



**Testimony of**

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**On behalf of  
Healthcare Leadership Council**

**Legislative Proposals to Promote Electronic Health Records and  
a Smarter Health Information System**

**U.S. House of Representatives  
Committee on Energy and Commerce  
Subcommittee on Health**

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Chairman Deal and Members of the Subcommittee, I want to thank you on behalf of the members of the Healthcare Leadership Council (HLC) for the opportunity to testify on legislative proposals that will promote electronic health records and a smarter health information system.

My name is Mark Neaman and I am president and CEO of Evanston Northwestern Healthcare of Evanston, Illinois. We are an academic health center connected with Northwestern University, comprised of three hospitals, a 463-physician medical group, a home health services agency and a medical research institute.

My interest in coming before you today is twofold. First, I am chairman of the Healthcare Leadership Council (HLC), a not-for-profit membership organization comprised of chief executives of the nation's leading health care companies and organizations. Fostering innovation and constantly improving the affordability and quality of American health care are the goals uniting HLC members. Members of HLC – hospitals, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies and academic medical centers – envision a quality driven system built upon the strengths of the private sector.

More to the point, the Healthcare Leadership Council shares President Bush's goal that most Americans have electronic health records by 2014. And we appreciate the bi-partisan commitment by Congress to encourage widespread adoption of health information technology.

I'm also here to share my own institution's experiences with health information technology. In July of 2001, the Board of Directors of Evanston Northwestern Healthcare gave the go-ahead to design and implement a patient-centric electronic health record system, a system that we call EPIC. Our goal was to utilize health information technology in a way that would improve clinical outcomes, enhance patient safety, provide greater patient satisfaction, and create a better working environment for our system's health care professionals.

I can testify, from our own experience, that all of the discussion about the promise of health information technology is not hyperbole. It is quite real. Let me give you some examples.

EPIC was launched in our Medical Group offices in January 2003 and then introduced incrementally in our hospitals over the next 12 months. We now have, throughout our three hospitals and all of our physician offices, a single, unified source of clinical information. With this accessible, comprehensive database, we have cut in half the amount of time it takes to deliver the first dose of an antibiotic to an inpatient, because of the speed with which we can check the possibility of conflicting medications or allergic reactions. In one year, we reduced by 20 percent the number of reported medication errors.

I think it would be useful for the committee to hear of a particular anecdotal benefit of the EPIC system. When the drug Vioxx was pulled from usage by the drug's manufacturer, we were able to use the EPIC system to remove the drug from our hospitals and physician offices, block future orders, send notices to physicians regarding which of their patients were on the drug, and send electronic links to websites with information on Vioxx substitutes. This process affected over 2,000 patients and was completed in just three hours. To undertake this same task manually, utilizing paper records to try to find which patients were taking Vioxx, would have taken days if not weeks.

It is important to note that Health Information Technology is not just limited to electronic medical records, it also includes integrated medication delivery systems that reduce bedside intravenous medication delivery errors and the resultant harm to the patient. These state-of-the-art systems enable communication between doctors, patients, and pharmacies to ensure that the proper patient is receiving the proper drug in the proper dosage after the proper precautions were taken.

The Healthcare Leadership Council has such a strong interest in this issue because we've seen firsthand what widespread adoption of HIT can mean for patients and health care providers. Several HLC member organizations have been among the earliest adopters and pioneers of health information technology. We believe HIT has the power to transform our health care system and provide increased efficiencies in delivering health care; contribute to greater patient safety and better patient care; and achieve clinical and business process improvements.

Our interest in this issue is long-standing. In the summer of 2003, HLC established a Technical Advisory Board, comprised of clinicians and others with information technology expertise within HLC's member companies to provide information about their HIT implementation experiences.

Attached to my testimony is a copy of the White Paper that resulted from this effort. The paper attempted to quantify key benefits of HIT along with barriers to HIT implementation. The paper concluded with the following recommendations:

- Standards to assure interoperability;
- Financial incentives and funding mechanisms;
- Liability protections to facilitate sharing of safety and quality data; and
- Stakeholder collaboration on best practices.

In looking at these recommendations, it is clear that there has been significant progress since 2004.

Last summer, the President signed into law the, "Patient Safety and Quality Improvement Act." HLC advocated for this legislation as an important step toward fostering a culture of safety – through liability protections to allow voluntary information-sharing and reporting. I thank the Subcommittee members for all of your work to enact this important legislation.

In the area of standards, several public and private sector initiatives are making great strides to identify or develop health information interoperability standards that will enable disparate systems to "speak the same language." And the work of the Certification Commission for Health Information Technology will complement these efforts by certifying that products are compliant with criteria for functionality, interoperability and security. This will help reduce provider investment risks and improve user satisfaction.

