STATEMENT FOR THE RECORD

OF THE

AMERICAN COLLEGE OF PHYSICIANS

TO THE HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

"Promoting the Adoption and Use of Health Information Technology"

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I am Yul Ejnes, MD, FACP. I am a practicing general internist in Cranston, Rhode Island. I am a member of the medical faculty at Brown University and serve on the Board of Directors of the Rhode Island Quality Institute, the state's Regional Health Information Organization (RHIO). I am also a member of the Board of Regents of the American College of Physicians (ACP), and chair of the College's policy committee that has overall responsibility for both payment-related policies and health information technology (HIT). I am pleased to present ACP's views on the adoption and use of HIT.

ACP, representing 126,000 internists and medical students, is the largest medical specialty society and the second largest medical organization in the United States. ACP commends Subcommittee Chairman Fortney "Pete" Stark and Ranking Member Dave Camp for holding this hearing on the adoption and use of HIT. We share the optimism conveyed in the announcement of this hearing by Chairman Stark, that HIT has the potential to improve quality of health care and reduce costs. We commend the Subcommittee for specifically focusing on the need for incentives to facilitate HIT adoption and use.

Introduction

The Institute of Medicine's (IOM) 2001 Report, "*Crossing the Quality Chasm – A New Health System for the 21st 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 information technology. Since then, numerous studies and other policy experts have confirmed that full adoption and utilization of HIT has the potential to result in major gains in health care quality of care and patient safety.[1] Some studies have also concluded that HIT can achieve very substantial reductions in health care costs.[2] Even skeptics who are less certain about the ability of HIT to lower costs recognize that providing physicians and other clinicians with access to information systems to help them manage and coordinate patient-centered care, especially for patients with multiple chronic diseases, offers the potential of achieving gains in quality and overall savings.[3]
The Congressional Budget Office (CBO) May 2008 paper "Evidence on the Costs and Benefits of Health Information Technology" states that HIT generally refers to the use of computer applications in the practice of medicine. It notes that those applications (including clinical decision support and

[1] DesRoches, Catherine, et al., "Electronic Health Records in Ambulatory Care—A National Survey of Physicians", New England Journal of Medicine, July 3, 2008.
[2] RAND Health, "Health Information Technology: Can HIT Lower Costs and Improve Quality?," Research Highlight, at http://www.rand.org/pubs/research_briefs/RB9136/RAND_RB9136.pdf.
[3] Sidorov, Jaan, "It Ain't Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs," Health Affairs, July/August 2006.

electronic prescribing) can be housed in an electronic health record (EHR).[4] While physicians can use individual HIT applications independent of an EHR, use of an EHR is often used to measure HIT adoption.

Benefits of Health Information Technology

The benefits of HIT that are most often cited are: avoidance of medical mistakes; storage and preservation of medical data; avoidance of medical errors; reductions in malpractice premiums; and improved quality outcomes.[5] We elaborate on each of these benefits below.

- *Medical Mistake Avoidance/Provision of Recommended Care*: 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 by facilitating recommended evidence-based preventive, acute, and chronic care. Examples of this benefit include alerts about vaccinations, anti-coagulation reminders, diabetes, hypertension, thyroid and anemia screening in the elderly, health maintenance and preventive care measures. HIT can also be an important conduit for providing clinicians with unbiased information on the comparative effectiveness, clinical as well as cost, of different treatments, a topic that the ACP has addressed in some detail in a new position paper on comparative effectiveness.
- *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 that can be difficult to duplicate from memory. In addition, when patients become incapacitated, storage of the data can be critical.
- *Medication Error Avoidance*: The use of electronic prescribing (e-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. E-prescribing can also increase appropriate use of generic drugs. We note, however, the e-prescribing systems will be more effective if they are integrated with fully functional electronic health records.
- *Quality Improvement, Patient-Centeredness, and Care Management*: As noted earlier, HIT offers the potential to help physicians improve overall health care quality by having evidence-based clinical decision support at the point of care, generating patient reminders, providing access to more complete information, and reducing drug interactions. It can also have the benefit of preventing unnecessary and duplicative testing, helping patients achieve improvements in their own health care, delivering patient centered services (such as remote monitoring, secure access to email consultations), and reducing fragmentation in health care services that may increase costs and result in poorer outcomes. Further, it can shorten hospital stays or help avoid them altogether. It also enhances the ability of physicians to track and measure the quality of care they provide to their patients.

