American Academy of Family Physicians
Statement for the Record
Subcommittee on Government Management, Organization and Procurement "Too Many Cooks? Coordinating Federal and State Health IT"
November 1, 2007

On behalf of the 93,800 members of the American Academy of Family Physicians, we are pleased to submit this statement for the record for the November 1, 2007 hearing entitled "Too Many Cooks? Coordinating Federal and State Health IT." We support your desire to target federal resources to reduce health disparities using health information technology (HIT).

The American Academy of Family Physicians was one of the first medical societies to realize the importance of HIT in the American health care system and is extremely proud of our activities in this area. The AAFP established CHIT was established in 2003 because we realized family physicians' adoption of HIT was essential to improving the quality, safety and efficiency of medical practice. This mission extends to people in rural and urban underserved communities where many of our physicians practice. In addition to educating our members and the larger health community about HIT, we work aggressively with vendors to offer favorable terms to physicians to allow them to purchase these systems through our Partners for Patients Program. Right now, 50 percent of our members in active medical practice are either in the process of implementing an electronic health record (EHR) or have a fully implemented system. Our future goals include a focus on continuing to increase the percentage of members adopting EHRs and to assist physicians that have adopted them to optimize their use of the technology.

The AAFP has reviewed your draft outline of a bill to use HIT to improve health outcomes and reduce health disparities in underserved communities. From this draft, our impression is that the legislation is entirely consistent with the Academy's policies and we would be delighted to work with you on finalizing your proposal.

Furthermore, in our opinion the acquisition and use of health information technology envisioned by your bill are realistic and can be accomplished in a relatively short period of time, given the appropriate know-how and experience to match the resources. Electronic medical records that are affordable, interoperable, and capable of addressing some of the issues that contribute to health and health care disparities are available on the market today. And, although the transformation from paper systems to computerized health information management is not easy by any stretch of the imagination, we have seen directly that it can be accomplished smoothly and with minimum disruption of the practice, even in rural and urban community health centers and private practices in underserved or disadvantaged communities.

We believe it is very important to focus attention on providing continuity of care through continuity of information and data flows with these computerized systems. EHRs and other information technology used in medical practices should be able to read, import and export a core set of most relevant data about a patient – such as demographics, a problem and diagnosis list, medication list, allergies, and immunizations – and store these data securely on the Web, where they can be accessed by the right people, at the right time, to help make the right decisions and avoid errors and wasted resources.

The Academy has led in the development of the Continuity of Care Record (CCR) standard, which offers this basic level of interoperability for computerized medical records, and which any community can adopt and deploy without incurring large costs or having to build complex new data exchange organizations.

We join with the Institute of Medicine in encouraging federal funding for health care providers to purchase HIT systems. According to the US Department of Health & Human Services, billions of dollars would be saved each year with the wide-spread adoption of these systems. Use of HIT also aids in reducing errors and allows for ongoing care assessment and quality improvement in the practice setting.

AAFP Policy on HIT

The AAFP recently created and updated new policy around health information technology (HIT) whose emphasis is on "data fluidity," that is, ensuring that data flows freely and unimpeded throughout the entire health care system. Your outline's emphasis on the federal government helping to "connect health resources" within medically-underserved communities seems to be consistent with this policy.

Our belief, however, is that the federal government must switch its current emphasis from a focus on hospitals and large enterprises to one that helps networks of small and medium-sized physician practices acquire affordable and interoperable HIT systems. We need to link these offices so that primary care physicians, specialist physicians, pharmacists, and hospitals can communicate, locally as well as across the globe, to provide integrated, coordinated, quality care for all patients.

When HIT was in its infancy, it seemed simple and efficient for the federal government to support large entities and hospitals with grant funding to encourage the adoption of HIT. The current governmental approach has tended to support large enterprises and their HIT vendors in efforts to build large-scale, complex systems, such as Regional Health Information Organizations (RHIOs). These coalitions, most often led by hospitals or large enterprises, have received federal dollars to integrate health information in a single area. However, regional solutions may or may not be transferable to another venue, do not reach the majority of U.S. communities, and are proving to be economically unsustainable.

The problem with continuing this approach, however, is that most health care in America does not take place in hospitals or large enterprises: it takes place in doctors' offices and, specifically, in primary care practices with five or fewer physicians or other clinicians.

For example, nearly half of all ambulatory care visits in the U.S. are made to family physicians, pediatricians, and general internists in the outpatient setting: *over 400 million visits each year.* As the need for practical HIT systems in the US becomes more urgent, we need federal support that builds on and provides incentives for current private sector initiatives.

We will not improve health care in America if federal dollars only empower large enterprises -- at great cost and complexity -- to communicate with other big institutions, while doctors and patients in tens of thousands of local community practices and clinics cannot access and share information for the good of their patients.

Specific Comments on Draft HIT Outlines

<u>Focus on Solo and Small Practices</u>

We urge you to include provisions in your legislation to ensure that individual physicians and small practices are the focus, rather than large health facilities, for the reasons noted above.

Target Federal Dollars to Support Physicians Who Are Serving the Underserved

Our new policy states that any specific payments to physicians to purchase HIT systems should go to those serving in underserved areas where the capital to purchase electronic health records is hardest to obtain and practices may be small or medium-sized. These payments should not go through third-parties such as hospitals, integrated health systems, or health plans, but directly to clinics and practices based on financial need. While not all of our physicians work in underserved areas, we want to support those members who do.