As important as it is to applaud the progress that has been made, it is necessary to focus on the barriers that stand in the way of widespread HIT implementation. We have some significant challenges ahead of us, and I'll begin by discussing patient privacy regulations and standards.

Developing a multi-state, interoperable system depends on national technical standards as well as national uniform standards for confidentiality and security. The Health Insurance Portability and Accountability Act (HIPAA) governs the privacy and security of medical information. Though HIPAA established federal privacy and security standards, it permits significant state variations that create serious impediments to interoperable electronic health records, particularly when patient information must be sent across state lines.

We believe Congressional action to establish a uniform federal privacy standard is essential in order to ensure the viability of a national health information network.

Because the HIPAA Privacy Rule's preemption standard permits significant state variation, providers, clearinghouses and health plans are required to comply with the federal law as well as many state privacy restrictions that differ to some degree from the HIPAA privacy rule.

State health privacy protections vary widely and are found in thousands of statutes, regulations, common law principles and advisories. Health information privacy protections can be found in a state's health code as well as its laws and regulations governing criminal procedure, social welfare, domestic relations, evidence, public health, revenue and taxation, human resources, consumer affairs, probate and many others. Virtually no state requirement is identical to the federal rule.

HLC is not alone in calling for action in this area. The 11 member Commission on Systemic Interoperability, authorized by the Medicare Prescription Drug,

Modernization, and Improvement Act to develop recommendations on HIT implementation and adoption, recommended that Congress authorize the Secretary of HHS to develop a uniform federal health information privacy standard for the nation, based on HIPAA and preempting state privacy laws, in order to enable data interoperability throughout the country.

H.R. 4157, the "Health Information Technology Promotion Act of 2005," which several Members of the Subcommittee have cosponsored, anticipates and addresses this need.

The bill sets forth a process by which the Secretary of HHS develops a uniform standard for privacy laws. The bill does not simply adopt HIPAA "as is." Rather, the legislation requires the Secretary to conduct a study of state and federal security and confidentiality laws to determine the degree of variance and how such variation adversely impacts the privacy and security of health information as well as the strengths and weaknesses of such laws.

The Secretary then submits a report to Congress including a determination as to whether state and federal security and confidentiality laws should be conformed to create a single set of national standards; and what such standards should be. If the Secretary determines that a single federal standard is necessary and Congress does not act to create a standard in three years, the HIPAA privacy regulation, as modified by the Secretary based on the results of the study, will become the national standard. We believe that this legislation is critical to achieve our critical HIT objectives.

Since 1996, HLC has led the Confidentiality Coalition, a broad-based group of organizations who support workable national uniform privacy standards. The Confidentiality Coalition includes over 100 physician specialty and subspecialty groups, nurses, pharmacists, employers, hospitals, nursing homes, biotechnology researchers, health plans, pharmaceutical benefit management and pharmaceutical companies.

Many organizations and companies that are members or supporters of the Confidentiality Coalition sent a letter to Chairman Deal in support of a national standard for privacy and the provisions of H.R. 4157 that lay the groundwork for developing such a standard.

In discussing this issue, let me make one point abundantly clear. While we believe strongly in the need for a national privacy standard, HLC believes just as strongly that any regional or national system designed to facilitate the sharing of electronic health information must protect the confidentiality of patient information.

Health care providers and others involved in health care operations have appointed privacy officers, adopted compliance plans and conducted training with

their employees to assure patients that they will protect their privacy in accordance with the HIPPA privacy rule.

Addressing this issue appropriately will be essential to achieving the interoperability necessary to improve the quality and cost effectiveness of the health care system – while still assuring patients' confidence that their information will be kept private.

To further underscore the importance of this issue to HIT development, I have attached to my testimony a map developed by the Indiana Network for Patient Care. Each dot represents a patient seen at an Indianapolis hospital during a six month period. While the dots are stacked very deep around Indianapolis as you would expect, patients served by the Indiana health providers during this period were also located in 48 of the 50 states. Today's health care providers, meeting the needs of a mobile society, serve patients from multiple and far-flung jurisdictions. Looking at this map it is easy to see why regional agreements will not be adequate to address the myriad regulations with which providers and others will need to comply to achieve "interoperability."

In addition to national privacy standards, the lack of funding or adequate resources – combined with the high costs of HIT systems – was repeatedly cited in our member study as a barrier to effective implementation of HIT systems. There are significant front-end and ongoing maintenance and operational costs for HIT, including software, hardware, training, upgrades, and maintenance. Systems are virtually unaffordable for those providers who do not have ready access to the operating capital needed for such an investment.

