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**Presentation**

**“The Value of Health IT to Solo and Small Medical Practices”**

**Location**

**Congressional Subcommittee on Regulations Health Care & Trade of  
the House Committee of Small Business.  
Chairman, Representative Gonzalez**

## **CHALLENGES/BARRIERS TO IMPLEMENTATION**

- **Set up/maintenance**
- **Secure connection**
- **Reliance on electricity**
- **In house computer expert**
- **Interface with other electronic data sources**
- **State dependent pharmacy issues**
- **Acceptance of electronic signature**
- **Government/work forms**
- **Insurance audit and review**
- **Medical/legal risk**

## **BENEFITS**

### **Chart**

- **Legibility**
- **Accuracy**
- **Immediate access**
- **Standardized format**
- **Self audit/interrogation**
- **Fast templates**
- **Ease of coping/transfer**
- **Reduction in duplicate testing**

### **Patient Care**

- **Improved Quality**
- **Improved Efficiency**

## **FEDERAL GOVERNMENT INTERVENTION**

- **Funding**
- **Pharmacy**
- **Standardized pharmacy laws**
- **Acceptance of electronic signature**
- **Connectivity**
- **Electronic data storage; private versus regional**

Chairman Gonzalez, Congressman, congresswoman, it is a pleasure to have this opportunity to meet with you today. As a practicing rural family physician I am challenged with the management of health information and integration of technology in my office.

I feel that it is important that you know my background so that you can understand my perspective on this topic. I practice medicine full time. My partner and I own and manage our business. We purchased an electronic health record in 2004. We operate a two-physician practice. We have two offices which operate simultaneously, one in the township and the other in a rural setting. We provide inpatient medical care at one hospital and four nursing homes.

In addition, I presently serve as the president of the medical staff at Jameson Memorial Hospital. This is a two hundred-bed community hospital. Just as I am challenged in my office with the management of health information this hospital is challenged on a much larger scale. In a small community the hospital and physicians are dependent upon each other to deliver quality medical care.

I have been practicing medicine for fifteen years. I have seen the transition from handwritten medical record to the current electronic health record. Over this time span the requirements of record keeping have increased dramatically. The records in the 70's and 80's were sometimes written on index cards containing little documentation. The current insurance and medical/legal requirements demand extensive documentation, making a more efficient charting method necessary.

We were motivated to purchase an electronic health record for a number of reasons. We were a four-physician practice anticipating growth to a third office. We wanted instantaneous connectivity between all offices and access to our files from outside

locations. With the insurance and medical/legal requirements for more thorough documentation, we were spending a considerable amount of time documenting, subsequently reducing our time for direct patient care. We wanted to reduce documentation errors by eliminating the handwritten record. We wanted to standardize our record to level not possible with a handwritten chart. We wanted to be able to electronically audit our performance.

Unfortunately, as you will see, the road to using an electronic health record in the community setting is a difficult one.

The return on investment, whether that be improvement in patient care, or financial savings is really not known.

We purchased our system three years ago. The financial cost of this was considerable. The initial investment was two hundred thousand dollars. Our annual costs for support and updating average fifty to sixty thousand dollars. All of the electronic health record companies will tell you that you will save money due to reduced employee time and benefits and increased efficiency. However, as businessmen, we had to take a long hard look at the numbers in order to justify such expenditure. When it came down to the bottom line, we felt that the system would help us improve our quality of patient care. While we have been able to realize some savings, the electronic record is still an expenditure for us.

As a medical practice, we are required to keep records for extended periods of time. In Pennsylvania, these limits were now extended further with the new malpractice legislation. The pressures of medical record keeping and maintenance are tremendous. As a small businessman with the prospect of retirement in the future, you are always

concerned about how you will maintain or transfer your records. With paper charts this could be very costly, not the type of expense one would like to have at the end of a career. These concerns also prompted us to move toward an electronic record.

We have realized a number of benefits and challenges with our implementation of an electronic record. Our first challenge was deciding which medical record system to purchase, this was lengthy process that took us at least six months to research the options available. With no independent computer consultants available with family practice experience we took this responsibility upon ourselves.

Our next challenge was to develop the necessary electronic connections between our two offices. Our rural office had no internet access subsequently we installed dedicated a T1 line. This creates a direct and secure phone connection.

The implementation of our record system required considerable staff and physician education and training. This created a financial challenge for our business. As physicians this required a commitment of time and effort. This was difficult for us in a busy practice. This was also challenging for us as physicians since neither of us were educated, at a time, when computer use was common. This challenge tends to discourage many physicians from investing in electronic health records.

