

**STATEMENT FOR THE RECORD**  
**OF THE**  
**AMERICAN COLLEGE OF PHYSICIANS**  
**TO THE HOUSE COMMITTEE ON SMALL BUSINESS**  
**SUBCOMMITTEE ON REGULATIONS, HEALTHCARE AND TRADE**  
**“The Value of Health IT to Solo and Small Medical Practices”**

**March 28, 2007**

The American College of Physicians (ACP) -- representing 120,000 physicians and medical students -- is the largest medical specialty society and the second largest medical organization in the United States. Internists provide care for more Medicare patients than any other medical specialty. Of our members involved in direct patient care after training, approximately 20 percent are in solo practice and approximately 50 percent are in practices of 5 or fewer physicians. We greatly appreciate Subcommittee Chairman Charles Gonzalez and Ranking Member Lynn Westmoreland for focusing attention on the barriers solo and small health care practices face in adopting health information technology.

ACP strongly believes the goal of widespread adoption and use of health information technology will only be successful if we first recognize the complex issues surrounding financing, assistance with redesign of practice workflow, and ongoing technical support and training. We believe Congress has an important role to play in these areas, particularly for physicians in solo and small practices, to support the goal of transiting to a paperless office.

### **Background**

The Institute of Medicine's (IOM) 2001 Report, *“Crossing the Quality Chasm – A New Health System for the 21<sup>st</sup> Century,”* suggested that up to 98,000 Americans die each year as a result of medical errors. The report introduced the notion that many of these lives could be saved through advantages of information technology. The IOM report cautions, however, “In the absence of a national commitment and financial support to a build a national health information infrastructure...the progress of quality improvement will be painfully slow.”<sup>1</sup> Since then, numerous studies and other policy experts have confirmed

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<sup>1</sup> Institute of Medicine, *Crossing the Quality Chasm – A New Health System for the 21<sup>st</sup> Century*, March 2001, and U.S. Department of Human Services, *Information for Health: A Strategy for Building the National Health Information Infrastructure*, Report and Recommendations from the National Committee on Vital and Health Statistics, November 15, 2001.

that full adoption and utilization of health information technology (HIT) can revolutionize health care delivery by improving quality of care and reducing high medical costs.<sup>2</sup>

Despite all the positive claims about the value of HIT, however, few physician practices are able to afford the substantial initial capital, or afford the lifetime of costs associated with training and maintaining the technology. According to a 2006 review by the Robert Wood Johnson Foundation, only between 13 to 16 percent of solo practitioners were able to adopt HIT.<sup>3</sup> The National Ambulatory Medical Care Survey (NAMCS), an annual, government-funded, nationally representative survey of all ambulatory visits to physicians whose practices are not hospital-based, recently added questions about Electronic Health Record (EHR) use. While they found that 23.9 percent of physicians were using EHRs, further analysis to physicians who had at least four of the key functionalities of an EHR, as identified by the IOM, adoption rates drop to only 9 percent.<sup>4</sup> Similar studies conducted since 2003 have also shown a steady increase in the rate of adoption, but solo and smaller practices have been slowest among all groups to adopt.<sup>5</sup> The substantial cost of acquiring the equipment is the most-often cited reason.

Meanwhile, the Administration has taken initial steps to advance the adoption of a HIT. The most significant commitment was made by President Bush in April 2004 calling for the widespread adoption of interoperable electronic health records within the next decade. To oversee this bold ten-year initiative, the President announced the creation of the Office of National Coordinator for Health Information Technology (ONCHIT). ONCHIT followed with an ambitious 10-year funding strategy for policymakers to consider in speeding HIT adoption nationwide. According to ONCHIT's "Framework for Strategic Action," *Congress should consider several funding options, including additional Medicare reimbursement as well as the use of loans, tax credits, and grants.* Since that time, however, Congress has introduced dozens of bills to begin to mold the framework for adopting HIT infrastructure. Unfortunately, no single bill has made it out of both Houses, making the President's 10-year goal seem out of reach.

