, those things will happen. And they must be dealt with appropriately for our community to have real trust and not be concerned about Tuskegee coming back again.

Ms. CHRISTENSEN. While you're at your mic, Dr. Price, do you have any ideas, just in MNA membership, how many MNA physicians are using electronic medical records now?

The USA Today says under 35, 44 percent; 65 and older, 18; 55–64, 18 and the rest somewhere in between that. Do you know—do we have any idea?

Dr. PRICE. It is 35 percent of those who are in hospital based systems. It is probably closer to 10 percent for individual practitioners and the ones that are using practices.

We are in the process of finalizing a survey that we are going to do electronically and by fax of our entire membership to be able to give you those numbers, so hopefully within the next couple of months.

Ms. CHRISTENSEN. Do you think that it is possible to do pay-for-performance across the board without having electronic, you know, electronic medical records in a fully network system?

Dr. PRICE. Absolutely not. Not effectively, and it is pay-for-performing for many of our physicians. We are concerned about the methodology that is used. As many of you are well aware, if the right data is not being used to set up the metrics for pay-for-performance, with a sicker population we suffer in any of those schemas, in particularly if they use as a method of reimbursement.

Ms. CHRISTENSEN. Ms. Evans and Dr. Mostashari, I am sorry that I had to step out and take a call during part of each of your testimony. You may have talked about this before. But what specific outreach was made to ensure that providers in poor—your poor communities in New York City were able to participate?

Dr. MOSTASHARI. I am very happy to answer that.

Our target population are Medicaid providers in New York City. We also—so our first group of outreach was community health centers, and that was a group of community health centers, a consortium that we brought together of every single community health center network in New York City. So that was the first kind of the backbone of our safety net system that we worked with.

Then we started looking at the small providers, and we actually have a program in Harlem, South Bronx and Central Brooklyn, and we went to every single practice in Harlem, South Bronx and central Brooklyn, every single one. We visited them, we talked to them, we developed this brochure that talks about readiness for adopting electronic health record system, protecting patient data, the small practice economics, health information exchange; what does it mean to the practice?

So we actually get more time with the providers than the pharmaceutical companies do.

And we are also, you know, continuing to put the word out there to hospital affiliated providers, to the ethnic IPAs and others to say this is exactly the—if you care for medically underserved populations, we want to sponsor you to get in the electronic health record.

And I think an important point I want to add here, I am not sure if I made that point clearly in my testimony was, you can't support people getting electronic health records by just giving them cash. To effectively create a cocoon of services around EHR adoption and quality improvement, we need boots on the ground. Mailing a check from Washington isn't going to do it, and that is what we have built. That is what we found; we need to have in our community and every community that the Federal Government wants to see the entire EHR adoption really happen and really have gains for prevention and gains for population health, we need that local presence, that community network.

Ms. CHRISTENSEN. Thank you.

Mr. TOWNS. Let me ask you, one question to you, Ms. Marchibroda.

I'm sure you know that people of color can be less trustful of the Federal Government and of the Federal agencies and, of course, technology, too. Since you are one of the primary health IT collaborators, how do you intend to address these concerns?

Ms. MARCHIBRODA. Chairman, getting to agreement on policies for information-sharing is probably one of the most important things that folks at the State and local levels engage in. What we tell them and what they're doing—and those who are successful are having those hard conversations about building trust and what policies will work for us, whether we're in New Hampshire or in Oklahoma City or in Los Angeles, around what rules or policies will we put in place to protect privacy and confidentiality. What are we comfortable with among us? How do patients and consumers feel about this?

There are a number of tools out there that are actually helping State and regional leaders, including one delivered by Connecting for Health with the Markle Foundation and with support by the Robert Wood Johnson Foundation that is providing a toolkit, if you will, for having those tough conversations.

But you can't shortcut it. You can't get to the technical aspects of this, until you begin to have those tough conversations about what policies will be put in place to build trust.

Mr. TOWNS. Let me thank all of you for your testimony, and, of course, we really appreciate your sharing with us. And we are convinced we have a long way to go, no ifs, ands or buts about it.

Dr. Calman, I am really impressed with what you're doing, and I know it has not been easy because of the fact that, at times, the support system has not really been in place or has been cooperative. But we really realize, in order to really deal with the health care disparities that this is one thing that we need to try and fix and try and fix it as soon as possible.

So you can be assured that we will be working on this side to try and get the resources out and to try and highlight how important it is to move forward in this direction. And we'll be recognizing that there will be problems as we move forward, but in working together, I am sure we'll be able to solve them.

Thank you again for your testimony.

The subcommittee stands adjourned.

