

“Health IT Adoption and the New Challenges Faced by Solo and Small Group Healthcare Practices”

Purpose of the Hearing:

The hearing will discuss the challenges solo and small group practices face in adopting health information technology (IT). The Subcommittee will also examine the implementation of policies in the American Recovery and Reinvestment Act of 2009 to promote Health IT adoption.

Testimony:

Distinguished members of the Committee, I am Robert C. Jackson, Jr., M.B.A., FACHE, Chief Executive Officer of Grove City Health System. Grove City Health System is composed of Grove City Medical Center, a 91 bed acute care hospital, Wolf Creek Medical Associates, a multi-specialty physician group, and GCHS Foundation, a foundation that support the mission and efforts of the hospital. We are the nearest healthcare facility to the intersection of Interstate 79 and Interstate 80 in Northwestern Pennsylvania. For a geographic perspective, we are one hour due north of Pittsburgh and one hour and fifteen minutes due south of Erie. The hospital serves a primary service area of approximately 55,000 people in the communities of Grove City, Mercer, and Slippery Rock. About 100 physicians have privileges at our hospital with 35 of them considered Active members of the Medical Staff.

In order to provide a framework to analyze my testimony, I need to explain where Grove City Health System is as far as its journey toward an electronic medical record. In the hospital, all clinical documentation (nursing, physical therapy, social services, etc.) with the exception of the physician’s notes and orders are done electronically. We have invested close to \$2,000,000 in software, hardware, and training costs to accomplish this.

As part of this ongoing process, we have implemented a Picture Archival and Communications Systems (PACS) in our medical imaging department that captures and stores images digitally making them available to physicians in their office as well as in the hospital. At GCMC every medication does in electronically verified to assure that the right patient is

getting the right does at the right time. All of our internal systems have from finance to nursing are compatible and communicate information transparently back and forth to facilitate the clinical care, coding for services, and billing.

In our physician practice, we are about 90% paperless. Utilizing the MEDENT EMR product has resulted in the six physicians who are employed by Wolf Creek Medical Associates documenting, storing information, and ordering tests for their patients electronically. At GCMC, we also have eight other physicians who use the same product so we have invested in the development of an interface that electronically transmits the laboratory test result to the physician who ordered the test.

Overall, we consider our hospital and medical staff to be early adopters of electronic medical record technology. Strategically, our Board of Trustees and Medical Staff leadership felt that we needed to be ahead of the curve rather than attempting to play catch up.

Our next phase of EMR implementation includes the development of Computerized Physician Order Entry and additional interfaces to facilitate the resulting of other non-laboratory diagnostic tests electronically to the ordering physician.

It has been set forth that the purpose of today's hearing is to discuss the challenges solo and small group practices face in adopting health information technology (IT). The Subcommittee will also examine the implementation of policies in the American Recovery and Reinvestment Act of 2009 to promote Health IT adoption.

To that end, I wish to share with you some of the pros and cons of EMR implementation and use, some of the experiences that our employed and independent physicians had with the implementation of their EMRs, and offer some thoughts on the direction for managing electronic health records.

I would like to acknowledge the Hospital Association of Pennsylvania, CPSI, Susan Hirst of the Sage Group, Family Healthcare Partners, and the Triangle Urology Group for their willingness to provide information for my testimony.

Pros and Cons:

Not everything is made better with automation. However, EMRs offer physician offices the opportunity to streamline office procedures and share information among staff members in an incredibly efficient manner. Use of an EMR brings a higher level of patient safety and regulatory compliance to a practice. For example, with its ability to review a drug through volumes of information to identify any potential pharmaceutical interactions with other medications the patient may be taking or allergies that they may have. This review is done in a blink of an eye giving both the healthcare practitioner and the patient greater confidence in the care they are receiving. The documentation capture with an EMR is more detailed and provides an easily searchable repository of information and patient history at the physician's fingertips. Hospitals and physicians have begun sharing information electronically at the local level but, what is astounding to consider is the potential of the information that can be exchanged and how it could improve the health of our nation. As I mentioned before, at GCMC, we have the means to electronically result laboratory results to physicians who use EMRs in their respective offices and this is only the beginning.

