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Health and Technology Subcommittee
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Testimony
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Good morning Madame Chairwoman and distinguished members of the committee, especially Congresswoman Herrera-Beutler who represents my hometown of Olympia, Washington. My name is Sasha Kramer; I am a board-certified dermatologist and I appreciate the opportunity to speak to you today about health information technology (HIT) and the challenges facing physicians surrounding the selection, purchase and implementation of electronic health record (EHR) systems in their practices.

I am a solo practitioner in Olympia where we only have four full-time dermatologists, and one who works part-time, serving the metro area population and beyond, including Lewis and Pacific counties, which have limited access to practicing dermatologists. In addition, I volunteer for the Thurston County Project Access, which provides health services to the uninsured and underinsured populations in Thurston County, Washington. I opened my practice two years ago after four years of working within a larger group practice. I currently employ two and a half employees, see an average of 100-125 patients per week and generate 40-45 percent of my revenue from Medicare and Medicaid patients.

Over two years ago, I purchased an EHR system at a total cost of $41,349. I received $19,964 through a grant funded by the Washington Health Information Collaborative for Health Information Technology. Using business cash reserves, I paid for the remaining amount, totaling $25,385. As a solo practitioner, I was exclusively responsible for the research, selection, and ultimate implementation process of the EHR vendor and system. I spent over eighty hours selecting the vendor that best fit my practice needs. Once my EHR vendor was selected, an additional eighty hours was dedicated to training. During system implementation, my patient volume was dramatically reduced in order to integrate the EHR system into my practice. Initially, I saw one patient per hour so that the office staff and I could learn how to use the new system. It took about four weeks before I was able to return to my normal routine of 4 to 6 patients per hour.

To this point, it may appear that I have a relatively successful story to tell. However, just two years later, I am forced to re-invest in a completely new HIT system. One and a half years after I implemented my original system, I was notified by my software vendor that it had been acquired by another company and that the new vendor's products would not support my current network platform. The new vendor offered a different product, but because of the significant cost and concerns about the company's stability, I am looking at alternative vendors. Currently, I am looking at a new system that will cost in excess of $27,000 with $6,000 in annual charges; all of which must come out of my business cash reserves. It's not just the financial investment; I will again have to take time away from my patients to implement and train my entire practice on this new system. Currently, I am booked for the next five months for new patients; implementing a

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new system will again involve decreasing the number of patients that I can see for several weeks, further straining dermatology access in Thurston County.

Despite these factors, I fully support the infusion of health information technology into physician practices; it is a critical component in improving the health care delivery system and, more importantly, providing optimal patient safety and care. HIT serves as a foundation for efforts to reform the health care delivery system including integrated care models, quality measurement and analysis, payment reform, and improve technology to document and coordinate patient care. My practice and patients benefit from HIT in a number of ways, including the following:

- **Patient Safety and Care** – I have each patient's chart and information with me for each encounter and can accurately and carefully track drug interactions and medication refills and past medical history.
- **Practice Efficiency** – It is much easier to communicate with other providers and I am able to operate more efficiently with less employee time spent pulling and organizing charts.
- **Revenue Stream** – At the conclusion of each visit, my staff is able to send charges to the clearinghouse immediately for processing of claims and payments are quickly applied to accounts using electronic remittance.

Significant Barriers Prevent Optimal HIT Implementation

HIT holds promise as a tool to increase quality and efficiency in the health system. However, there are significant barriers to full-scale adoption and implementation of HIT – specifically, cost, regulatory barriers, financial penalties, an unpredictable marketplace and system integration. It is imperative that Congress ensure small physician practices are able to make the investment in technology that will enable the American healthcare delivery system to coordinate care and make a measurable impact on quality without imposing overly burdensome procedures or failed financial investments upon physician practices.