[Whereupon, at 5:15 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]



Overview

President George W. Bush launched an initiative in 2004 to reform health care through the improved adoption of health information technology and empowerment of consumers through information. In support of President Bush's initiative, Governor Sonny Perdue issued two Executive Orders relating to Health Information Technology and Transparency (HITT):

1. Signed in October 2006, the first created the HITT Advisory Board to facilitate and encourage the use of electronic health records, establish a statewide health information exchange strategy and promote marketplace transparency
2. The second, signed in February 2007, encouraged marketplace transparency by providing cost and quality data to consumers, and application of industry best practices that facilitate the use of electronic health records

The Board members, which are representative of various health care providers and businesses, will advise the Georgia Department of Community Health (DCH) in applying industry best practices for facilitating and encouraging the use of electronic health records and establishing a statewide strategy that will enable health information to be available across the full continuum of care.

The Information

The Web site will feature service, cost, quality and educational information regarding pharmacies, nursing homes, personal care homes, home health and other long term care services, health insurers, hospitals and ambulatory surgery centers.

The Comparison

Through the Transparency Web site, health care consumers will have the opportunity to identify providers, services, average charges, quality, length of stay and other factors with regard to certain health care services.

Because no two patients are alike, and neither is the patient base which facilities serve, the site will help consumers understand how to compare options and the data will be risk adjusted to standardize comparative data.

The Experience

Empowering Georgians with an easy-to-use Web site featuring health care services, cost, quality and educational information will lead to healthier outcomes, result in engaged, savvy consumers that are in control of their own health, and address the growing cost of health care.

On the Transparency Web site consumers will find information such as, the location of over 10,000 health care facilities and providers throughout the state, medication pricing, long term care planning information, Medicare and Medicaid rules for coverage, quality of care information for nursing homes, personal care homes, hospitals, health plans and other settings, tips for choosing a nursing home or making alternative care arrangements, and preventive care and disease management educational information.

NMA RECOMMENDATIONS

The NMA would urge the U.S. Congress to take the following concrete steps:

- **Bridge the Digital Divide** – there are many vulnerable communities in America where information technology is still not commonplace. In others, broadband access is in the hands of all too few. This must change, and comprehensive legislation at the Federal level is fundamental to making this dream a reality;
- **Amend the charter of the American Health Information Community** - to require increased participation of minority and medically underserved communities;
- **Create HIT Empowerment Zones** - specifically, companies could be encouraged to build HIT 'Incubators', akin to Biotech or IT Incubators run by some universities across the nation. The idea would be to get the companies, universities, and "community partnerships" in each Empowerment Zone engaged in a long-term process that feeds on itself, in which the process would eventually create the 'Silicon Valleys' of HIT. Empowerment Zones and would represent the ultimate realization of effective '*public-private partnerships*';
- **Implement Medicare/Medicaid Demonstration Projects** – to identify payment methodologies that encourage the participation of small group and solo practitioners, especially those that serve medically underserved communities. These demos should integrate the two entities described above.
- **Coordinate the Federal Data Collection Process** –HIT's main role is to streamline and organize the collection, transfer, and integration of health information, which necessitates a well-thought out process, from the very outset. It is through this coordinated harmonization of secure, inter-operable, real-time, exchange of health data for all populations that the full realization and benefit of this Nation's HIT program will be realized. It is especially critical at the federal level, for the Office of the National Coordinator for Health Information Technology (ONCHIT) to take the lead as key regulator and referee in assuring that this goal is fulfilled.

CONCLUSION

The Health Information Technology evolution in America represents a sharp, fine turned instrument in the country's quest to improve our healthcare industry. However, often times the tool currently is being wielded aimlessly by some well-intended individuals, occasionally recklessly by some unskilled, uninformed or unconcerned entities regarding its potential to cause collateral damage, and often times the tool sits well out of the reach of those who have the skill and/or potential to best utilize its keen cutting edge. Mr. Chair, your Committee has exhibited remarkable wisdom in the past on many critical issues facing our Nation and the people of this great Nation again look to you to provide the strategic oversight on HIT to assure that the most vulnerable professional caretakers and the most vulnerable citizens are not left behind, forgotten & wounded as this most critical incision is made into the very core our health care empire. Yes, HIT holds the promise toward maximizing efficiency, reducing medical errors, facilitating consumer involvement in healthcare decisions while at the same time assuring adequate disaster readiness for all Americans. But we must keep the chiasm from widening any further for too many have already fallen through the cracks and the price for America to not get this right early is too dear.

I want to once again thank the most honorable chair and the other esteemed members of the sub-committee.

Demographic Profile
Total Residents, Income, Age, Race/Ethnicity, Citizenship, Population Living in Non-Metropolitan Areas
Notes: *Source:* KCMU and Urban Institute analysis of the Current Population Surveys, March 2006 and 2007.
Notes: These demographic data may differ from Census Bureau figures due to grouping by health insurance unit (HIU) rather than household.