Status of Physician Health Information Technology Use

Despite the tremendous upside associated with HIT, relatively few physician practices have it—with small practices having the lowest rates. A 2006 review by the Robert Wood Johnson Foundation found that approximately 24% of physicians in ambulatory practice have an EHR, with a solo

[4] Evidence of the Costs and Benefits of Health Information Technology, Congressional Budget Office, May 2008.
[5] Sidorov, Jaan, "It Ain't Necessarily So: The Electronic Health Record and the Unlikely Prospect of Reducing Health Care Costs," Health Affairs, July/August 2006.

physician practice adoption rate of only 13% to 16%.[6] A 2006 ACP member survey demonstrated that practices with five or fewer physicians have a significantly lower EHR adoption rate (18%), than practices with 20 or more physicians (58%).[7] Other studies have shown that while EHR use is rising slowly, adoption by small practices continues to lag.[8]

Barriers to Physician Health Information Technology Use

The barriers to the acquisition and use of HIT, especially for small physician practices, are numerous, with the major obstacles described below.

- *Substantial Cost in Acquiring and Maintaining the Technology*: Depending on the size of the practice and its applications, acquisition costs, on average, $44,000 per physician. The average annual ongoing costs of maintenance and support are about $8,500 per physician.[9] Physicians cite these costs are the largest adoption barrier.[10] In addition, there are costs associated with training and lost productivity. In a 2005 study, 14 small practices implementing a HIT system experienced a decline in revenue because of lost productivity of $7,500 per physician.[11] Collectively, investment and maintenance is a financial commitment that spans the life of the practice. This obstacle is especially acute for physicians in small practices, where three-fourths of all Medicare recipients receive outpatient care.[12]
- *HIT Savings Accrue to Others and Not the Physician Making the Investment*: Public and private payers generally realize the financial benefit associated with HIT use, which can come in the form of a reduction in duplicative or unnecessary care, the avoidance of costly medical errors, a reduction in hospital days, an improvement in quality outcomes, and lower administrative costs.
- *Lack of True Interoperability*: Physicians lack confidence that an EHR will be able to communicate with an information system used by another clinician, hospital, laboratory, or other entity. Manual integration of information from disparate sources requires additional work and prevents full using EHRs to their full capability. This situation discourages EHR adoption.
- *Medicare and Other Payment Systems Generally Incentivize Volume over Quality*: Paying physicians on a per-procedure or per-service basis encourages volume and actually may act as a disincentive to acquire information systems that can result in the more efficient provision of services. For example, a physician receives less financial compensation if he or she refrains from conducting a test known to be duplicative because of HIT. Medicare payment policies for the most part are, at best, neutral on acquisition and use of HIT, except for some limited reporting of "structural" measures in the Physician Quality Reporting Initiative

[6] The Robert Wood Johnson Foundation (2006), Health Information Technology in the United States: The Information Base of Progress, chapter 3, p. 26.
[7] American College of Physicians, E-Health and Its Impact on Medical Practice. Philadelphia: American College of Physicians; 2008: Position Paper.
[8] 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.
[9] 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.
[10] DesRoches, Catherine, et al., "Electronic Health Records in Ambulatory Care—A National Survey of Physicians", New England Journal of Medicine, July 3, 2008.
[11] 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.
[12] Center for Studying Health System Change, "Most Medicare Outpatient Visits Are to Physicians With Limited Clinical Information Technology," July 2005.

(PQRI) and several Medicare demonstration projects that provide reimbursement incentives for HIT. Medicare also systematically undervalues primary care services, making it particularly difficult for primary care doctors whose practices may be struggling and near the breaking point to spend the money needed to acquire HIT.

- *Uncertainty Surrounding Medicare Physician Payments*: The flawed mechanism for updating Medicare payments to physicians, the Sustainable Growth Rate (SGR) system, is a complicating factor. The system—and its need to be perpetually corrected, makes planning for significant practice investment a challenge. We appreciate the congressional action, despite the budget challenge and other obstacles, to avert what would have been a devastating 10.6% across-the-board cut in physician payments that was set to begin on July 1, 2008 and substituting the additional 5.4% cut slated for 2009 with a 1.1% increase. This action provides some stability and buys time to fashion a long-term legislative solution. The relatively modest increase, especially considering rising practice costs, and the uncertainty regarding payment updates beyond 2009 make it difficult for practices to make the investment in EHR and other HIT. ACP also recognizes and appreciates that the Children's Health and Medicare Protection (CHAMP) Act—reported out of the Ways and Means Committee, with the support and leadership of Chairman Stark, and that passed the House of Representatives in 2007—would have provided further relief from the SGR cuts and improved payments for primary care services had it become law.