However, this is not to say that it does not have a down size. The introduction of EMRs to the Hospital and physician practice environment adds to the cost of patient care. A private practice physician office is potentially looking at \$50,000 for hardware and software, a group practice could easily be spending \$200,000, and at the hospital level GCMC has spent about \$2,000,000 and counting. That is just to get started. These systems require monthly maintenance and service contracts, which add to the monthly cost of operating the business without adding any revenue. Once you have installed the system, the physician and the physician staff need to be trained on the system and that costs money as well. Again, this is all before they have even seen the first patient. The initial implementation of an EMR could reduce the throughput of a physician practice up to 50% for several months while the physician and staff learns how patient throughput will actually work with the new system versus how they have been trained. Considerations need to be made for those staff that may not be able to or choose not to learn the new system and the impact that could have on practice operations. The use of an EMR also affects the sacred relationship between the physician and the patient. Patients need to feel like they have been heard when they visit with their

physician. The introduction of the EMR in to the patient visit has the potential to take the physicians attention from the patient to assuring that he is capturing all of what he needs in the EMR. This area should not be taken lightly. Any time there is the potential of disrupting the interaction between the physician and the patient the physician must be cognizant of the change and take active steps to compensate for it.

Incentives make sense when you begin to think about what a physician practice would have to give up to be able to say they have an EMR. As a physician practice grows in the number of providers and locations, the use of an EMR increases the efficiency of the practice operations and assures that all providers have access to the patient's information regardless of what location of the practice they visit. As a one or two physician practice, you would think long and hard before making this decision.

An EMR improve information exchange and provide the physician with a greater depth of information, but the introduction of an EMR in to a practice causes significant disruption in terms of patient care and the potentially the financial viability of the practice in the short run.

The Experience in Grove City:

Of the physicians in Grove City that have made the EMR leap, I would say that 90% of them are glad they did it. The hospital owned group, Wolf Creek Medical Associates (6 physicians) and Family Healthcare Partners (an independent family practice and pediatric group with 6 physicians) made the transition at the same time about 3 years ago. If you were to talk to any of the physicians involved, I believe that they would tell you that it was a difficult transition. Both physician groups experienced the decline in productivity and revenue during the install phase and when either group bring in a new physician one of the biggest challenges they face is the initial introduction to the EMR technology.

Family Healthcare Partners is about 98% paperless and Wolf Creek Medical Associates is about 85% paperless. The management of information within both practices is efficient and now completely dependent on the EMR system.

In both of these groups, it required individuals that could see the potential to positively impact patient care through better and more efficient data management and exchange.

All of the challenges described in the previous section occurred in both implementations with physicians from our hospital. These groups were successful because they saw a bigger picture and they were able to mitigate some of the financial risks because of multiple physicians or financial support from a larger organization. However, it does reinforce the reluctance of solo and small physician groups to elect to disrupt their practice financially and operationally when they may already be having a difficult time paying all the bills due to declining reimbursement.

Where is this going?

The physician and hospital that cares for me on a regular basis both have EMRs. The question is how does that help me when I need emergency services when I am visiting Washington DC? Providing incentives through the ARRA is a great step to move those physicians and other healthcare providers that may have been on the fence to begin the adoption process of an EMR. Nevertheless, at the end what has been created? There will be physicians on a myriad of systems and in some cases they will be able to transfer information to and from the hospitals they admit to. As EMR adoption is a central tenant of cost savings in a redesign of the health care system there needs to be a plan for how this will actually improve the health of individuals and not just provide another mechanism to penalize reimbursement of healthcare providers. We need to stay vigilant so that EMR adoption benefits the patients and the physicians and does not simply become a solution in search of a problem. Incentives provided for in the ARRA will increase the use of EMRs, but the EMRs will still be physician specific and stand alone and depending on the resolution of the healthcare redesign discussion the ARRA incentives may become too costly to attain with all of the proposed reduction in payments to healthcare providers.

Conclusions:

The impact of EMR adoption is significant regardless of the size of the healthcare provider. The group that has the greatest risk is the small independent physician practice. EMR adoption can improve the operation

of the office, but while traveling on the journey to a more efficient office practice, it can disrupt the physician/patient relationship, staffing, and the cash flow of a practice. In our experience in Grove City, we saw all of these things happen. Once through the transition period, many of the physicians would not go back to traditional paper records. The incentives in the ARRA will help move providers off the fence in terms of adoption. However with the plan for healthcare redesign happening concurrently we need to be ever cognizant of the unintended consequences of these two important initiative colliding and the focus of EMR adoption becoming only a cost reduction strategy and not improving the quality of care that is provided by our physicians and hospitals.