A Metropolitan Statistical area must have at least one urban cluster of at least 10,000 but less than 50,000 population. A Non-Metropolitan Statistical Area lacks at least one urbanized area of 50,000 or more inhabitants

Total Medicaid Spending in Millions
Source: Urban Institute estimates for KCMU based on CMS Form 64 for FY2006.
Notes: All spending includes state and federal expenditures. Expenditures include benefit payments and disproportionate share hospital payments; do not include administrative costs, accounting adjustments, or the U.S. Territories. Total spending including these additional items was about $315.3 billion in FY2006.

"Health Information Technology: Managing Federal Resources to Reduce Health Disparities"

Subcommittee on Government Management, Organization and Procurement



Testimony of

Neil S. Calman MD
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November 1, 2007

Institute for Family Health
November 1, 2007

"Health Information Technology: Managing Federal Resources to Reduce Health Disparities"

Subcommittee on Government Management, Organization and Procurement

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President and CEO
The Institute for Family Health

EXECUTIVE SUMMARY

The Institute for Family Health is a federally qualified health center (FQHC) network operating primary care practices in the Bronx, Manhattan and, recently in the Mid-Hudson Valley as well. Founded in 1983, the Institute is dedicated to developing innovative ways to provide primary health services to underserved populations based on the family practice model of care. The Institute operates 16 full-time practices, and eight part-time practices that provide care for the homeless. Several additional clinical programs serve special populations, such as five Ryan White HIV/AIDS programs, and two free clinics that provide comprehensive primary care to the uninsured. Of the 75,000 patients served at the Institute's sites, 67% are Black or Hispanic; 12% are uninsured; 40% receive Medicaid; 65% are below 200% of the federal poverty level; and 18% are estimated to require services in a language other than English. In 2006, over 1,000 patients served were homeless and more than 600 had HIV/AIDS. **Patients served by the Institute's centers suffer disproportionately from an array of health problems prevalent in low income neighborhoods, including high rates of asthma, diabetes, hypertension, obesity, depression, mental illness, and substance abuse.**

In 2002, the Institute became one of the first community health center networks in the nation to implement a fully-integrated electronic medical record and practice management system throughout its network of ambulatory clinical sites. The Epic EHR (Epic Systems, Verona, Wisconsin) has allowed the Institute to enhance its services and significantly improve patient care through improved record-keeping, tracking systems, best practice alerts at the point of care, printable visit summaries given to patients at the end of each visit and a vast library of health education materials available to patients in multiple languages.

The motivation to develop this system was due, in part, to work developed by Bronx Health REACH, a CDC-funded project of which I am principal investigator. Bronx Health REACH involves more than 40 diverse organizations committed to eliminating racial disparities in diabetes and cardiovascular disease. Through its preliminary research and the implementation of a community action plan, the Coalition identified and highlighted vulnerabilities to disparate care faced by people of color: the importance of consistent, preventive care; building trust in our services in the communities we serve; and managing the chronic diseases suffered by our patients through sophisticated technology. **The Institute's leadership recognized that, when placed in the service of underserved communities, EHRs offer tremendous potential to improve health outcomes and to aid in the reduction of racially and ethnically based**

disparities. However, this is not a guaranteed outcome of their implementation. Similarly, though health information exchange can improve care, it runs the risk of increasing disparities in care unless certain very specific criteria are developed. What follows below are specific recommendations for insuring that we get the maximum benefit for vulnerable populations out of the funding that we are about to spend on implementation health information technology nationally and implementing the national health information network.

Recommendations for Implementing Health Information Technology and Health Information Exchange to Maximize the Potential Benefits in Reducing Racial, Ethnic, Language and Economic Disparities in Health Care and Health Outcomes

The following recommendations are made to assist the legislature in maximizing the opportunities that health information technology provides in helping to reduce disparities in health care practices and health outcomes for people of color.

1. Insure that all legislation that supports the implementation of electronic health records targets those patients at highest risk on our society. This requires that
   a. all developments have organized ways to ensure community participation in their planning and execution; and
   b. providers in the health care safety net – community health centers and public hospitals – are included as primary targets for funding implementation of health information technology.

2. Insure that all legislation that supports health information exchange (HIE) includes provisions that safety-net providers – specifically community health centers and public hospitals – must be included in HIE networks.
   a. This requires that they first be given the resources to implement electronic health records; and,
   b. Specific funding for implementation and maintenance of connectivity to HIE networks for safety net providers who may otherwise be unable to pay for the needed interfaces of their systems with these networks.

3. Fund the integration of all EHRs, especially those in safety net facilities, into local, regional and state health department systems that monitor the disease burden in the community and help people optimize their preventive health care measures.

4. Mandate that all EHR systems capture data on race, ethnicity, gender and primary language so that providers can examine disparities that exist in treatment within their systems and address them through targeted efforts aimed at high risk populations.

