



May 15, 2008

US House of Representatives
Washington, DC 20201

Dear Representative:

On behalf of the 93,300 members of the American Academy of Family Physicians (AAFP), I am writing to express our support for provisions in pending legislation that would remove barriers to widespread adoption of electronic prescribing. E-prescribing is just one component of AAFP's longstanding efforts to encourage adoption of health information technology (HIT) by family medicine practices. While family physicians make up only 7 percent of the physician workforce, AAFP members are responsible for nearly one quarter of all ambulatory care visits in this country, approximately 220 million patient visits per year. Thus, family medicine has a strong interest in using HIT to provide coordinated, high-quality and safe health care to our patients.

The AAFP has been a leader in health information technology. In fact, the AAFP has facilitated purchase of HIT systems for our members. Nearly 50 percent of our members already have made a significant investment in electronic medical records, far higher than any other medical specialty society. Family physicians want this new technology, and realize it will help improve health care quality and patient safety. Ideally, e-prescribing should be part of an integrated electronic health record, but we recognize that standalone e-prescribing could be a step in this direction.

Unfortunately, the health care industry does not value those physicians who adopt and use health information technology. In other industries when a business invests in innovation that adds value to the consumer, it can increase the price of its products and services; this is not the case for family physicians who have invested in health-IT innovations. E-prescribing saves money for health plans, consumers, and employers and potentially makes money for pharmaceutical companies. It is unfair to mandate that physicians invest in the technology while others reap the benefits of improved health of our patients. What is fair is increased payment for e-prescribing over a period of time to increase adoption; lower costs of software applications; and solidify standards and best

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practices. This would mimic how the market deals with innovation in other industries – increasing costs of products and services that equal the added value of the innovation to consumers while competition brings the costs down over time.

While the AAFP recognizes the importance of e-prescribing, we also are keenly aware of the increasing financial pressures that impact the lives and practices of our members. In the face of declining Medicare reimbursement and escalating business expenses, members inform us that they are working harder for less compensation than ever before. This problem is particularly acute among rural and solo physician practices who operate on tighter margins. More realistic information is needed to determine the direct and indirect costs of e-prescribing systems.

E-prescribing will not work in a vacuum: data must be “liquid” and flow throughout the health care system based on patients’ needs and preferences. It is imperative that large and small physician practices, and chain and community pharmacies, whether urban or rural, all be able to transmit data electronically. It is equally imperative that the disparate information systems, controlled by these entities, exchange not only data, but its meaning. This “interoperability” is crucial to enabling significant quality and safety improvements. Some rural physicians may not only be struggling to survive financially but also struggling to get a cell phone signal or Internet connectivity. We need to ensure that e-prescribing capabilities exist in remote areas before we mandate its use. Additionally, according to the American Health Information Community, 30 percent of pharmacies cannot accept medication orders via e-prescribing. As a result, patients in many rural and underserved areas have no choice of pharmacies.

Currently, e-prescribing of many Drug Enforcement Agency (DEA)-controlled substances is prohibited. This prohibition will not work in a system in which physicians are required to e-prescribe medications. It is far too costly, cumbersome, and unsafe for physicians to maintain two separate records: one for e-prescribed drugs and another for DEA-controlled medications. This prohibition is not rational in today’s electronic world.

In brief, our recommendations for any e-prescribing provisions include the following:

- Financial incentives for physicians to purchase, implement and maintain e-prescribing systems, i.e., software and hardware, in their practices, particularly in light of declining Medicare reimbursement.
- System-wide interoperability of e-prescribing systems to link any and all physician practices and pharmacies, large and small, and to enable a path from stand-alone e-prescribing systems to fully integrated care management systems.
- Inclusion of all drugs, including Drug Enforcement Agency (DEA)-controlled substances, in e-prescribing requirements. This also applies to several state medical boards and legislatures that currently require printed prescriptions for certain medications.
- Recognition of e-prescribing and use of other HIT as a public good and thus equalization of the costs and benefits to all players.

America's family physicians stand ready to move from the prescription pad to the computer screen. Please allow us to do so in a manner that allows us to succeed. We look forward to working with you on this important step toward adoption of HIT by the nation's physicians.

Sincerely,

A handwritten signature in cursive script that reads "Rick Kellerman MD". The signature is written in black ink and is positioned above the printed name.

Rick Kellerman, MD, FAAP
Board Chair