In sum, for many physicians, the business case to invest in EHR/HIT simply does not exist. Even so, there are physicians who have become early adopters even though the economic case for doing so is poor.

I have had an EHR in my own medium-sized practice for the past two years and have been writing prescriptions electronically for the past five. I made this investment because I felt it was in the best interests of my patients, even thought it was not necessarily in the best interest of my practice's "bottom line." But, I fully understand why so many of my colleagues have deferred making such an investment given the poor business case to support it and the lack of any reimbursement incentives for doing so.

The Need for Congressional Involvement

The complex issues surrounding financing, assistance with redesign of practice workflow, and ongoing technical support and training must be recognized and addressed for the goal of widespread adoption and use HIT to be realized. ACP strongly believes that the Congress has an important role to play in overcoming the challenges posed by these issues, particularly pertaining to physicians in small practices.

Both Medicare and the private sector have recently provided some incentives to facilitate HIT adoption and use. Unfortunately, the programs are limited to far too few physicians. These experiences do, however, demonstrate physician interest and provide reasonable assurance the physicians will respond to adequate incentives. This should provide Congress with a level of comfort that physicians will use incentives if they are made available to more physicians.

The Bridges to Excellence (BTE) program that encourage practices to maintain structural capability, including HIT components, aimed at improving patient care provides an example of physician practices responding to financial incentives. BTE is a coalition that encourages leaps in quality of care by recognizing and rewarding health care providers who demonstrate that they provide safe, effective, efficient, and patient-centered care. The BTE program pays physicians who are recognized

under the National Committee for Quality Assurance (NCQA) Physician Practice Connections Physicians Office Link (PPC-POL) program as having the systems to improve care up to $50 per patient per year. Over 1,500 physicians are recognized through the NCQA PPC program, with an average practice size of 5 physicians. This shows that small physician practices are responsive when financial incentives are aligned with the transition to this type of care.

Beginning January 2008, BTE started to make bonus payments to practices in eligible areas that earn NCQA PPC-POL or PPC Patient Centered Medical Home (PPC-PCMH) recognition, plus the required recognition for other condition-specific modules (e.g. diabetes, heart/stroke). This is evidence of the growing interest of the PCMH and the willingness of the private sector to provide incentives to encourage practices to pursue PCMH recognition.

Recommended Financial and Other Incentives

Many physicians' small practices will be unable to acquire and use HIT without sufficient financial assistance from the federal government. Leaving behind these practices, from which the majority of Medicare beneficiaries receive their care, will prevent the goal of widespread use of fully integrated technology from becoming a reality.

We caution Congress, though, against trying to mandate HIT use, especially given the lack of financial incentives to help practices. For many small practices, an unfunded mandate to acquire and use HIT could literally put them out of business. It is also does not make sense to mandate HIT given that issues relating to interoperability, standards, and functionality have yet to be fully resolved. Mandates are not sensitive to differences in practice resources, patient case mix, staffing ratios, geographic locations, ownership, and a myriad of other factors that will affect the ability of practices to acquire and use HIT. A practice that is part of a large academic system, large group practice, or owned by a hospital is very different from a small physician-owned practice.

We instead recommend that Congress establish targeted financial incentives aimed at facilitating HIT in small practices. Specifically, ACP recommends that the Congress take the steps below to provide the financial incentives necessary to facilitate widespread HIT adoption and use.

- *Establish an Add-on Payment for Evaluation and Management Services*: The College recommends establishing an add-on code for office visits and other evaluation and management (E/M) services when the visit is supported by qualified HIT systems. The payment mechanism should make it possible for the physician to report that the E/M service was supported by HIT. The amount of the add-on should relate to the complexity of HIT adopted by the practice. For example, Medicare could establish three levels or tiers of HIT adoption, similar to the NCQA PPC-POL module. The level of the add-on then would depend not only on whether the physician had the information systems in their office, but how those systems are used to improve patient care. A practice that had only a simple stand-alone e-prescribing system and patient registry would be paid less than one that had a fully functional EHR with e-prescribing, patient reminders, clinical decision support at the point of care, and the ability to measure and report on clinical performance measures imbedded in the system.
- *Include Reporting of Structural HIT Measures in Quality Reporting Programs*: Medicare should reward physicians who incorporate either some or all aspects of HIT and participate in reporting on endorsed quality measures as part of the PQRI. We note that the PQRI currently includes a small number of structural measures, and beginning in 2009, Medicare will begin