5. Encourage EHR vendors to provide a mechanism for alerting providers to clinical trials which may be relevant to their patients. People of color are underrepresented in many clinical trials in this country and EHRs provide an easy way to identify patients who meet clinical trial criteria so that they may be offered the opportunity to participate. This improves the relevance of clinical findings of these studies to ethnically diverse populations.

6. Create criteria for EHR certification that require that information produced for patient consumption, such as health education materials, visit summaries, portals that allow patients internet access to their own health information – all be made available in multiple languages and at a 4th grade literacy level when needed.

7. Insure that rural areas are funded to deploy broadband technology and that broadband access is provided in all public housing being built. A timetable should be set to retrofit all existing public housing facilities with broadband capability.

8. Require the input of communities of color in planning privacy and security requirements for health information exchange, and in developing consent procedures for participation in health information exchange. There are well documented, legitimate reasons that issues of privacy, security and consent procedures will play out differently in communities of color. It must be re-established that information provided by patients and entered in their electronic health records, as well as information shared in health information exchange networks, is not subject to government use for purposes of identifying undocumented immigrants.

9. Provide resources for health information technology adoption in prisons, in the foster care system, for homeless health care providers, for migrant health care providers and for other providers serving vulnerable populations, so that these mobile and transient patients can have records that are available wherever they go for care.

10. Create a national system for specifically monitoring the impact of health information technology and health information exchange efforts on vulnerable populations, and tie future funding to successes in eliminating disparities in participation in these efforts and ultimately in the care improvements which result.

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American Academy of Family Physicians
Statement for the Record
Subcommittee on Government Management, Organization and Procurement "Too Many Cooks? Coordinating Federal and State Health IT"
November 1, 2007



On behalf of the 93,800 members of the American Academy of Family Physicians, we are pleased to submit this statement for the record for the November 1, 2007 hearing entitled "Too Many Cooks? Coordinating Federal and State Health IT." We support your desire to target federal resources to reduce health disparities using health information technology (HIT).

The American Academy of Family Physicians was one of the first medical societies to realize the importance of HIT in the American health care system and is extremely proud of our activities in this area. The AAFP established CHIT was established in 2003 because we realized family physicians' adoption of HIT was essential to improving the quality, safety and efficiency of medical practice. This mission extends to people in rural and urban underserved communities where many of our physicians practice. In addition to educating our members and the larger health community about HIT, we work aggressively with vendors to offer favorable terms to physicians to allow them to purchase these systems through our Partners for Patients Program. Right now, 50 percent of our members in active medical practice are either in the process of implementing an electronic health record (EHR) or have a fully implemented system. Our future goals include a focus on continuing to increase the percentage of members adopting EHRs and to assist physicians that have adopted them to optimize their use of the technology.

The AAFP has reviewed your draft outline of a bill to use HIT to improve health outcomes and reduce health disparities in underserved communities. From this draft, our impression is that the legislation is entirely consistent with the Academy's policies and we would be delighted to work with you on finalizing your proposal.

Furthermore, in our opinion the acquisition and use of health information technology envisioned by your bill are realistic and can be accomplished in a relatively short period of time, given the appropriate know-how and experience to match the resources. Electronic medical records that are affordable, interoperable, and capable of addressing some of the issues that contribute to health and health care disparities are available on the market today. And, although the transformation from paper systems to computerized health information management is not easy by any stretch of the imagination, we have seen directly that it can be accomplished smoothly and with minimum disruption of the practice, even in rural and urban community health centers and private practices in underserved or disadvantaged communities.

We believe it is very important to focus attention on providing continuity of care through continuity of information and data flows with these computerized systems. EHRs and other information technology used in medical practices should be able to read, import and export a core set of most relevant data about a patient – such as demographics, a problem and diagnosis list, medication list, allergies, and immunizations – and store these data securely on the Web, where they can be accessed by the right people, at the right time, to help make the right decisions and avoid errors and wasted resources.

The Academy has led in the development of the Continuity of Care Record (CCR) standard, which offers this basic level of interoperability for computerized medical records, and which any community can adopt and deploy without incurring large costs or having to build complex new data exchange organizations.

We join with the Institute of Medicine in encouraging federal funding for health care providers to purchase HIT systems. According to the US Department of Health & Human Services, billions of dollars would be saved each year with the wide-spread adoption of these systems. Use of HIT also aids in reducing errors and allows for ongoing care assessment and quality improvement in the practice setting.

AAFP Policy on HIT
The AAFP recently created and updated new policy around health information technology (HIT) whose emphasis is on "data fluidity," that is, ensuring that data flows freely and unimpeded throughout the entire health care system. Your outline's emphasis on the federal government helping to "connect health resources" within medically-underserved communities seems to be consistent with this policy.

Our belief, however, is that the federal government must switch its current emphasis from a focus on hospitals and large enterprises to one that helps networks of small and medium-sized physician practices acquire affordable and interoperable HIT systems. We need to link these offices so that primary care physicians, specialist physicians, pharmacists, and hospitals can communicate, locally as well as across the globe, to provide integrated, coordinated, quality care for all patients.

