ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

July 22, 2014

The Honorable Chairman Fred Upton
Committee on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Committee Members:

The American College of Physicians (ACP), the largest medical specialty organization and second-largest physician group in the United States, representing 141,000 internal medicine specialists (internists), related subspecialists, and medical students, thanks you for the opportunity to provide input into these very important issues. We appreciate the Committee's efforts to address the significant gaps that exist between practice and potential within the digital health care arena.

Overall, we support the direction that the Committee is taking to address these gaps in the digital health care system, and respectfully offer our comments on the areas of concern identified by the Committee in the "21st Century Cures – Digital Care" white paper.

The ACP believes that, notwithstanding the very significant benefits to some, viewing the potential of health information technology (health IT) enabled care as only leading to "new" cures is too narrow a view; and one that risks the defocusing of policy away from what we believe are more immediate benefits of health IT that are relevant to the majority of Americans, as well as paving the way for reducing overall healthcare costs. Americans are now living longer and are generally healthier because of healthier life styles, better screening and prevention, more consistent identification and treatment of key chronic conditions, and advances in heart disease and cancer treatments. We believe that there is real potential for the emerging digital healthcare system to markedly broaden those advances – leveraging electronic health records to help further the consistent application of existing knowledge, and utilizing the EHR as a learning system to more quickly diffuse new knowledge and changes in best practices.

For example, if the goals of the Million Hearts® program, which call for more consistent attention to known and proven cardiovascular risk reduction strategies, were broadly applied

across the United States, a million new heart attacks and strokes could be prevented by 2017 – reducing healthcare costs. And while this can occur without new expensive discoveries and treatments, Million Hearts® does require the technical support of robust software within electronic health records along with financial incentives to physicians such that cardiovascular risk reduction is made a routine part of primary care.

We stress to the Committee, when drafting legislation, to guard against imposing new data collection and reporting requirements on physicians, as the benefits of more data collection and reporting to patients are unproven, and the impact of the administrative burden and distraction to physicians is clear.

We urge you to keep the following general concerns in mind as you move forward.

- The focus of what is done must keep both the patient and advancing the patient's health and healthcare delivery in the center. As technology rarely presents a solution within itself, we believe that having a viewpoint that puts technology in the center of one's thinking can add barriers between patients and doctors, and even to necessary care.
- That said, to advance health and healthcare, we cannot continue to add requirements for data collection and reporting that fall on physicians. Before EHRs, physicians used to complain that they "spent more time on paper work than on patient care." And now with EHRs, the issue is expressed as "spending more time on EHR data collection and documentation than on taking care of patients."   We believe this widely held sentiment has led to a new barrier to physician optimization of health IT in clinical practice – and without reducing this barrier – the chances that new digitally based cures, such as those addressing underserved populations, will be appropriately used is low.
- Historically, in other fields that have experienced technology diffusion, over time IT and new digital workflows have made people more efficient. This has not been the case in medical practice. While EHRs and Meaningful Use have established a framework for making healthcare better and safer, instead of healthcare operations becoming more efficient, they have become less efficient. And while some have blamed the technology for this failing, we believe that the primary cause is the lack of a policy framework and guiding principle that supports optimization of physician time and the patient-physician experience. For example, where most information necessary for prior authorizations is contained within an EHR, payers still require uniquely formatted paper forms.
- EHRs and other physician-facing health IT cannot fix inefficiencies in healthcare operations without cooperation from both public and private payers. Meaningful Use requirements only address physician use of health IT. This imbalance in addressing the healthcare ecosystem has led to this paradox – what should make physicians more efficient (and thus lead to more time spent in patient care) has instead led to more administrative work and less face time with patients.   Health IT would be able to achieve far more in terms of driving recommended care, if this imbalance was addressed and fixed.