- *Pay Physicians a Care Coordination Fee if they Acquire and Use the Information Systems Needed to Function as a PCMH and Regularly Report on their Performance.* The ACP recommendations on the PCMH are discussed in depth later in this testimony.
- *Assist Small Physician Practices with the Initial Investment to Acquire HIT*: Congress should make available grants, loans, and/or tax credits to help practices currently least able to purchase the necessary HIT hardware and software. ACP notes, however, that the impact of these incentives is limited absent changes in Medicare payment policies to create incentives for HIT use.
- *Ensure Clear Guidance on the "Safe harbor" Exception to the Self-referral Prohibition*: The law allows hospitals and other entities to assist physicians in acquiring HIT. The CBO May 2008 paper, "Evidence on the Costs and benefits of Health Information Technology", notes that three federal agencies are establishing rules related to this safe harbor and the lack of present clarity can be an impediment to HIT expansion.
- *Explore Mechanisms to Assist Practices in Implementing HIT*: Physicians face significant challenges in selecting, integrating, and optimizing HIT. 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, includes questions about EHR use. While the NAMCS found nearly 24% of physicians using EHRs, further analysis determined that only 9% are using an EHR with at least the four key functionalities identified by the IOM.[13] Congress should facilitate resources that provide support throughout the HIT implementation continuum that will make selection less daunting, minimize productivity throughout implementation, and result in optimal use. The College urges Congress to review the recommendations/options in the October 2007 "eHealth Initiative Blueprint: Building Consensus for Common Action," which is available at http://www.ehealthinitiative.org/blueprint/eHiBlueprint-BuildingConsensusForCommonAction.pdf.
- *Support the Establishment of Standards to Facilitate Interoperability and Reporting Quality Data*: ACP strongly supports efforts by those in the Administration and the Congress to speed the adoption of uniform standards for HIT. In order to oversee the ten-year initiative to achieve widespread adoption of EHRs that President Bush announced in 2004, the Administration created the Office of National Coordinator for Health Information Technology (ONC). ONC and related initiatives are working toward establishing the standards necessary to provide physicians with confidence that their investment in HIT will be supported by sustainable processes and infrastructure that enable them to use HIT to the optimal benefit of the patient and system efficiency.
- *Support for Information Exchange Projects that Promote Interoperability*: Congressional support for state and regional health information exchange efforts will move toward the true interoperability needed for physicians to use EHR products to their maximum potential and to achieve the greatest benefit to the health care system.

Patient Centered Medical Home as a Means to Facilitate HIT and its Associated Goals

ACP, like many others, believes that use of HIT alone will not enable the health care system to deliver improved quality in a way that maintains or lowers costs to its full potential. The College believes that HIT in the context of a Patient Centered Medical Home will yield the greatest benefit. ACP worked with the American Academy of Family Physicians (AAFP), the American Academy of

[13] Institute of Medicine, "Key Components of an Electronic Health Record System: Letter Report," July 2003.

Pediatrics (AAP), and the American Osteopathic Association (AOA) to jointly establish principles that define the PCMH. The PCMH is a delivery model that involves a patient with a relationship with a personal physician who works with a practice team to provide first contact, whole-person, continuous care. The PCMH model 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. A PCMH practice must demonstrate that it has the infrastructure and capability to provide care consistent with the patient's needs and preferences. The PCMH joint principles call for enhanced payment to support the practice transformation and increased value to the patient and the health care system.

ACP, AAFP, AAP, and AOA, as the four organizations that represent a significant number of primary care physicians, worked with the National Committee on Quality Assurance (NCQA) to establish an independent process by which physician practices can be recognized as a PCMH. The NCQA established process, the Physician Practice Connections-PCMH (PPC-PCMH) module, requires practices to meet core requirements and attain a minimum score to be recognized as a medical home. Practices that meet these core requirements and achieve at or above the minimum total score are identified as one of three progressive levels of PCMH. The highest level of medical home, a Tier 3 PCMH, is generally associated with the greater use of HIT.

