

HIT Testimony in DC January 11, 2011

My name is Scott Monteith, a board-certified psychiatrist and Fellow of the APA from Michigan. I work in private practice and with Community Mental Health (CMH). I also teach in MSU's medical school.

My 21 year interest in HIT includes:

- being a CCHIT Juror;
- appointed by our Governor to three terms on the Controlled Substances Advisory Commission, which has a role overseeing Michigan's Automated Prescription System;
- a member of the Business Operations Workgroup for Michigan's Health Information Network;
- working with malpractice insurance companies to manage growing risks from EHRs;
- and more.

I'm "pro-HIT." For all intents and purposes, I haven't handwritten a prescription since 1999.

That said and with all due respect to the capable people who have worked hard to try to improve health care through HIT, here's my frank message:

ONC's strategy has put the cart before the horse. HIT is not ready for widespread implementation. The problem isn't Luddite doctors not adopting; the problem is that HIT isn't ready, especially if we want safe and efficacious bells and whistles like CDS, interoperability, etc.

To describe ONC's handling of HIT promotion, let me use an analogy:

It's as if policy makers said, "Let's promote a cure for cancer. By curing cancer, we can save money and improve the quality of people's lives."

Like our collective fantasy for the benefits of widespread HIT use, which I share, who can argue with the dream of curing cancer, or the good intentions behind it?

The problem is that finding a cure for cancer isn't as simple as declaring a cure, and then merely getting resistant doctors to start using it.

Continuing the analogy, ARRA dollars are incenting doctors to use Laetrile, the supposed cancer cure that was not evidence-based and didn't work.

ONC has promoted HIT as if there are clear evidence-based products and processes supporting **widespread** HIT implementation.

But what's clear is that we are experimenting...with lives, privacy and careers.

As a clinician, I'm here to report that certified EHRs are not necessarily producing better documentation or improved care.

Yes, EHR-generated documentation is usually more legible, but it's often "legible gibberish." And there's a lot of it, including meaningless data, burying relevant information.

Example:

A colleague requested records for his mother's nearly two-week hospital stay; this particular hospital is an early adopter of EHRs. He received almost 2,900 pages.

Finding relevant data in the midst of 2,900 pages can be like finding a needle in a haystack.

Here's another example of EHRs degrading documentation:

In our CMH, administration inserted language into the doctors' treatment plans. The problem is that the language is patently false and untrue.

Unfortunately, administration controls the EHR, and physicians cannot change the untrue language.

"Ghost writing" clinical notes – often incorrectly – is increasingly common, whether through fixed fields, no or limited free text, inserted language that cannot be changed, multi-authored documents, or other means.

I have documented scores of error types with our certified EHR, and literally hundreds of EHR-generated errors, including consistently incorrect diagnoses, ambiguous eRx, etc.

As a CCHIT Juror, I've seen an inadequate process. Don't get me wrong, the problem is not CCHIT. The problem stems from MU.

EHRs are being certified even though they take 20 minutes to do a simple task that should take about 20 seconds to do in the field. Certification is an "open book" test. How can so many do so poorly?

For example, our EHR is certified, even though it cannot generate eRx from within the EHR, as required by MU.

To CCHIT's credit, our EHR vendor did not pass certification. Sadly, our vendor went to another certification body, and now they're certified.

MU does not address many important issues. Usability has received little more than lip-service. What about safety problems and reporting safety problems? What about computer generated alerts, almost all of which are known to be ignored or overridden (usually for good reason)?

The concept of "unintended consequences" comes to mind.

All that said, the problem really isn't MU and its gross shortcomings, it is ONC trying to do the impossible:

ONC is trying to artificially force a cure for cancer, basically trying to promote one into being, when in fact we need to let one evolve through an evidence-based, disciplined process of scientific discovery and the marketplace.

Thank you for the opportunity to be a part of this process.