ACP strongly supports efforts by those in the Administration and the Congress to speed the adoption of uniform standards for health information technology. The College is committed to providing its own members with practical tools to help them improve quality. ACP's Physicians Information and Education Resource (PIER) provides ACP members—at no cost to them—with access to "actionable" evidence-based guidelines at the point of care for over 300 clinical modules. PIER has also been incorporated into several electronic health record systems. PIER is also creating paper order sets that imbed such quality measures so that physicians who have not made the transition to

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<sup>2</sup> A 2005 RAND analysis estimated that national adoption of the EHR could lead to between \$81 billion and \$161 billion in annual savings.

<sup>3</sup> The Robert Wood Johnson Foundation (2006), *Health Information Technology in the United States: The Information Base of Progress*, chapter 3, p. 26.

<sup>4</sup> Institute of Medicine, "Key Components of an Electronic Health Record System: Letter Report," July 2003.

<sup>5</sup> Jha, Ashish K., Ferris, Timothy G., et al., "How Common Are Electronic Health Records in the United States? A Summary of the Evidence," *Health Affairs*, web exclusive October 11, 2006.

electronic health records could still utilize PIER content to support their participation in performance measurement initiatives. ACP's Practice Management Center has developed resources to help internists in the decision-making process on electronic health records and is leading an initiative to provide internists with tools and best practices to help them redesign their office processes to improve health care quality.

We also believe, however, that physician practices will not be able to do this alone. Without sufficient financial assistance from the federal government, particularly to those in solo and small medical practices, we will be unable to achieve a smooth transition into a fully-integrated HIT society. **Therefore, we believe it is absolutely essential for Congress, as a first step, to begin to offer targeted financial assistance programs to fund HIT in solo and small medical practices. Solo and small practices, in particular, need financial assistance for the initial start-up costs of acquiring the technology, but also financial recognition of the ongoing costs.**

### **The Importance and Benefits of HIT**

While there is no universal definition of HIT, consensus seems to be building around several key components. Some of the more accepted components include the following items: Electronic Health Records (EHRs); the ability to exchange electronic information across organizations (referred to as "interoperability"); and disease surveillance. Within the EHRs, the IOM offers the following elements: (1) a longitudinal collection of electronic health information for and about persons, where health information is defined as information pertaining to the health of an individual or health care provided to an individual; (2) immediate electronic access to person- and population-level information by authorized, and only authorized, users; (3) provision of knowledge and decision-support that enhance the quality, safety, and efficiency of patient care; and (4) support of efficient processes for health care delivery.

Despite the many components of HIT, the potential benefits are likely to be substantial. The most-often cited benefits include: avoidance of medical mistakes, storage and preservation of medical data, avoidance of medical errors, reductions in malpractice premiums, and improved quality outcomes.<sup>6</sup>

- *Medical mistake avoidance:* The use of clinical-decision support tools at the point of care has the potential to offer a tremendous advantage to both physicians and their patients. Examples of this benefit include alerts about vaccinations and anti-coagulation reminders, diabetes, hypertension, vitamin B12 deficiency, thyroid and anemia screening in the elderly, health maintenance and preventive care measures, etc.
- *Storage of Other Encounter Data:* An often-cited example is the disappearance of paper medical records and charts following Hurricane Katrina. Having medical data stored electronically assures the safe keeping of complete medical histories

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<sup>6</sup> Sidorov, Jan, "It Ain't Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs," Health Affairs, Vol. 24, No. 4, July/August 2006.

that can be difficult to duplicate from memory. In addition, where patients become incapacitated, storage of the data can be critical.

- *Medication Error Avoidance:* The use of EHRs has the potential to reduce medication errors substantially. The 2001 IOM report cited medical errors as the most common medical mistake. The use of electronic prescribing offers promise because it eliminates problems with handwriting legibility and, when combined with decision-support tools, automatically alerts prescribers to possible interactions, allergies, and other potential problems.
- *Malpractice Reductions:* It is also widely believed that the reduction of errors and medical mistakes will lead to fewer lawsuits and a reduction in malpractice premiums. While insurers have yet to link the usage of certain HIT equipment to a reduction in premiums, we believe the evidence is clear that HIT reduces malpractice claims.
- *Quality Improvements:* All the above factors, coupled with a reduction in duplicative care, the lowering health care administrative costs leading to lower health insurance rates, and reducing hospital admissions will lead to better patient outcomes.