Having a process by which an independent, third-party determines whether a physician practice is a PCMH is one reason why the model has gained considerable traction over the past few years. Assurance that practices are transforming to meet the full needs of patients has contributed to the decision of many employers, health plans, consumer organizations, policymakers, and other health care stakeholders to embrace the model. It is our understanding that CMS intends to use a recognition process to identify the medical home practices that participate in the Medicare medical home demonstration project authorized by Congress in 2006 and enhanced through the Medicare legislation that become law earlier this month.

In its June 2008 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that it establish a robust PCMH pilot project that focuses on practices that use significant HIT.

We appreciate the Congress's support of the PCMH and urge it to consider additional payment reforms that incentivize the adoption and use of HIT in the context of the PCMH. We specifically recommend that Congress:

- *Provide Additional Funding to the Centers for Medicare and Medicaid Services (CMS) to Expand the Medicare Medical Home Demonstration to More Practices and States.* ACP appreciates the $100 million in increased funding for the Medicare Medical Home Demonstration that was included in H.R. 6331 but believe that even higher funding levels would enable the PCMH model to be expanded nationwide and evaluated as a national pilot rather than a limited demonstration project. We also believe that Congress should consider working from the medical home demonstration language and funding that was in the CHAMP Act as a basis for expanding the model into a national pilot. ACP cautions the Subcommittee, however, not to delay the existing demonstration even as it considers additional legislation to expand and test the PCMH on a national scale.
- *Require that the Secretary Transition to a New Payment Methodology for Qualified PCMH, should the Medicare Medical Home Demonstration be Successful in Improving Quality or Achieving Savings or Both*: The alternative PCMH payment structure should pay PCMH recognized practices, including practices recognized through the NCQA PPC-PCMH

    - Prospective, risk-adjusted per beneficiary per month PCMH fee for each beneficiary that chooses that practice as their PCMH to cover the work and practice expenses involved in providing care consistent with the PCMH model (e.g. increased access, care coordination, disease population management and education) that are not currently covered under the Medicare Physician Fee Schedule. Such prospective, risk-adjusted per beneficiary payment should be set at a level and magnitude that is sufficient to support the acquisition, use and maintenance of clinical information systems needed to qualify as a PCMH and that have been shown to facilitate improved outcomes through care coordination.
    - The Secretary should consider the impact of qualified PCMHs on reducing preventable hospital admissions, duplicate testing, medication errors and drug interactions, and other savings in Medicare Parts A, B (including Part B services not included in the Medicare Physician Fee Schedule) and apply a portion of the aggregate estimate of such savings to determining the aggregate amount of payment for the PCMH fees that would then be provided to qualified practices. Should aggregate actual savings after three years be higher than the estimate, the Secretary should apply a portion of such additional aggregate savings to fund the PCMH fee.
    - Performance-based bonus fee determined by meeting specified clinical, patient satisfaction and efficiency benchmarks.
    - Continued fee-for-service payment for evaluation and management services.
- *Require Separate Medicare Payment for Designated Primary Care Services and Services and Capabilities that Promote Patient-centered Care:* Congress should mandate that the Secretary pay for care coordination services provided by a primary or principal care physician to a beneficiary. Medicare should make separate payment for a comprehensive care coordination service described in a yet-to-be-defined procedure code(s). Medicare should also make separate payment for discrete services defined by existing procedure codes that describe a clinical interaction with a beneficiary that is inherent to care coordination, including interactions outside a face-to-face encounter. These services should include:
    - Care plan oversight;
    - Evaluation and management provided by phone;
    - Evaluation and management provided using internet resources;
    - Collection and review of physiologic data, such as from a remote monitoring device;
    - Education and training for patient self management;
    - Anticoagulation management services; and
    - Current or future services as determined appropriate by the Secretary.

Estimating Savings from HIT Use and Other Promising Projects

ACP believes that much of the additional expense involved in funding the financial incentives it recommends in this statement can be covered by the anticipated savings that the improved care can generate. Congress should develop a mechanism to assess the system-wide savings that HIT and other innovative delivery and payment reforms, such as the PCMH, that aim to improve quality generate. Savings can be used to help fund Medicare's assistance to physicians with initial HIT investment and on-going maintenance.

In addition, we are encouraged that the Department of Health and Human Services is in the process of assessing the system-wide savings expected to be generated through the EHR demonstration

project and the Medicare medical home demonstration project. HHS intends to fund the enhanced payments to physicians participating in the EHR demonstration project through the system-wide savings that it expects it to generate. HHS is determining the savings it expects the improved interventions that result from the Medicare medical home demonstration project will generate. It will use the expected savings to fund payments to individual physicians in PCMH practices for the enhanced services they provided to better coordinate patient care. Congress should monitor these important efforts to assess the impact of HIT and other promising reforms across the entire Medicare program, as opposed to the historical tendency to assess changes within individual components of the Medicare program.