As a medical office, our positions require some degree of front office business training, medical office or clinical training. Some of our clinical employees had a very difficult time learning how to use a computer and the program effectively. We had to offer some employees different positions since they could not master the electronic record. As part of our hiring process we now screen for computer literacy in addition to the screens for basic math and communication skills, which were performed in the past.

In order to maintain and operate our system we created a job position with one of our established employees. He now serves as our in house computer consultant, responsible for training, maintenance and upkeep.

We have benefited from the efficiency of our electronic record, which requires less maintenance and less space compared to a paper chart and we have eliminated the costs of creating a paper record. However, we still have the cost of receiving faxes, scanning written material and then shredding all paper correspondence that continues to arrive at our office from other entities. Unfortunately, this will continue to occur until these entities develop the ability to communicate with us electronically after the development of interfaces.

Our electronic record allows multiple users simultaneous and immediate access to a legible, accurate and standardized chart. This instantaneous access has definitely improved our capabilities. Now when we receive a phone call about a patient, I have all patient information at my fingertips.

With the electronic record you are forced to record data in a standardized manner that is easily retrievable. This further adds to the value of the record.

The electronic health record has allowed us to create more thorough and in depth notes than anyone could create with a handwritten chart. The creation of templates for commonly performed components of the history and physical examination or other items creates further efficiency and reduces transcription costs. However it has come to our attention that the use of templates are often scrutinized by insurance chart reviewers, claiming that it is an easy way to create documentation in order to bill at higher levels. For those of you who are not familiar with this, your billing codes are divided into five

levels. Justification for billing at a higher level is dependent upon the content of the physician's documentation. A larger amount of documentation substantiates a higher-level code, which pays a higher level of reimbursement.

Clearly as a physician running a small business, I need to be able to document efficiently so that I can continue to provide my services to patients in the community. Ethically I have a very difficult time justifying spending two hours a day documenting my visits so that I could pass a chart review when there is a shortage of physicians in the community.

Likewise, a medical legal concern is that template notes are often attacked in the courtroom or in a deposition. An insinuation is made that the examination was not done and the documentation was not appropriate. While I accept that the template examination may not be as precise as a narrative dictated exam, the essential documentation in support of ones medical actions and decision-making are clearly present in both. It is my belief that as we move into an electronic health record, templates must be accepted as a standardized type of record keeping. I believe that congressional support of this would be beneficial.

Federally mandated forms and documents need to be standardized. Employers and organizations interpret government forms differently, a good example of this being the FMLA form. I currently fill out at least six different versions of this form. Some are two pages long and some are six to eight pages long. Employers will only accept "their form". The same goes for the Department Of Transportation Commercial Drivers License forms. As we move into an electronic health record, I believe that Congress needs to standardize these forms and not allow individual interpretation and design. The

standard form can then be incorporated into all electronic health records. We can then print or send their form. Electronic signature must be recognized on these forms. I ask your assistance to make the system more efficient.

The copying of medical records is now easy for us to accomplish. However we are still limited by the fact that other entities are not capable of accepting electronic transfer of information and until this occurs we recreate a paper chart by printing our electronic records and then inefficiently mailing them to another entity. All health care entities must be required by some point in time to have the capability of accepting the electronic transfer of information. Only then can the efficiencies of an electronic health record be truly realized.

Currently we can hand write, print, or fax prescriptions. As soon as our local pharmacies come on line we will E-Prescribe. The most error prone and inefficient prescription is the handwritten/hand signed prescription. Unfortunately not all states or suppliers accept electronic signatures, or my typed prescriptions. Some even demand a signed prescription from a pad or that there own forms with bar codes and cut/paste format be completed. This doubles my workload. I believe that all pharmacies should be mandated to accept the E-prescriptions with an option to use their original forms. I believe federal regulation would be beneficial in this regard.

Pharmacy rules and regulations do not appear to be consistent in all states. Most times mail order pharmacies are located out of state. These pharmacies then apply their own state laws when prescriptions are being filled. Some pharmacies have refused to accept our electronic signature, while other states have no problem with it. I believe it is

time for the federal government to standardize pharmacy laws as they pertain to the interstate filling of prescriptions if we are going to move this process forward.