## **Privacy and Security Concerns**

ACP has long recognized the need for appropriate safeguards to protect patient privacy and security. We believe that trust and respect are the cornerstones of the patient-physician relationship and to quality health care. We further believe that these attributes will enhance treatment by restoring confidence in the health care system. ACP recognizes that patients have a basic fundamental right to privacy that includes the information contained in their own medical records – whether in paper or electronic form.

We strongly believe that physicians -- already governed by strict ethical codes of conduct, state professional disciplinary codes, and the Hippocratic oath -- who collect protected health information have a duty and responsibility to protect patients from violating their privacy. Patients need to be treated in an environment in which they feel comfortable disclosing sensitive and confidential health information to a physician they can trust. Otherwise, there may be a “chilling effect” for patients to fully disclose the most sensitive of information (conditions or symptoms), thereby reducing the effectiveness and timeliness of treatment, or, they may avoid seeking care altogether for fear of the negative consequences that could result from disclosure. Patients must have assurances that adequate firewalls against unauthorized individuals gaining access to sensitive data is in place. Congress must ensure these safeguards are present.

## Financial Barriers

The single greatest barrier to achieving fully interoperable HIT across the nation is the substantial cost in acquiring the necessary technology. This obstacle is especially acute for physicians practicing in solo and small office settings, where three-fourths of all Medicare recipients receive outpatient care.<sup>7</sup> The initial start-up costs for the purchase of a fully interoperable HIT system can be substantial. **Depending on the size of the practice and its applications, acquisition costs on average \$44,000 per physician. The average annual ongoing costs are about \$8,500 per physician.**<sup>8</sup> The ongoing costs associated with training, productivity losses, maintenance and upgrades, and system support of the HIT system make the investment in HIT a financial commitment over the lifetime of the practice. For many physicians, the “business case” does not exist to make this kind of capital investment.

An additional related barrier is that savings from interoperable HIT will largely go unrecognized for those physicians making the initial and lifetime investment to convert their practices. In other words, public and private payers -- not the physicians -- will realize the savings from physician investment in acquiring the necessary HIT. The savings will come in the form of a reduction in duplicative care, the lowering health care administrative costs leading to lower health insurance rates, avoiding costly medical errors, and improving quality outcomes and reducing hospital admissions. **Therefore, ACP strongly believes that physicians’ collective and individual contributions must be recognized in order to achieve Medicare and Medicaid savings through HIT adoption. Current reimbursement policies should allow for individual physicians to share in the system-wide savings that are attributable to their participating in HIT and other quality improvement programs.**

While the College and the physician community recognize the great potential for improving the overall quality of care that HIT brings, the majority of solo and small practices cannot afford to expend the necessary capital to make the initial investment. For physicians dealing with a multitude of financial issues – ranging from low reimbursement under Medicare and Medicaid, declining fees from managed care, the rising costs of medical malpractice insurance, and the cost of compliance under increasing state and federal regulation – the majority are not in any financial position to make the per physician initial \$44,000 investment or commit to the ongoing annual \$8,500 cost.

Even for those physicians who are able to afford the initial costs, many challenges await. As described in the August 2, 2005 *Annals of Internal Medicine*, the conversion to electronic medical records impacts a practice's finances, productivity, and office environment. According to the authors of this 4-physician medical practice in Philadelphia, Pennsylvania:

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<sup>7</sup> Center for Studying Health System Change, “Most Medicare Outpatient Visits Are to Physicians With Limited Clinical Information Technology,” July 2005.

<sup>8</sup> Miller, Robert, West, Christopher, et al., “The Value of Electronic Health Records in Solo or Small Group Practices.” *Health Affairs*, Vol. 24, No. 5, September/October 2005.