We are troubled, however, by the CBO view, expressed in its May 2008 paper, that HIT will not likely reduce overall health care spending and that incentives may actually increase spending in the absence of mandates. This position goes against the views of many other experts who believe that HIT, especially if used to support patient-centered care coordination by primary care physicians, can improve quality and achieve efficiencies that decreases overall spending. The CBO position may itself become one of the greatest barriers to HIT adoption if it results in Congress being unwilling to provide the financial incentives needed to support HIT.

We also note that most other industrialized nations have decided that it is necessary and appropriate to make large public investments in HIT. ACP recently published a position paper in the College's peer-reviewed journal, the *Annals of Internal Medicare*, that compared the United States' health care system with those of other industrialized countries. Citing data from the Commonwealth Fund and other sources, the paper found that compared with countries with well-performing health care systems, the United States lags seriously in the implementation of EHR systems in office practice. Compared with primary care doctors in six other countries, U.S. physicians are among the least likely to have extensive clinical information systems. In 2006, nearly all primary care doctors in the Netherlands (98%), and 79% to 92% of doctors in Australia, New Zealand, and the United Kingdom, have EHR systems, while the rate was only 28% in the United States (and 23% in Canada). Most doctors in countries with high rates of EHR systems routinely use them to electronically order tests, prescribe medications, and access patients' test results. Compared with doctors in the U.S. doctors in these countries are more likely to receive computerized alerts about potential problems concerning drug dosages and interactions, have reminder systems to notify patients about preventive or follow-up care, and (except for the Netherlands) receive prompts to provide patients with test results. More than 60% of the doctors in the four countries with high EMR use, as well as those in Germany (where 42% have EMR systems), say it is easy to generate lists of patients by diagnosis or health risk; in contrast, only 37% of U.S. doctors say it is easy, and 60% say it is somewhat difficult or worse to generate such lists. Likewise, doctors in countries with high rates of EMR systems are two-to-four times as likely to say it is easy to generate lists of patients who are due or overdue for tests or preventive care; only 20% of doctors in the United States report that it is easy.[14]

Privacy and Security Concerns

ACP recognizes that patients have a basic fundamental right to privacy that includes the information contained in their own medical records—whether in electronic or paper form. ACP has long recognized the need for appropriate safeguards to protect the privacy and security of patient data. Trust and respect are the cornerstones of the patient-physician relationship and are key to quality

[14] "Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries," ACP position paper, *Annals of Internal Medicine*, January 2008.

health care. Patients who trust their physician are more like to fully participate in their treatment and comply with their care plan.

We strongly believe that physicians—already governed by strict ethical codes of conduct, state professional disciplinary codes, and the Hippocratic oath—have a duty and responsibility to protect patient 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. While physicians must have access to clinically relevant information to safely and effectively treat patients, patients must have assurances that adequate firewalls against unauthorized individuals gaining access to sensitive data are in place. Congress must ensure these safeguards are present.

Conclusion

The barriers to HIT adoption in physician practices can best be overcome by building financial incentives into Medicare and other programs. Supporting small practices with their initial acquisition costs and including an add-on payment for services documented and facilitate by an EHR will provide an infusion of funding that small practices need to invest in and maintain HIT. It also sends a signal that the federal government is committed to facilitating this goal. Financial incentives to facilitate the promising PCMH delivery model provide a mechanism to further HIT adoption and use in the context of an improved delivery system that further achieves these goals. PCMH practice recognition that is inherent in the model provides assurance that the practice has acquired and uses HIT in an optimal manner. Collecting, analyzing, using, and reporting how care compares to vetted measures of clinical quality is also inherent in the PCMH model.

ACP is pleased that the House Committee on Ways and Means Health Subcommittee on Health is examining the issues pertaining to HIT option and use. We strongly believe Congress has a very important role in promoting HIT adoption and providing the necessary initial and ongoing funding mechanisms to assist small physician practices. The benefits of full-scale adoption of interoperable HIT will be significant, leading to a higher standard of quality in the health care system. Unfortunately, without adequate financial incentives, small physician practices will be left behind the technological curve and their patients with them.

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