When HIT was in its infancy, it seemed simple and efficient for the federal government to support large entities and hospitals with grant funding to encourage the adoption of HIT. The current governmental approach has tended to support large enterprises and their HIT vendors in efforts to build large-scale, complex systems, such as Regional Health Information Organizations (RHIOs). These coalitions, most often led by hospitals or large enterprises, have received federal dollars to integrate health information in a single area. However, regional solutions may or may not be transferable to another venue, do not reach the majority of U.S. communities, and are proving to be economically unsustainable.

The problem with continuing this approach, however, is that most health care in America does not take place in hospitals or large enterprises: it takes place in doctors' offices and, specifically, in primary care practices with five or fewer physicians or other clinicians.

For example, nearly half of all ambulatory care visits in the U.S. are made to family physicians, pediatricians, and general internists in the outpatient setting: *over 400 million visits each year.* As the need for practical HIT systems in the US becomes more urgent, we need federal support that builds on and provides incentives for current private sector initiatives.

We will not improve health care in America if federal dollars only empower large enterprises -- at great cost and complexity -- to communicate with other big institutions, while doctors and patients in tens of thousands of local community practices and clinics cannot access and share information for the good of their patients.

Specific Comments on Draft HIT Outlines
Focus on Solo and Small Practices
We urge you to include provisions in your legislation to ensure that individual physicians and small practices are the focus, rather than large health facilities, for the reasons noted above.

Target Federal Dollars to Support Physicians Who Are Serving the Underserved
Our new policy states that any specific payments to physicians to purchase HIT systems should go to those serving in underserved areas where the capital to purchase electronic health records is hardest to obtain and practices may be small or medium-sized. These payments should not go through third-parties such as hospitals, integrated health systems, or health plans, but directly to clinics and practices based on financial need. While not all of our physicians work in underserved areas, we want to support those members who do.

Section 102 of your draft outline, which provides grants for "technical support, promotion and support of planning and adoption of health information technology" is entirely consistent with our view that underserved communities need greater assistance to be successful. In an HHS-supported EHR Pilot Project conducted by the AAFP, we learned that practices with a well-defined implementation plan and analysis of workflow and processes had greater success in implementing an EHR. The Center for Health Information Technology used this information to develop a practice assessment tool on its Web site, allowing physicians to assess their readiness for EHRs. These are the sorts of tools that would help underserved communities be successful in their adoption of HIT.

In addition, we believe that any grant process should be as streamlined as possible. As you know, individual physicians, small practices and even community health centers in underserved communities do not have the time or expertise to write complicated grant proposals. A simple requirement, e.g., financial need or location in a medically-underserved are may be all that should be required for access to these grants.

In addition, we urge you to recommend special payments for physicians who can demonstrate the use of EHRs and other HIT as a way to improve and coordinate care. Current reimbursement methods tied to face-to-face visits discourage the efficiencies gained by the use of EHRs, for example, asynchronous communication with patients using secure email and web-based consultations. Reimbursement strategies must change to reward quality and efficiency enabled by HIT. This does not mean, however, that we would take dollars away from physicians who are not yet using EHRs.

Role of Federal Agencies
Your draft outline's emphasis on expanding activities within the Agency for Healthcare, Research and Quality, the Health Resources and Services Administration, Office of Minority Health, Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention to focus on HIT and health disparities within urban and rural medically underserved communities seems to be a reasonable way to encourage consistency of purpose throughout these agencies. If the goal is to make it easier for underserved communities to use HIT, then all relevant federal agencies should be required to have activities that support this end. (Sections 103, 104, 106, 107.)

Health Information Technology Empowerment Zones
Section 108 of your draft outlines gives the Secretary of Health and Human Services authority to designate "Health Information Technology Empowerment Zones" to assist states in reducing health disparities and improve health outcomes by using HIT.

The establishment of HIT empowerment zones should be to direct resources into those communities that need assistance and not dictate a particular solution, such as a community RHIO. Instead, the empowerment zone should allow the community to establish the HIT infrastructure needed to support the underserved individuals and the physicians that provide their care.

We have seen the private sector, including individual physicians in community practices, hospitals, health plans, and large employers, as well as a growing number of American consumers, start a rapidly-growing market for interoperable electronic health records, personal health records (PHRs), and health data exchange technology that is scalable, does not require multi-million dollar federal investments in new enterprises, nor require purchase of proprietary and possibly redundant local "infrastructures." The results have been exciting: most of the progress towards health information technology adoption, as well as the portability and interoperability of health data, is due to this research and experimentation in the private sector.