“Its financial impact is not clearly positive; work flows were substantially disrupted; and the quality of the office environment initially deteriorated greatly for staff, physicians, and patients. That said, none of us would go back to paper health records, and all of us find that the technology helps us better meet patient expectations, expedites many tedious work processes (such as prescription writing and creation of chart notes), and creates new ways in which we can improve the health of our patients.”

The experience of this small practice is not atypical. While this practice should be commended for weathering the myriad of challenges in adopting EHRs, Congress needs to recognize that most physician practices are not financially positioned to absorb the many hardships that lie ahead.

### **The Need for Congressional Involvement**

The current Medicare physician reimbursement system, the Sustainable Growth Rate (SGR), does not reward physicians for quality or the use of HIT. Because physicians are paid on a per-procedure or per-service basis, the Medicare reimbursement structure emphasizes volume over quality. In recognition of the need for a Medicare reimbursement system that rewards innovation and quality, Congress is examining the role that reporting on approved quality measures might play in the Medicare program. Meanwhile, physicians are facing an estimated 9.9 percent payment cut in January 2008. This continuous threat of payment cuts deprives physicians of the resources needed to invest in HIT and quality improvements. Therefore, the SGR should be repealed and replaced with a system of payment that is more predictable and keeps pace with the actual cost to provide medical care.

**ACP strongly believes a solution to this problem lies in changing the Medicare physician payment policies to reward physicians who incorporate either some or all aspects of HIT and participate in reporting on endorsed performance measures.<sup>9</sup>**

As a first step, the College recommends Congress consider legislation that builds into the Medicare physician payment system an add-on code for office visits and other evaluation and management (E/M) services. The amount of the add-on should relate to the complexity of HIT adopted by the practice. This approach would more fairly recognize the lifetime costs associated with maintaining such systems. This payment mechanism should identify that a service was facilitated by electronic health data systems, such as electronic health records, electronic prescribing and clinical-decision support tools, and/or the use of a patient registry, and reimburse the physician accordingly.

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<sup>9</sup> Similar to the Bridges to Excellence program which provides physician offices with a bonus of up to \$50 per patient per year if they have certain systems in place to improve quality care.

As a second step, Congress should also allocate the necessary funding for solo and small practices to make the *initial* HIT investment to purchase the necessary hardware and software. The majority of bills that have been introduced in the last Congress included the option of grants, loans, tax credits, or a combination of the three. We believe those funding mechanisms, coupled with a Medicare add-on, are sufficient to put the necessary HIT systems into the hands of solo and small physician practices. We believe the offering of SBA loans, which what the Small Business Committee has jurisdiction over, is an appropriate mechanism to accomplish this goal.

As a third and final step, we and many others believe that HIT alone will not lead toward full recognition of the potential benefits that include improved quality and better outcomes.<sup>10</sup> We believe that directly linked to the use of HIT should be the concept of organizing care around primary and principal care. This model, called the “medical home,” is based on the premise that the best quality of care is provided not in episodic, illness-oriented care, but through patient centered care that emphasizes prevention and care coordination.

Attributes of the medical home include promotion of a personal relationship with your physician who knows your medical and family history. Physicians in the medical home practice are responsible for working in partnership with patients to help them navigate the complex and often confusing health care system. They provide the patient with expert guidance, insight and advice, in language that is informative and specific to the patient’s needs. In the medical home, patients will have a personal physician working with a team of health care professionals in a practice that is organized according to the needs of the patient.

ACP envisions that qualified practices will have the following kinds of services in place:

- Primary care physicians who practice in a medical home would be responsible for partnering with the patient to assure that their care is managed and coordinated effectively;
- The practice would use innovative scheduling systems to minimize delays in getting appointments;
- Physicians in the medical home would use evidence based clinical decision support tools at the point of care to assure that patients get appropriate and recommended care;
- They would partner with patients who suffer from with chronic diseases, like diabetes, better understand and manage their own conditions to prevent avoidable complications. Patients would have access to non-urgent medical advice through email and telephone consultations;

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<sup>10</sup> Sidorov, “It Ain’t Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs.”

- The practice would have arrangements with a team of health care professionals to provide a full spectrum of patient-centered services; and
- Medical home practices will also be accountable for the care they provide, by using HIT to provide regular reports on quality, efficiency, and patients' experience measures.