Financial and Regulatory Burdens

Dermatologists and other physicians in small practices face unique barriers to integrating EHR systems into our small businesses. According to the American Academy of Dermatology Association's (AADA) 2009 practice profile survey, 40% of dermatologists deliver care as solo practitioners; though solo practitioners make up 50% of rural practices. If efforts to modernize the practice of medicine are to succeed, we must figure out a way to assist physicians, particularly those in small practices, to overcome the significant financial barriers.[1] According to the American Medical Association, the average cost of an EHR system is estimated to be $30,000 per physician with an average maintenance cost between $3,000 and $15,000 per year. In addition, practices are also not convinced that operating costs will decrease with EHRs as 38% of practices responding to the 2011 Medical Group Management Association (MGMA) EHR Survey noted that their practice operating costs increased after implementation and 36% stated that they stayed the same.[2]

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[1] According to American Academy of Dermatology Association's (AADA) 2009 practice profile survey, 28% of dermatologists reported that they have implemented an EHR system.

[2] Medical Group Management Association, *Electronic Health Records: Status, Needs and Lessons – 2011 Report Based on 2010 Data Snapshot of an Infrastructure under Construction*. (http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=1248574.)

The financial cost is exacerbated by two factors – an unpredictable marketplace and access to capital. In a rapidly changing marketplace, which has already required me to purchase a second EHR system within two years, the inability to anticipate technology changes and the lack of system interoperability places a significant burden on my practice and my ability to care for patients. This unpredictable marketplace has certainly impacted my practice as I will invest more than $53,000 – it would have been $73,000 if not for the state grant – in two systems over the last three years. In addition, physicians seeking investment capital are having issues finding a lender willing to provide them with an unsecured loan. Others may attempt to finance their HIT system purchase with the vendor, but solo or small practices have little or no leverage in negotiating terms and rates because of our limited market share. [3]

Congress took an important step under the American Recovery and Reinvestment Act (ARRA) of 2009, when it authorized $20 billion in funding the EHR incentive program, but it is not enough.[4] The program should help stimulate interest in the adoption of EHRs by eligible physicians and hospitals through payments of up to $44,000 over five years under Medicare, or up to $63,750 over six years under Medicaid. Providers will need to meet several requirements to be eligible for the incentive funds including using a certified EHR system and become *meaningful users*, the regulations for which are currently flawed and unmanageable for many specialists. For example, one potential requirement would recommend that 10% of patients/families view and download their longitudinal health information, which would have to be made available within 24 hours of the patient's visit to meet Stage 2 meaningful use criteria.[5] The physician does not have control over the patient's ability, nor their desire, to view and download their longitudinal health information. In addition, a 24 hour requirement for making the information available to patients is a burden that affects a physician's workflow.

Dermatologists and other providers investing in EHRs are struggling with the structure of the CMS Meaningful Use timeline. The current schedule calls for the administrative rule governing Phase 2 Meaningful Use to be released in mid-2012. For early adopters who purchase a system and have contracts with technology service providers to meet 2011 and 2012 requirements (Phase 1), there will be a very short window between the release of Phase 2 requirements and the deadline for physicians' vendors to fully update their systems in order to qualify for the incentive payment in 2013.[6] This short timeline could cause early adopters of EHRs to fall short of Meaningful Use requirements based on the inability of their vendor to provide the required updates in the time allowed. In this instance, the ability of a provider to meet Meaningful Use criteria is completely dependent on whether the vendor is capable of implementing these changes in a timely manner. As dermatologists and other physicians make the decision to invest in an EHR, Congress and the Centers for Medicare and Medicaid Services (CMS) must ensure that early adopters are held harmless and not penalized based on their vendor's ability to meet the deadline.

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[3] Ibid. The 2011 MGMA EHR Study found that 72% of practices believe that insufficient capital resources are a significant barrier to EHR adoption.

[4] Ibid. The 2011 MGMA EHR Survey estimated that the full $44,000 in stimulus funds available to physicians would only cover the median up-front cost and up to two years of the operating cost of an EHR system.