Other Recommendations

Standards

In addition, as you work on your legislation, we urge you to apply longstanding industry standards of portability and Interoperability to HIT. Personal health information can be discovered, acted upon, and managed in much the same way as in the banking, financial services and global e-commerce industries, which have operated electronically for years. Longstanding standards and protocols have proved their effectiveness in secure data transport and interoperability over public networks, notably the Internet.

Ensure Privacy Protections for Patients

The AAFP believes the right to privacy is personal and fundamental, and protections for this privacy ought to apply to all parties who wish to become custodians of personal health information, not merely to those entities covered under HIPAA. Patients should have a right of access to, and correction of, medical records in electronic formats that are familiar and easy to use with today's desktop computing tools. AAFP understands there are rare cases in which full and direct disclosure to the patient might be harmful and in those cases, special exceptions should apply.

Patient-Centered Medical Home

Finally, I cannot speak about HIT without mentioning the Patient-Centered Medical Home, a proven model in health care delivery that the AAFP has proposed along with the American College of Physicians, the American Academy of Pediatrics and the American Osteopathic Association.

I emphasize the medical home since it is predicated on the presence of health information technology, i.e., the electronic health record, in the physician's office. In this new model, the traditional doctor's office is transformed into the central point for Americans to organize and coordinate their health care, based on their needs and priorities.

At its core is an ongoing partnership between each person and a specially-trained primary care physician. This new model provides modern conveniences, like email communication and same-day appointments; quality ratings and pricing information; and secure online tools to help consumers manage their health information, review the latest medical findings and make informed decisions. Consumers receive reminders about necessary appointments and screenings, as well as other support to help them and their families manage chronic conditions such as diabetes or heart disease.

The primary care physician helps each person assemble a team when he or she needs specialists and other health care providers such as nutritionists and physical trainers. The consumer decides who is on his or her team and the primary care physician makes sure they are working together to meet all of the patient's needs in an integrated, "whole person" fashion.

This is an improved way to approach health care based on a proven model. In fact, the Patient-Centered Medical Home (PC-MH) will be recognized by an independent organization so that payers can be assured that their small investment in this model of care delivery will result in a higher standard of care.

Medical Homes Diminish Health Care Disparities

Finally, of interest to members of the Subcommittee, in June, 2007, the Commonwealth Fund released a report entitled, *Closing the Divide: How Medical Homes Promote Equity in Health Care,* which made the following statement:

> *The Commonwealth Fund 2006 Health Care Quality Survey finds that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. The results suggest that all providers should take steps to create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients.*

In our view, this report makes a compelling case that a medical home that includes HIT would do much to transform the quality of health care provided to Americans in underserved communities.

Conclusion

The Academy is pleased to work with you on any legislation to improve health care in underserved areas using health information technology and, in particular, suggest projects and pilots that would meet these goals.

Statement of
Joel White
Executive Director
The Health IT Now! Coalition

"Narrowing the Gap:
How Health Care Information Technology Is
Reducing Racial Disparities in Care"

Submitted to the U.S. House of Representatives
Committee on Oversight and Government Reform,
Subcommittee on Management, Organization and Procurement

November 1, 2007
Hearing: "Too Many Cooks? Coordinating Federal and State Health IT"

Chairman Towns, Ranking Member Bilbray, and Members of the Subcommittee:

About The Health IT Now! Coaltion

My name is Joel White and I am the executive director of the Health IT Now! Coalition. Health IT Now! is a diverse coalition of nearly thirty medical professional groups, patient advocacy organizations, disease advocacy associations, consumers groups, large employers and unions promoting the rapid deployment of Health Information Technology (Health IT). Our coalition is co-chaired by former Senator John Breaux (D-LA) and former Representative Nancy Johnson (R-CT).

Our members have crossed traditional political and ideological lines to join together in support of an important goal, because it's something we all enthusiastically believe: Health IT will improve the quality of care, save money, and save lives.

The Health IT Now! Coalition urges Congress to pass legislation that will:

- Establish a public-private process to establish national standards for health IT system interoperability, product certification, and quality measures and an accelerated process for standards improvement;
- Provide federal financial incentives to practitioners of care to facilitate the adoption of health IT, and for communities, states, and other entities to plan health IT components and to develop Health Information Exchanges;
- Empower consumers through patient education tools that encourage patient use of electronic health records and provider quality information; and
- Promote federal leadership of a federal-state process to resolve policy issues central to a secure and safe care system, like privacy and professional licensure.

In 2008, the Congressional agenda will be taken up with election-year issues and, the following year, the priorities of a new Congress and Administration. That is why we urge Congress to act before the end of 2007, to avoid denying Americans the benefits of Health IT any longer.

Introduction

It is not enough to talk about the power of Health IT to "lift all boats."

As the members of this panel know, when the latest and greatest technical advances are rolled out, too often our nation's rural residents and communities of color are left behind.