One of our major barriers is our ability to communicate with other electronic health record media, whether this be radiology centers, x-ray departments in the hospitals, laboratories in the hospitals or labs in the outside community. In order for us to communicate with these different types and brands of programs, an interface between them must be built or purchased to allow effective communication. Unfortunately these are costly and the individual vendors are certainly never interested in building an interface with another vendor's software. They would rather have you buy their software program. Certainly from my standpoint as a small businessman, I cannot pay for multiple interfaces. Until EHR application is universal there is little incentive for these entities to invest the time or the money to build interfacing software. This threat of isolation is used by companies to help encourage you to buy more of their product where there would be no interfacing issues. This is very frustrating, and I believe there should be regulation that forces all electronic health record programs to have the capability to interface with any other licensed program. This would allow the free market pricing of different technology systems and break down the communications barriers, which are currently penalizing me and dissuading many physicians from investing in electronic health records.

As you can see from my presentation above, my practice currently suffers from a number of inefficiencies because we cannot interface electronically with the other medical providers in the community. A cost savings would be available to everyone if medical information were moved electronically. We waste countless hours of employee

time trying to have information faxed to us or mailed to us. Hospitals waste countless hours of employee time searching for old records, copying mailing old records, faxing lab results and x-ray results unnecessarily. We must then receive them on a fax machine, print them and pay someone to scan them into our system electronically. As you may be aware a scanned document consumes a much larger amount of disc space than an electronically submitted document at a further cost over the long term. If an electronic record were in place these inefficiencies would be eliminated. Most importantly the information would be available to help provide effective patient care.

From a payor standpoint as electronic health record with universal connectivity could eliminate the unnecessary repetition of testing. Tests are repeated because of physician concern for the patient and also because of medical legal concern, if the results from a contemporaneous test are not immediately available. I have seen tests repeated unnecessarily in the same day because results from the first test were not available.

I think that the only way to provide incentive for the adoption of Health IT is to provide financial assistance. The burden of financing an electronic record is significant. My practice has spent over \$400,000, starting and maintaining a EHR. I believe physicians and hospitals should be given no interest loans from the government to adopt this technology. Providers should then be paid a higher reimbursement fee for a limited period of time such as a five or ten year period. In that period of time their loans are paid back and the efficiency of the system is realized by the payer physicians and the providers and in effect what the government has done was to front the money, recoup their loan, provide financial support for the physicians to cover the expense of the upstart cost and in the long run create a safer and more efficient health care delivery system.

Local community hospitals, which make up the backbone of medical support in suburban and rural communities, are struggling with the acquisition of information technology. They do not have in house experts. They can't afford to keep these individuals on a full time basis like major teaching hospitals or regional health systems. When it comes time to develop the information technology systems they are very reliant on consultants. They don't have the staffing or the financial resources of large institutions for the training and retraining of their staff.

I see my local health system struggling and performing a balancing act trying to fund emergency room expansion, operating room expansion, and move toward a scanned inpatient record.

Jameson Hospital is at a crossroads when it comes to delivery of outpatient health information to the physicians in the community. Presently, they fax or courier results to offices as they try to map their way through the difficult process integrating internal computers based record systems. These individual systems such as lab, x-ray and pharmacy have been acquired at different times and it is difficult to interface these systems. It is not financially feasible for a hospital to discard all the existing systems and purchase a whole new system. They just do not have the money for that, so they try to run a balancing act of providing the necessary hospital services for the community and improve IT both in the hospital and in the community.

Many physicians will rely on medical hospitals for guidance and direction. Again, this all comes down to the financial challenge and hardship that is faced by these small health care institutions trying to perform a balancing act in providing healthcare in the community with a dwindling income stream.

As you can see, I function in a small town and rural community where health care is fragmented between multiple physicians, multiple hospitals, which includes one main community hospital, multiple lab services and multiple x-ray services. We don't have the asset of having one large health care system, like a university hospital that owns all the practices and owns most of the facilities and has these tied up in one medical record system. I believe I practice in the same type of environment as most physicians. Clearly, there are a number of financial barriers and a number of logistic barriers, however I am confident that if the financial incentives are in place and there is a uniform adoption of electronic health record the efficiencies of this system will be realized by both the payers, physicians and other healthcare providers. Most important the quality of patient care will improve.

In summary, as a small business it has been quite costly from the financial perspective for my practice to implement an electronic health record. We have not yet realized financial gain because of this. As a businessman I would like to at least break even on my investment. As a physician it is gratifying to see electronic health record eliminate handwriting errors improve efficiency, and create an immediately available medical record. Clearly, I have concerns regarding connectivity of different electronic media. I believe it is essential that all software used in medical application be able to communicate with other software packages in order to prevent a progression of the barriers that are already in place. I believe that federal regulations need to be placed to standardize the states pharmacy laws as they apply to the interstate transmission of prescriptions. I believe that funding needs to be put in place to help individual physician,

physician practices, and the smaller health care institutions to acquire the hardware and software necessary to bring an electronic health record to reality.

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