Dr. Jaan Sidorov, an associate in the Department of General Internal Medicine, Geisinger Medical Center in Danville, Pennsylvania, recently wrote in *Health Affairs*:

“Patient-centeredness, shared decision making, teaming, group visits, open access, outcome responsibility, the chronic care model, and disease management are among the proposals intended to transform medical practice. The EHR’s greatest promise arguably lies in the support of these initiatives, versus the prospect of less efficiency, greater cost, inconsistent quality, and unchanged malpractice burdens resulting from a simple engraftment onto the current health care system.”<sup>11</sup>

Of course, all three of these innovative ways of assisting physicians will come at a cost, so Congress should seek to reform the scoring models used by the Congressional Budget Office (CBO) to more accurately reflect the anticipated savings from efficiencies and cost savings that will result from the use of HIT linked to coordination of care, prevention, and other quality initiatives.

### **Legislation in the 109<sup>th</sup> Congress**

In the 109<sup>th</sup> Congress, a flurry of legislative proposals were introduced that tried to define the federal role in speeding the adoption of HIT. ACP was supportive of many of the bills that came forward, especially of those that we believed would place the emphasis on the greatest need: those in solo and small physician practices.

**The College was particularly supportive of the bipartisan bill, H.R. 747, the “National Health Information Incentive Act,” sponsored by Reps. Charles Gonzalez (D-TX) and John McHugh (R-NY), because it specifically targeted those solo and small physician practices who are in need of the most financial assistance.** Like most of the legislative proposals introduced, H.R. 747 sought to offset the initial start-up costs of acquiring interoperable HIT systems by providing grants, loans, and refundable tax credits. But more importantly, the legislation would have built into the Medicare physician payment system an add-on code for office visits and other evaluation and management (E/M) services, care management fees for physicians who use HIT to manage care of patients with chronic illnesses, and payments for structured email consults resulting in a separately identifiable medical service from other E/M services. Under the Gonzalez bill, these fees would be triggered if the procedure or service was facilitated by an electronic health data system (such as electronic health records,

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<sup>11</sup> Sidorov, “It Ain’t Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs.”

electronic prescribing and clinical decision support tools) when used to support physicians' voluntary participation in performance measurement and improvement programs.

**In addition, the College was also strongly supportive of the bipartisan bill, S. 1227, the "Health Information Technology Act," introduced by Sens. Debbie Stabenow (D-MI) and Olympia Snowe (R-MA).** Like the Gonzalez-McHugh bill, S. 1227 included one-time tax credits and grants for the purchase of HIT as well as Medicare physician payment changes that recognize the ongoing costs in maintaining HIT by authorizing adjustments to Medicare payment when an identifiable medical service is provided using HIT. We supported these approaches because we believe that recognition of the ongoing costs is absolutely essential to making the "business case" for those in solo and small practices to make the capital investment.

In summary, the College strongly believes Congress should provide the necessary funding to offset the initial costs in obtaining HIT, but it should also recognize the unquantifiable and ongoing costs in utilizing HIT. It is this combination of *one-time* and *on-going* financial incentives put forward by H.R. 747 and S. 1227 that, we believe, will substantially speed HIT adoption and improve access to physician practices with HIT, resulting in tremendous system-wide savings. **Only when Congress begins to recognize the collective and individual contributions of physicians will we begin to achieve savings through the adoption of HIT. Therefore, we believe funding initiatives should allow for individual physicians to share in the system-wide savings that are attributable to their participating in HIT and other performance measurement and improvement programs.**

## Conclusion

ACP is pleased that the House Committee on Small Business Subcommittee on Regulations, Healthcare and Trade is examining the barriers solo and small physician practices face adopting HIT. We strongly believe Congress has a very important role in promoting HIT adoption and providing the necessary initial and ongoing funding mechanisms to assist solo and small physician practices. The benefits of full-scale adoption of interoperable HIT will be significant, leading to a higher standard of quality in the U.S. health care system. Unfortunately, without adequate financial incentives, solo and small physician practices will be left behind the technological curve and their patients with them.

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