The benefits of Health IT—of saving up to 100,000 lives a year presently lost due to medical errors, increasing access to medical care, providing instant access to complete medical histories—can literally be a life-and-death matter for all Americans.

The good news: Many of the benefits of Health IT directly address stubborn and long-term challenges for our rural and minority communities.

What are those challenges? Here are just a few, according to the U.S. Health and Human Services' recent National Healthcare Disparities Report—the first national effort to measure differences in health care access and quality:

- "Blacks and poorer patients have higher rates of avoidable hospital admissions."
- "Minorities are more likely to be diagnosed with late-stage breast cancer and colorectal cancer compared with whites."
- "Patients of lower socioeconomic position are less likely to receive recommended diabetic services[,] and more likely to be hospitalized for diabetes and its complications."
- "When hospitalized for acute myocardial infarction, Hispanics are less likely to receive optimal care."
- "Many racial and ethnic minorities and persons of lower socioeconomic position are more likely to die from HIV. Minorities also account for a disproportionate share of new AIDS cases."[i]

Communities of color have everything to gain from Health IT because it remedies real disparities in health care.

It will narrow the gap between whites and non-whites in terms of quality of medical care, outcomes, longevity, accuracy and precision of treatment, in accessibility of doctors and other health care professionals, convenience, follow-up care, preventive medicine—in short, Health IT tears down many of the significant barriers that have disproportionately affected communities of color and the medical treatment they need and deserve.

Creating Partnerships: The More the Merrier

One of the questions asked here today is whether the federal government can and will work in harmony with the states and the private sector. My answer is an unequivocal yes. In fact we must all work together. One of the principles of the Health IT Now! Coalition is to establish a public-private partnership to establish standards for interoperability and product certification and quality standards and a process for improvement.

Some believe we cannot have a top down and bottom up approach at the same time. The Health IT Now! Coalition believes you can have both, but that standards should pull technology that may be particularly important in New York to allow interaction with information technology in Southern California. That's the whole point. We must pull together across localities, states, regions and the nation, to create standards for interoperability that everyone can trust and comply with.

In addition to the question of whether there are too many cooks in the kitchen, the Health IT Now! Coalition believes it is important to ask if Health IT will make a difference in fixing these inexcusable disparities in access, treatment and outcomes.

Because if it will not, many of you would much rather spend time, resources and energy on something that will.

Again, our coalition firmly believes Health IT is an historic solution to remedy disparities in health care. And below, I will discuss how we believe Health IT can close the health care gap.

Health IT: measuring the extent of the health care gap

First, while the existence of health care disparities is not in dispute, we still lack a complete measure of the disparity.

Ironically, the lack of Health IT means we don't have the data to allow us to measure the full magnitude of the health care gap to begin adequately addressing the many challenges. Health IT will not only help close the gap, it will first help measure the gap, in the form of verified data and reporting of who is being hurt by discrimination, how they are being hurt, and where we should deploy our resources to remedy it.

In short, Health IT diagnoses the gap by delivering detailed evidence we have never had access to before.

Health IT removes opportunities for discrimination

Second, Health IT removes opportunities to discriminate against racial minorities. Since Health IT is machine- and software-based, it is no "respecter of persons"—meaning that everyone, regardless of race, receives the same high level of service from the system.

Some individuals don't trust the health care system—or much of any formal system, for that matter. Given the facts of history, this makes sense—which is another reason why Health IT is so promising. Health IT systems remove the opportunity for race-based discrimination and favoritism. The software doesn't care where you were born, what color your skin is, or in many cases even what language you speak.

Because Health IT is an electronic system medical records are recorded, shared and retrieved the same way for all people. Health IT doesn't discriminate—because it cannot discriminate.

Health IT prioritizes care for those who need it most

Next, let me tell you how Health IT picks out patients in need and moves them to the front of the line.

One of our coalition members is The Marshfield Clinic in Marshfield, Wisconsin. Marshfield is one of the largest group medical practices in the U.S., with 750 physicians, 6000 employees and 40 locations.

Marshfield is also on the cutting edge of Health IT. Marshfield has been using Health IT for 20 years, and over that time it has collected significant data on effectiveness.

Marshfield uses Health IT to serve a rural and relatively poor area with a declining economy, and Marshfield has made it a high priority to ensure equal and quality treatment for underserved populations.

Marshfield has recently introduced what they call the "Intervention List"—or iList. This software application accesses electronic medical records to produce a list by provider of patients who have one of three chronic illnesses—diabetes, heart failure or hypertension—and who are not meeting all of their recommended health goals.

This Health IT tracking tool helps identify and reach out to patients who are overdue for services and not meeting quality-of-care goals.

Dr. Daniel Erickson of Marshfield's Lakes Center family practice said that the iList has been "an eye-opener for me [for finding] patients who could be slipping through the cracks." He said that physicians sometimes "over-estimate how [they're] doing on quality measures," and that this helps bring a dose of reality to doctors' perspectives.

