BEFORE THE

HOUSE SMALL BUSINESS SUBCOMMITTEE ON REGULATORY REFORM AND OVERSIGHT

"CAN SMALL HEALTHCARE GROUPS FEASIBLY ADOPT ELECTRONIC MEDICAL RECORDS TECHNOLOGY?"

PRESENTED BY

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Mr. Chairman, fellow AAFP member Rep. Christensen, and members of the subcommittee, thank you for the opportunity to provide testimony today on implementing an electronic health record system (EHR) in a small family practice. I am Dr. Christopher Normile and I am a partner in a two-physician practice in St. Charles, Missouri.

I am also a member of the American Academy of Family Physicians (AAFP), one of the largest national medical organizations, with more than 94,000 members. AAFP has over 57,000 members in active practice, the vast majority of whom serve in small and medium size practices - effectively small businesses. Your subcommittee's concern for physician practices is well placed. As small businesses, family physicians have a significant economic impact on their communities. The average economic impact of one family physician office in a rural area is $1.2 million; for urban areas direct and indirect impact for a family physician office, approaches a million dollars a year. But our impact is greater than economic since family physician offices are where most people first encounter the health care system. Nearly a quarter of all physician office visits each year are made to general internists and family physicians. That translates to 215 million office visits each year.

As a physician, my mission is to serve my patient. But in order to continue that mission, I also need to function as a businessman. The business of caring for patients is unique, in both the services we provide and how we are paid for those services. From federal reimbursement rates, which are not keeping up with the cost of providing care, to a variety of different insurance plans with a variety of different rates, a family physician's office is deluged with information. As payment complexity grows and patient visits increase, technology will play a greater role in office efficiency and quality of care. AAFP views EHRs as part of a larger practice redesign that will allow family physicians to integrate patient care and provide for ongoing quality improvement at the practice level.

Family physicians are leading the transition to EHR systems in large part due to the efforts of AAFP's Center for Health Information Technology. The Center was established to increase the availability and use of low-cost, standards-based information technology among family physicians. To complement its educational mission, the Center provides interactive tools including a readiness assessment, physician product review, and an e-mail discussion list. As a result, over 30 percent of AAFP's members have adopted EHR in their practice.

I have been using an EHR in my own practice for over 2 years now. My partner and I had, until January 2003, been employed by a hospital group. We decided that we wanted to regain control of our own destinies and left to form our own business. We were impressed by the powerful tools coming available at the time and we believed a computerized medical record system would increase the efficiency and quality of patient care and the management of our business.

Let me give you a glimpse of how the EHR affects my practice. My day begins by electronically synchronizing my laptop with the server to transfer to the office system

work I have done at home, phone calls returned, and notes I've taken. I then log on to my internet connection to our local hospital to check the condition of patients I have there. I review labs and phone messages my staff has received, sending my response with a tap of my pen. I then carry my laptop with me as I see patients, making notes as I take histories, printing or faxing prescriptions and orders. After office hours, I dictate more complicated information, which is immediately transcribed by my voice recognition software.

In the near future we will be communicating with patients electronically, although this will be another expense we will have to absorb. Currently, time I set aside for an electronic communication with a patient, whether it is to answer a question, check on compliance, or send information is gratis. We cannot be reimbursed by insurance or by Medicare, even if this electronic consultation is done in lieu of an office visit. Recognizing the value of ongoing communication and compensating the physician for *all* the time involved in caring for a patient will be an integral part of accelerating this technology.

EHR Adoption

Of AAFP members that use EHR systems, 78 percent would recommend such a system to a colleague and nearly 80 percent believe these systems improve the health of their patients.

Indeed we have seen many improvements in my office. We no longer see stacks of charts and papers everywhere. Nor must we employ a person to keep them in order and to fetch them for us when we need them. Now, if a doctor calls to discuss a patient I have all the information immediately at my fingertips. Drug interactions are analyzed with the click of a button. Prescriptions are faxed directly to the pharmacy from the patient's room, and *they are legible.* I can easily consult information sources on the Internet while the patient is in front of me, providing her or him with an opportunity to ask questions without needing to schedule another office visit. It is easy to manage a diabetic patient's course of treatment and manage care of chronically ill patients *and* to keep track of our results for quality improvement. We have saved thousands of dollars monthly by limiting our use of a transcriptionist and now have powerful tools to analyze our business. Billing accuracy and speed of reimbursement have also significantly improved.

Cost of Implementation

Technology does not come cheap, however. Among AAFP members not utilizing an EHR, over half cite affordability as the primary barrier to adoption. The cost of implementing an EHR system can range from $5000 to more than $50,000, per physician with the largest percentage – 25 percent – falling between $10,000 and $20,000 per physician. The system I use in my practice in Missouri cost $50,000 and annual maintenance costs, including software upgrades, total an additional $10,000.

In addition to the upfront investment, I have learned this tool is something of a double-edged sword. One of my goals was to get my paperwork and dictations done more efficiently, to allow me to get home to my family at a reasonable hour. This just hasn't occurred. In fact, I now spend more time at the office than ever. Data still must be entered into the chart, and currently it still takes longer than dictating. The costs of my time have been immense.

Those of you who hate setting the clock on your VCR can't even imagine the complexity of installing and using the hardware and software required to run an already complex business. Because of dwindling third party reimbursement, especially in our local market which is dominated by a few powerful insurers, as well as continued increases in the cost of doing business, we have found ourselves with progressively shrinking incomes. Because I pushed for the purchase of this system, its upkeep has fallen upon me. We simply cannot afford to pay consultants or new staff to manage any but the most complicated of problems. Computer consultants charge about $150 an hour for their services. Currently, that is more than 3 times my hourly income - 5 times more when you calculate the time involved with paperwork and phone calls.

If a laptop breaks down, we try to scavenge parts from another laptop that previously crashed. It takes an incredible amount of time to research the available hardware and software options on the market. When we first started using our system we had to reduce the number of patients we could see while we learned to use it. It took months before we were up to normal speed.

In a Commonwealth Fund case study dedicated to EHRs in small and solo group practices, initial EHR costs averaged $44,000 per year for a full time health care provider; ongoing annual costs averaged $8,500 or 19 percent per year. Software, training, and installation costs averaged $22,038. The actual cost for the twelve practices studied ranged from $37,056 to $63,600. Revenue losses from reduced visits during training and implementation averaged $7,473 per physician, ranging from none, in practices already technologically savvy, to $20,000 per physician. The return on investment ranges from two and half years to more than 9 years – and counting - for one practice.

These divergent ranges demonstrate one of the difficulties in implementing these systems. There is little transparency in the marketplace, which makes assessing risk more difficult. As these systems become more widely adopted, costs will eventually decrease. But in order to accelerate adoption, AAFP recommends that Congress works to provide financial incentives for small to medium-sized practices, establish federal standards of interoperability, and support technical assistance programs to help small practices through the cycle of selecting, implementing and redesigning their clinical workflow.

Again thank you for this opportunity, I would be happy to answer any questions you may have.