

Testimony for ONC, 11 January 2011

I was one who initially chose to put my head in the sand. My residency program, Cabarrus Family Medicine, adopted an EHR in late 2003. By the time the rollout reached the office to which I was assigned, I had less than three months until graduation, and with a little bit of what counted as tenure, politely refused to learn the new system. Unfortunately, the Residency Director agreed to let me continue dictating and writing my notes rather than learn the new system, and I missed out on the opportunity to begin training on an earlier version of the system which I would later purchase. Had I known in 2003 and 2004 that A4 would merge with Allscripts, that I would purchase an Allscripts product, and that Allscripts Professional EHR would become one of the initial vendors to become CCHIT certified, the value in this initial training would not have been lost on me.

Despite the fact that I stubbornly refused to learn the new system, I did participate (albeit somewhat peripherally) in its selection. The process took quite some time given the size of our residency program, and the experience, though I could not see it at the time, would prove to be a good one. In 2005, my first employers saw fit to include me in a group including the office manager and billing department in an unofficial committee charged with early research into EHR implementation. The four of us attended some small regional vendor conventions, and I began to do some of my own research into electronic health records. Also during this time period I was asked to sit on the hospital committee involved in selecting an EHR for Bayhealth Medical Center. Ironically, one of the reasons that I left my first practice was the fact that I was told that we would “never” be implementing an EHR, “at least if [the office manager] had anything to do with it.”

The result of my training and early practice experiences was that I began to realize that efficiency and patient care could in fact be greatly improved through the use of an EHR. I also realized that we were and are looking at a shifting paradigm, and to succeed at the next level an EHR vendor which would be able to keep up with the incredible pace of change would be very important. When we founded Southern Delaware Medical Group, we decided very early in the process that an electronic health record was to be an integral part of our practice. Working with the Delaware representatives of the Centers for Medicare and Medicaid Services, we chose A4/Allscripts as our vendor. Interestingly, it should be noted that my former employers chose the same vendor less than a year later.

All practices, regardless of size or resources, will relate frustrations with the implementation of their EHRs. Even new practices without the task of transitioning work flow and paper charts have their challenges. Relatively speaking, and with the benefit of hindsight, I can say that our transition to an electronic practice has gone as well as one can expect. That

being said, our challenges with the EHR have not ended with implementation. Continued and sometimes hidden cost, a server crash which resulted in several months of inefficiency and a new server, and a vendor whose customer service seems to have flagged as its resources have been directed more towards software development in preparation for CCHIT certification are but a few of the challenges we have faced over the last four to five years.

Through such technologies as electronic prescribing, access to the patient record from home, a computerized appointment phone reminder system, automatic medication interaction checking, and the ability to electronically receive lab and radiographic results, efficiency and patient safety have improved in our practice. Our scheduling, patient record and billing systems are fully integrated. I am proud of the fact that we are among the first practices in the nation moving forward with an electronic health record. I am also proud of the State of Delaware, the Delaware Health Information Network, and the potential we have to truly serve as a role model for the rest of the nation when it comes to the creation of an integrated, patient-centered electronic health record. There is no doubt in my mind that Southern Delaware Medical Group is using its electronic health record in a meaningful manner.

At significant personal expense, our practice has led the way in the implementation and use of an EHR. We have also seen some small direct financial return on our investments, receiving some incentive money via the Physician Quality Reporting Initiative, a task made possible by our involvement with CMS and through the use of our EHR. As an early adopter who has taken our share of leaps of faith when it comes to the use of an electronic record, and as a practice preparing to attest for Meaningful Use in 2011, I am hopeful that our efforts will be realized even further in the coming year.

While I have come to understand that a comprehensive, universal EHR is very important as we collectively move forward, I have the same concern as any small business owner. Our margins are slimmer than one might expect, and our reliance on Medicare and Medicaid dollars is significant given the demographics of our practice area. Our practice is 44% Medicare/Medicaid, and given the disparity in private insurance contracts which are far better than ours nationwide, our incomes are at the 5th to 10th percentile nationwide. The unexpected cost of a new server led to the owners of Southern Delaware Medical Group not getting paid early last year, and continued uncertainty regarding the SGR formula have made things quite uneasy. As we continue to transition towards a new model of integrated healthcare delivery in which some experts have predicted the “death of private practice,” uncertainty is rampant. While I do not expect the panel’s pity regarding our salaries, I do wish to point out that \$44,000 per provider over five years would be very significant, provided that money actually is intended for and reaches medical practices. It is my hope that the Meaningful Use funds have been made available to supplement practices such as my own, perhaps allowing us to be more

successful in the recruitment and retention of new physicians and dynamic staff, and therefore to continue to be at the leading edge of technology implementation.

A question that I think bears asking is whether the Meaningful Use dollars are intended for practices as a reward, as an incentive, or whether they are intended for medical practices at all. In terms of patient care and documentation, I have no doubt that we are using our EHR in a “meaningful” manner. It concerns me that more and more time and financial resources seem to be required to prove Meaningful Use. Our EHR vendor is charging an additional \$1,500 for its “meaningful use” package set up fee in addition to \$200/provider/year for MU reports, which although advertised as optional hardly seems as such. This is over and above the thousands of dollars we have already paid and continue to pay them. Our EHR is compatible with one or two patient portal companies, who are now charging more than \$1,000 per provider set-up fee and \$100-200 per provider per month maintenance fee. Our local technical support person who has expertise with Allscripts charges more than \$100 an hour, and his services are needed more frequently to ensure that we have the proper hardware required by CMS. The Regional Extension Center (REC) of Quality Insights of Delaware is charging \$10 per hour in its mission of assisting 1,000 Delaware practices to achieve Meaningful Use. Based solely on my average daily billing (not collections!) I would estimate the above costs to translate into roughly one extra week of work per provider in our practice. While I understand that some of the CMS requirements have been simplified and made less onerous, I feel that there are still several expectations that are perhaps more difficult and expensive than they should be, and I feel that the OHR should attempt to ensure that the net Meaningful Use dollars per provider remain significant enough to provide a true incentive to practices which currently teeter on the fence. At this point, \$8,800 per provider per year of Meaningful Use incentive is easy to see being taken up by the additional cost of trying to prove Meaningful Use!

Southern Delaware Medical Group is moving forward with optimizing the use of its EHR, and will continue to do so because the process has already been started. In order to recruit new practices into adopting EHRs and working towards Meaningful Use, the definition of what is meaningful and practical for government, private practices and patients needs to be further refined and simplified. CMS may consider making its definition of Meaningful Use more complicated after EHR adoption is more widespread, but while still in its relative infancy in this country, we should be honestly rewarding practices which are fully using EHRs for the risk that they have taken and continue to take, and we should be honestly incentivizing those that are interested.

Thank you for your time and for the opportunity to testify.