Clinical nurse specialist Ellen Vanderboom said that the iList, which puts evidence-based medicine into practice, is especially useful for patients who don't have a specific plan of care.

According to an article in the August 2004 New England Journal of Medicine, black patients and white patients are, to a large extent, treated by different physicians, and those treating black patients tend to be less well trained and have less access to important clinical resources.[ii]

This is exactly what this Health IT application remedies: patients do not even have to have been consistently seeking or receiving health care. If you start receiving medical care today the system is specifically designed to account for the special needs associated with that situation.

This approach is working in Marshfield, and it will work for the nation: providing better care for those who need it based not on the color of their skin but on the straightforward and unbiased measurement of the quality of their health care at the time they seek treatment.

Not only is this a vital goal for health care in our nation's underserved communities, it's something you simply cannot do unless you have Health IT in place.

Health IT and adherence to care plans

The next benefit of Health IT I'll describe is how it helps patients to follow through on treatment.

Residents of wealthy communities and comfortable suburbs are never more than a car ride—or even a short walk—away from a doctor.

But for residents of rural communities, or those without reliable transportation, it is a different story.

The Marshfield Clinic uses Health IT to ensure that underserved populations can conveniently follow-up—and follow-through—on their treatment.

This is especially important for those with chronic diseases, and members of minority communities disproportionately suffer from these conditions. For instance, African-Americans, Hispanics, Native Americans, Japanese Americans, Chinese Americans and Korean Americans are all more likely to have diabetes than white Americans. That naturally leads to greater complications such as kidney disease, eye disease, coronary artery disease, and more.[iii]

Diabetes and these associated conditions can be limited by easy access to follow-up care. But if you can't easily get the medicine and medical communication you need, you can't follow your care plan.

And the lack of adherence to care plans has a ripple effect through minority communities in terms of quality of life, cost of treatment, and mortality.

Marshfield is using Health IT to get at the root of the problem by making it easier to follow those plans. For instance, Marshfield has introduced a system that fills prescriptions on-the-spot and allows doctors to know that the prescription has actually been filled.

The Marshfield Health IT system uses cameras to connect pharmacists and to send along images of prescription orders. The pharmacist accesses patient records—with the patient's permission, of course—to make sure the new medicine doesn't negatively interact with anything the patient already takes. The pharmacist checks that the bottle and the label match the doctor's order, and the pharmacist can counsel the patient about any questions by using the video network.

Then there's a free mail order service to re-fill the prescription.

This isn't technology that's on the drawing board. This is a Health IT system that is in place and saving lives right now. Any hospital or clinic could roll out a similar system—if the Congress would pass a law to establish a federal foundation for Health IT in standards, infrastructure and incentives.

Passing such a bill this year—before the presidential campaigns of 2008 and a new Congress and Administration in 2009—would avoid what could well be at least a two-year delay in delivering the life-saving benefits of Health IT to our nation's underserved communities.

Other Benefits of Health IT

Finally, there are many other examples of how Health IT is already improving the quality of life and extending the longevity of minority Americans. Health IT reduces the delay between abnormal mammograms and follow-up tests—the wait is currently twice as long for minorities as white women. Health IT makes it easier to secure follow-up care for older Americans by minimizing the need for travel to offices and by making doctor-patient communication easier. Health IT means better screening and preventive medicine. And the list goes on.

Conclusion

In conclusion, I'd like to return to the National Healthcare Disparities Report of HHS. The 2006 report cites specific opportunities for reducing disparities, and these include cancer screenings, vaccinations, hospital treatment for heart attack and pneumonia, enhanced access to diabetes services, more timely treatment, and better doctor-patient communication.[iv] As described in several of the examples above, we believe Health IT can successfully address these recommendations.

Health IT is arguably the most effective initiative Congress can make to improve the quality of care for minority and rural Americans. The Health IT Now! Coalition urges you to pass legislation this year to bring these benefits to them – and to all Americans.

Thank you.

[i] National Healthcare Disparities Report 2003; Summary; http://www.ahrq.gov/QUAL/nhdr03/nhdrsum03.htm#Inequality; last accessed October 29, 2007.

[ii] Primary care physicians who treat blacks and whites; New England Journal of Medicine, August 5, 2003; Abstract; http://www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed&list_uids=15295050&cmd=Retrieve&indexed=google; last accessed October 29, 2007.

[iii] Diabetes Disparities Among Racial and Ethnic Minorities: Fact Sheet; Agency for Healthcare Research and Quality, HHS; http://www.ahrq.gov/research/diabdisp.htm; last accessed October 29, 2007.

[iv] Key Themes and Highlights from the National Healthcare Disparities Report 2006; http://www.ahrq.gov/qual/nhdr06/highlights/nhdr06high.htm; last accessed October 29, 2007.