Section 102 of your draft outline, which provides grants for "technical support, promotion and support of planning and adoption of health information technology" is entirely consistent with our view that underserved communities need greater assistance to be successful. In an HHS-supported EHR Pilot Project conducted by the AAFP, we learned that practices with a well-defined implementation plan and analysis of workflow and processes had greater success in implementing an EHR. The Center for Health Information Technology used this information to develop a practice assessment tool on its Web site, allowing physicians to assess their readiness for EHRs. These are the sorts of tools that would help underserved communities be successful in their adoption of HIT.

In addition, we believe that any grant process should be as streamlined as possible. As you know, individual physicians, small practices and even community health centers in underserved communities do not have the time or expertise to write complicated grant proposals. A simple requirement, e.g., financial need or location in a medically-underserved are may be all that should be required for access to these grants.

In addition, we urge you to recommend special payments for physicians who can demonstrate the use of EHRs and other HIT as a way to improve and coordinate care. Current reimbursement methods tied to face-to-face visits discourage the efficiencies gained by the use of EHRs, for example, asynchronous communication with patients using secure email and web-based consultations. Reimbursement strategies must change to reward quality and efficiency enabled by HIT. This does not mean, however, that we would take dollars away from physicians who are not yet using EHRs.

Role of Federal Agencies

Your draft outline's emphasis on expanding activities within the Agency for Healthcare, Research and Quality, the Health Resources and Services Administration, Office of Minority Health, Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention to focus on HIT and health disparities within urban and rural medically underserved communities seems to be a reasonable way to encourage consistency of purpose throughout these agencies. If the goal is to make it easier for underserved communities to use HIT, then all relevant federal agencies should be required to have activities that support this end. (Sections 103, 104, 106, 107.)

Health Information Technology Empowerment Zones

Section 108 of your draft outlines gives the Secretary of Health and Human Services authority to designate "Health Information Technology Empowerment Zones" to assist states in reducing health disparities and improve health outcomes by using HIT.

The establishment of HIT empowerment zones should be to direct resources into those communities that need assistance and not dictate a particular solution, such as a community RHIO. Instead, the empowerment zone should allow the community to establish the HIT infrastructure needed to support the underserved individuals and the physicians that provide their care.

We have seen the private sector, including individual physicians in community practices, hospitals, health plans, and large employers, as well as a growing number of American consumers, start a rapidly-growing market for interoperable electronic health records, personal health records (PHRs), and health data exchange technology that is scalable, does not require multi-million dollar federal investments in new enterprises, nor require purchase of proprietary and possibly redundant local "infrastructures." The results have been exciting: most of the progress towards health information technology adoption, as well as the portability and interoperability of health data, is due to this research and experimentation in the private sector.

Other Recommendations

Standards

In addition, as you work on your legislation, we urge you to apply longstanding industry standards of portability and Interoperability to HIT. Personal health information can be discovered, acted upon, and managed in much the same way as in the banking, financial services and global e-commerce industries, which have operated electronically for years. Longstanding standards and protocols have proved their effectiveness in secure data transport and interoperability over public networks, notably the Internet.

Ensure Privacy Protections for Patients

The AAFP believes the right to privacy is personal and fundamental, and protections for this privacy ought to apply to all parties who wish to become custodians of personal health information, not merely to those entities covered under HIPAA. Patients should have a right of access to, and correction of, medical records in electronic formats that are familiar and easy to use with today's desktop computing tools. AAFP understands there are rare cases in which full and direct disclosure to the patient might be harmful and in those cases, special exceptions should apply.

Patient-Centered Medical Home

Finally, I cannot speak about HIT without mentioning the Patient-Centered Medical Home, a proven model in health care delivery that the AAFP has proposed along with the American College of Physicians, the American Academy of Pediatrics and the American Osteopathic Association.

I emphasize the medical home since it is predicated on the presence of health information technology, i.e., the electronic health record, in the physician's office. In this new model, the traditional doctor's office is transformed into the central point for Americans to organize and coordinate their health care, based on their needs and priorities.

At its core is an ongoing partnership between each person and a specially-trained primary care physician. This new model provides modern conveniences, like email communication and same-day appointments; quality ratings and pricing information; and secure online tools to help consumers manage their health information, review the latest medical findings and make informed decisions. Consumers receive reminders about necessary appointments and screenings, as well as other support to help them and their families manage chronic conditions such as diabetes or heart disease.

The primary care physician helps each person assemble a team when he or she needs specialists and other health care providers such as nutritionists and physical trainers. The consumer decides who is on his or her team and the primary care physician makes sure they are working together to meet all of the patient's needs in an integrated, "whole person" fashion.

This is an improved way to approach health care based on a proven model. In fact, the Patient-Centered Medical Home (PC-MH) will be recognized by an independent organization so that payers can be assured that their small investment in this model of care delivery will result in a higher standard of care.

Medical Homes Diminish Health Care Disparities

Finally, of interest to members of the Subcommittee, in June, 2007, the Commonwealth Fund released a report entitled, *Closing the Divide: How Medical Homes Promote Equity in Health Care,* which made the following statement:

> *The Commonwealth Fund 2006 Health Care Quality Survey finds that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. The results suggest that all providers should take steps to create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients.*

In our view, this report makes a compelling case that a medical home that includes HIT would do much to transform the quality of health care provided to Americans in underserved communities.

Conclusion

The Academy is pleased to work with you on any legislation to improve health care in underserved areas using health information technology and, in particular, suggest projects and pilots that would meet these goals.