- We encourage learning from past and current technology initiatives to inform new initiatives. The 21st Century Cures initiative is not the 1st attempt this century to use health IT to improve care. Has ePrescribing reduced medication errors and deaths from prescription medications? Have mandated clinical visit summaries been found to be valuable to patients? More study of the effects of specific health IT interventions is necessary

- Physicians want and need the ability to use data to learn and to perform better. It is self-evident to thoughtful physicians that data exchange per se does not improve care, and that too much data exchanged too broadly may make it harder to provide good care, and can lead to confusion due to "data overload" and potential misuse and/or misinterpretation of the data.

- The ACP was an early supporter of the objectives of the EHR Incentive program. However, generally, financial incentives are not as helpful as policy makers imagine. Incentives inevitably become penalties. This can lead to gaming behaviors intended to avoid the penalties, thus the behaviors will not result in the desired positive changes.

- We are concerned that, while the government is focusing on the goal of an information-rich healthcare environment, the formats that are being pushed are too often "data rich but information and knowledge/insight poor." The focus should not be on the volume of data exchanged if these data do not add sufficient value or if they are difficult to find and separate from a large collection of less valuable data, or if the external data are delivered in formats that cannot be easily compared to local data and accurately reconciled. Specifically, a 2103 HHS RFI states, "HHS envisions an information rich, person-centered, high performance health care system where every physician has access to longitudinal data on patients they treat to make evidence-based decisions, coordinate care and improve health outcomes." This statement contains the underlying assumption that there is a correlation between physicians having a larger quantity of clinical information about each patient, and patients having improved health. In fact, it is possible that such data overload could result in adverse consequences for patient care. More importantly, value-based goals for HIE should focus on the delivery of services, such as those mentioned, that facilitate decision-making, facilitate care coordination, and effectively measure and track health outcomes.

- The current MU-mandated exchange of patient summaries presents a clear warning about the risks of pursuing a policy of expansive and inadequately organized data exchange that too often "buries the headline" such that the most important information is so difficult to find that it is missed. What was once more typically a carefully crafted page and a half of relevant information has, through the requirements of MU, expanded to 7 or more pages – too much of which is not helpful to the receiving physician, who now has to scan through this bloated document to try to determine what matters (diagnosis and thought processes) and what has changed (medications, test results, treatment plans). The government should refrain from incentives that encourage exchange without conciseness and high usability.

- We want to see the government use the levers available to facilitate the kinds of exchange that matter most to patients, and thus to physician efforts to maximize quality, safety and value, such as those listed in the next bullet. Policies must minimize the number of connections and protocols that practices will have to establish and manage. Currently, many EHR vendors are charging each practice thousands of dollars to establish each connection, and to exchange each document type. Vendors are also signaling that there will be ongoing maintenance charges for each connection for each practice. In addition, vendors are so overwhelmed with work that they are unable to respond to the needs of small practices in a timely manner. There is nothing to be gained from policies that encourage exchange if the exchange partners do not have cost-effective and readily available connections.
- There are many opportunities for valuable exchange that should be encouraged though policy. These include:
    - Directories of provider contact information – complete and up to date.
    - Reliable and accurate patient identification and matching.
    - Rapid notifications of patient care activities such as emergency department arrivals, and admission and discharge notifications to ambulatory physicians.
    - Cross-system management of patient consent.
    - Support for quality measures that track patients across care settings.
    - Data cleaning and standardization services.
    - Management of longitudinal care records.
    - Data analytics, alerts and public reporting services.

The Medical Informatics Committee of the American College of Physicians respectfully submits this letter in the hope that it will assist the House Committee on Energy and Commerce in developing plans to advance a legal and regulatory framework that fosters the development of a digital health care ecosystem, and allows it to serve as a catalyst for the discovery, development, and delivery of new treatments and cures for patients, as well as a usable and useful infrastructure for the more efficient and consistent delivery of existing best practices.

Sincerely,

Peter Basch, MD, FACP
Chair, Medical Informatics Committee
American College of Physicians