

November 9, 2007

The Honorable Hillary Rodham Clinton
United States Senate
476 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Clinton:

The undersigned organizations commend you for your efforts to foster the development and utilization of health information technology (HIT) with S. 1693, the “Wired for Health Care Quality Act.” We share your interest in optimizing the delivery of high quality patient care. We are similarly encouraged by the promise that HIT holds if properly developed and carefully integrated into the existing health care delivery system. It is imperative, however, in achieving these goals to ensure that certain safeguards are met.

Unfortunately, the undersigned organizations feel that key provisions in this bill do not adequately address the essential elements needed to ensure a national HIT network that is functional, interoperable, and adequately addresses barriers to adoption. We welcome, however, the opportunity to continue our dialogue.

In summary, we feel that the following issues must be addressed.

- The bill must ensure that reports generated from limited available data portray an accurate and useful picture of the quality of care provided.
- Quality Measures must be developed through a transparent consensus process, such as the Physician Consortium for Performance Improvement, that involves representatives of national physician and other health professional specialty organizations whose members treat the condition for which measures are being developed.
- The bill must include adequate physician input into standards development and those standards must be tested prior to widespread implementation.
- The bill must demonstrate that adequate measures are currently in place to ensure that patients’ most sensitive health information will be secure and remain private.

- The bill must ensure that adequate and direct funding will be in place to meet the needs of physicians who will bear the financial burden of implementing HIT while other sectors will financially benefit the most from this technology.

To this end, we offer the following comments concerning S. 1693.

Improving the Quality of Health Care

Title III of the bill would provide for public disclosure of federal health care data that would include quality and efficiency measures. This goal is laudable, but it requires a health care reporting infrastructure that has not yet been fully developed.

Adopting quality measures and reporting health care data to the public is an extremely complex undertaking, and legislation to accomplish this must contain adequate safeguards to ensure that any such data is accurate, as well as relevant and helpful to patients. Given the limited value of the available data, many significant issues need to be resolved to implement a valid and fair system that serves its intended purpose. Issues of concern involve, for example, the difficulty in attributing measures to an individual physician given the need for a sufficient patient population and adequate sample size for quality measurement purposes; the ability of quality measures to attribute care to any one physician in a health care system in which patients see multiple physicians in different settings; the ability to risk-adjust measures to prevent unintentional adverse patient selection due to age, health, socioeconomic status, or non-compliance; privacy breaches that could occur in the release of the health care data; and keeping the data collection burden low while maintaining the accuracy of the data. The bill should also require a mechanism to ensure that the data collected and reported is accurate. Moreover, it is critical that physicians have the opportunity for prior review and appeal with regard to any data that is part of the public review process, and physician comments should be included with any publicly reported data. This is necessary to give an accurate and complete picture of what is otherwise only a snapshot and possibly skewed view of patient care.

We also believe that Title III allows the Secretary of HHS too much discretion to develop health care quality measures. It would establish a designated organization to promote the development of quality measures under the Public Health Service Act. While we support this latter goal, we have strong concerns about the Secretary's discretion in developing physician level performance measures. The Secretary and the federal government are not equipped to unilaterally mandate the practice of medicine. Quality measures must be developed through a transparent consensus process, such as the Physician Consortium for Performance Improvement (Consortium) that involves representatives of national physician and other health professional specialty organizations whose members treat the condition for which measures are being developed. These measures must also be endorsed by the appropriate multi-stakeholder organization. Otherwise, there is the significant risk that the measures will not be appropriate or valid for the services that are to be measured, and, therefore, will not be useful to patients or could even harm patients. Further, the physician community has already made significant advances in measure development, and any related legislation must incorporate these advances. The

Consortium has already developed over 200 physician quality measures. We and the Consortium are committed to vetting these measures through consensus endorsement and implementation processes, such as the National Quality Forum (NQF) and AQA. Quality reporting legislation must ensure that these are the measures that will be used in any reporting program, and the Secretary must not have independent discretion to develop or modify these measures.

We recommend that the legislation specify that quality measures must be developed through a transparent consensus process, such as the Consortium, that involves representatives of national physician and other health professional specialty organizations whose members treat the condition for which measures are being developed.