Developing the EPIC system at Evanston Northwestern Healthcare required hard capital costs of \$35 million. This does not include an additional \$7.5 million for consultants to write code for the system and undertake other essential tasks. Furthermore, our annual operating costs are increased by \$5.5 million to support additional IT staff, training and software maintenance agreements.

In an age in which health care providers, in many cases, must deal with rising costs associated with uncompensated care, medical liability rates, homeland security needs and addressing staffing shortages, it is a simple fact that many providers do not have the financial wherewithal to invest in these new systems.

HLC believes that the federal government should drive the nation's implementation of HIT through financial incentives and funding mechanisms to help providers defray the huge costs of acquiring and operating HIT. Rapid implementation of interoperable HIT is also a critical component of the nation's emergency preparedness.

While the Agency for Healthcare Research and Quality (AHRQ) and Office of the National Coordinator for Health Information Technology (ONC) contracts and

grants will support the development of a national information network and interoperability standards, we need to do more to get every provider using electronic health records now.

HLC advocates the consideration and implementation of multiple HIT funding mechanisms. However, we also recognize that current fiscal deficits and budget constraints will limit the ability of Congress to directly fund any new program or initiative. HLC is working with the chief financial officers of our member companies and organizations to develop workable, creative financing proposals for HIT. We look forward to sharing those ideas with the subcommittee.

There is one other critical issue I need to address today. One way Congress can facilitate greater physician adoption of electronic health records is to allow hospitals and medical groups that have successfully implemented electronic health records to share their expertise and IT investment with physician offices. This will facilitate better integration of hospital and physician information systems to improve continuity of care, decrease duplicate tests and provide greater safety and quality of care to consumers. By providing exceptions to the physician self-referral prohibition (Stark) and anti-kickback rules for HIT, Congress can accelerate physician use of electronic health records.

Current law prohibits anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health care program business, including Medicare and Medicaid. Physicians are also prohibited from ordering designated health services for Medicare patients from entities with which the physician has a financial relationship – including compensation arrangements. The penalties for violating Stark and anti-kickback rules are significant. The Stark law is a “strict liability” statute and no element of intent is required. Violators are subject to significant civil monetary penalties and risk being excluded from participation in the Medicare and Medicaid programs. The anti-kickback law is a criminal statute that also provides significant penalties – including fines and imprisonment – for knowing and willful violations.

Though HHS has released proposed regulations that would provide limited exceptions to the Stark and anti-kickback rules for e-prescribing and electronic health records, industry analysis suggests that the exceptions will be of little value to hospitals and medical groups wanting to assist physicians with the adoption of HIT because they are too restrictive and contain overly burdensome requirements on donors and recipients of IT products.

Due to the severe consequences of violating these laws, providers need a workable safe harbor for HIT. Congress must provide a clear roadmap for hospitals, medical groups and others to provide HIT hardware, software, and related training maintenance and support services to physicians.

Pending legislation, such as H.R. 4157, establishes a safe harbor to the anti-kickback and physician self-referral rules for the provision of health information technology and related training services to health professionals.

Under the safe harbor, non-monetary remuneration in the form of HIT and training services is allowable if the remuneration is made without conditions that limit the use of HIT to services provided by physicians to individuals receiving services at the entity; restrict the use of HIT in conjunction with other HIT; or take into account the volume or value of referrals.

We believe that enactment of this type of safe harbor will help spur adoption of electronic health records and provide immediate benefits to consumers in the form of improved quality of care and patient safety.

In conclusion, HLC believes that HIT legislation should especially focus on areas in which Congress and the President *must act* to remove barriers and facilitate successful implementation of HIT. Therefore, HIT legislation should accelerate the adoption of health information technology and interoperable electronic health records by ensuring uniform IT standards including privacy and security and providing exceptions to Stark and anti-kickback rules to allow hospitals, medical groups and others to share their expertise and investment in electronic health records with physician offices. HLC will continue to work with Congress to continue to explore other funding mechanisms to promote wide spread adoption of HIT.

The Healthcare Leadership Council appreciates the opportunity to testify on the development of health care information technology, and I will also be pleased to discuss in greater detail with the subcommittee our firsthand experiences with health information technology at Evanston Northwestern Healthcare. Any questions about my testimony or these issues can be addressed to me or to Ms. Theresa Doyle, Senior Vice President for Policy, Healthcare Leadership Council (telephone 202-452-8700, e-mail [tdoyle@hlc.org](mailto:tdoyle@hlc.org)).