[5] The Office of the National Coordinator for Health Information Technology Meaningful Use Workgroup Meeting Materials May 26, 2011: *Meaningful Use Stage 2 Objectives*. (http://healthit.hhs.gov/portal/server.pt?open=512&objID=1472&&PageID=17094&mode=2&in_hi_userid=11673&cached=true).

[6] The Office of the National Coordinator for Health Information Technology Policy Committee Meeting Materials May 11, 2011: *Meaningful Use Presentation*. (http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__policy_past_meetings/1814).

Furthermore, quality measure reporting to achieve meaningful use is one of several burdensome reporting requirements physicians are facing through Medicare. The Physician Quality Reporting System, e-prescribing, and looming development of ACOs all require reporting of various disparate quality metrics. Simply understanding and implementing all of these different programs is extremely difficult, and often overwhelming, as a small practice.

Despite demonstrated financial and regulatory burdens, physicians face financial penalties starting in 2015. Dermatologists and other physicians who do not adopt certified EHR systems, meet the definition of "meaningful user," use e-prescribing and/or participate in the PQRS face phased-in penalties that reduce overall Medicare payments.

System Integration and Workforce Issues

Moreover, there remains a large question as to whether we can build an interoperable, national infrastructure, long a barrier to HIT adoption. Right now, we appear to be running the trains, but the tracks are not yet built.

To deliver on the promise of effective care coordination and improvement in quality of care, a fully functional health information exchange is a prerequisite to enable all physicians to maximize use of health information technologies. Dermatology is fortunate that it was able to recently develop specialty-specific criteria while many other specialties do not yet have specialty-specific HIT certification programs. This prevents the ability to build a seamless HIT network for patient care and leaves a sizeable group of physicians without the ability to take advantage of the stimulus funds to offset the cost. Physicians are hesitant to invest in systems that may not be up to par with the standards for a nationwide health information exchange. If you add in anecdotal evidence such as my practice having to invest in two different systems within three years, physicians are rightly justified in their hesitancy.

Those dermatology practices shifting from paper to electronic records or transitioning from one vendor's platform to another will have to address several critical issues; (1) large patient loads which require fast turn around and minimal disruption during the record transfer, (2) the cost of data conversion from one system to another, (3) the potential for creating even longer waiting periods for patient appointments, the average wait for dermatologic care being 5-6 months in my community, and (4) the need for specialized software to accommodate the practice of dermatology (such as the ability to draw and upload photos).

Most importantly, patient care could be at risk if we are unable to provide the necessary resources and protections to physicians for HIT adoption. I am concerned that we could exacerbate the physician workforce shortage facing the country, not just in primary care, but across specialties. Beyond the capital investment, physicians, particularly solo practitioners, will face significant financial penalties for failure to comply with e-prescribing, HIT, and potentially PQRS requirements. The AADA fears that those dermatologists and other physicians nearing retirement would simply retire earlier rather than comply with the new regulations.

I urge the committee to address three issues:

1. Provide sufficient financial and other resources so physicians are able to select and implement HIT systems.
2. Consider delaying the penalties associated with HIT adoption until such time that a functional integrated system is in place. At the very least, consider grandfathering

physicians of a certain age and exempt them from financial penalties so we do not push some into retirement and exacerbate the physician shortage in this country.

3. If penalties are not significantly delayed, provide a “safe harbor” for those early adopters of HIT to protect them from financial penalties related to the “meaningful user” requirement. They should not be punished for the failures of their EHR vendor to implement new criteria--- something completely out of their control.

It is imperative that HIT is adopted and implemented in a timely manner that is achievable for dermatologists and all physicians. We need to develop an interoperable and secure health information exchange network that is user friendly and protects patients’ privacy.

The challenges facing the overall Medicare program are complicated and carry significant fiscal implications as well as the potential for unintended consequences on access to care. We must work as partners and as responsible stewards of the nation’s health care resources. We must strike the right balance between modernizing the practice of medicine, delivering high quality care and protecting patient care. I, and the American Academy of Dermatology Association, look forward to working with you in hopes of achieving this balance.

Thank you for the opportunity to testify before the subcommittee today.