Improving the Interoperability of Health Information Technology

Currently, there are multiple government initiatives involved with HIT including the Certification Commission for Healthcare Information Technology (CCHIT), the Healthcare Information Technology Standards Panel (HITSP), the National Institute of Standards and Technology (NIST), and the federal advisory committee known as the American Health Information Community (AHIC). Title I of the bill includes provisions for a “Partnership for Health Care Improvement” and an “American Health Information Community.” It is critical that the myriad of federal initiatives be coordinated to avoid conflicts and the duplication of efforts.

Appropriate input into the development of mandatory standards for federal health information exchange is essential. Multiple stakeholders must be involved throughout the standard development process, including physicians who are expected to invest most heavily in these systems. While the bill contains provisions which broadly require provider participation within the Partnership and the Community, both entities should incorporate greater physician representation and involvement, especially representation from small medical practices.

Furthermore, standards adopted for use by the federal government will significantly influence private entities. Therefore, a final set of standards for federal use must be agreed upon by all stakeholders and in place prior to the widespread implementation of these standards.

Security, Privacy, and Confidentiality

We strongly caution against the premature requirement for the use of HIT as a means of transferring, storing, and analyzing patient information. While there have been impressive advances in the development of HIT from both a technical and policy perspective, much work remains to be done to ensure that HIT systems have the capability to safeguard patients’ most sensitive health information reliably and securely. It is essential that issues of patient confidentiality and security of health information are adequately addressed prior to the requirement for collection of and electronic exchange of this information.

Moreover, there exists a significant privacy risk to patients and physicians of the release of health care data and such disclosures undermine current concerted efforts to ensure quality health care performance data is available to patient consumers that accurately reflects the quality of care physicians deliver.

Facilitating the Widespread Adoption of Interoperable Health Information Technology

Title II of the bill contains provisions regarding the establishment of grant programs. Adequate funding should be provided to physicians investing in HIT to ensure the success of an undertaking of this magnitude, with due consideration for the constraints already faced by solo or small physician practices, who are already confronting declining reimbursement rates and increasing medical practice costs, and those who practice in rural, inner-city, and medically underserved areas.

The Committee acknowledges in its Report that “many physicians...operate with small financial margins and have difficulty affording modern health information technology systems for use in these clinical settings.” “...A large part of these economic savings will accrue to health insurers and large integrated health care systems, rather than to physicians in office practices or small community hospitals.”

As written, the bill’s provisions for the grant process do not take into account the circumstances of solo or small physician practices. In order to apply and receive grant monies, they would have to complete and submit an application, provide a strategic plan for the implementation of data sharing and interoperability measures, agree to adopt federal health care data standards once HIT standards have been formalized, commit to implement quality measures once measures are formalized and to report to HHS on such measures, agree to report to individuals if identifiable health information has been wrongfully disclosed, demonstrate significant financial need, and agree to provide matching funds (\$1 for each \$3 of federal funds provided under the grant). As written, the process is not well-suited for small medical practices or solo practitioners, who have limited resources. The lengthy, detailed application process described in the bill could deter practitioners from applying for grant monies. We recommend a separate, streamlined grant process for solo and small medical practices.

No single sector should bear the entire financial burden of implementing HIT, especially when so many parties would be benefiting from this technology. However, we question whether the appropriations authorized by this bill will meet the needs of physicians and adequately fund three national grant programs that affect so many stakeholders. Adequate financial incentives and support to assist with the costs of adopting HIT are critical. Adoption should be on a voluntary basis. We recommend a survey of existing cost studies on HIT to determine the optimal, cost-effective approach for this implementation. Finally, we believe that the creation of additional safe harbors to the federal anti-kickback statute for assisting physicians with the adoption of HIT is necessary in order to facilitate wide-spread usage of such technology.

In conclusion, a coherent HIT system that impacts millions of lives must be interoperable, secure, safeguard privacy, and integrate into the typical workflow of diverse medical practices.

We appreciate the opportunity to submit these comments and look forward to working closely with you on developing a national infrastructure that promotes the adoption of HIT.

Sincerely,

American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Facial Plastic & Reconstructive Surgery
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology – Head & Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Gastroenterology
American College of Osteopathic Surgeons
American College of Physicians
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Psychoanalytic Association
American Society for Clinical Pathology
American Society for Therapeutic Radiology and Oncology
American Society of Addiction Medicine
American Society of Cataract & Refractive Surgery
American Society of Plastic Surgeons
American Urological Association
Association of American Medical Colleges
Child Neurology Society
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
Medical Group Management Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery