

Statement of the American Academy of Family Physicians  
Before the  
Institute of Medicine/National Research Council Committee  
On the  
Review of Standards Activities of the Office of the National Coordinator  
Of Health Information Technology (ONC)

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Steven E. Waldren, MD MS

On behalf of the 93,800 members of the American Academy of Family Physicians (AAFP), I am pleased to come before the committee to provide you with our views on the state of the development and implementation of data and technical standards in health IT systems nationally.

I am Steven E. Waldren, MD, Director of the Academy's Center for Health Information Technology. I represent the AAFP on the Health Information Technology Standards Panel (HITSP), and I am a co-chair of the Certification Commission for Health Information Technology (CCHIT) Ambulatory EHR Working Group.

The AAFP is one of the largest national medical organizations, representing family physicians, family medicine residents, and medical students nationwide. Founded in 1947, our mission has been to preserve and promote the science and art of family medicine and to ensure high-quality, cost-effective health care for patients of all ages. The AAFP is the only medical society devoted solely to primary care. Nearly one in four of all office visits in the United States are made to family physicians. Today, family physicians provide the majority of care for America's underserved and rural populations.

The standards that are being developed both within ONC's framework and in the marketplace, especially those for portability and interoperability of health information, are extremely important to family physicians and other primary care physicians. They are also important to nurses and to the patients that are served in many thousands of small and medium size medical practices across this country.

We believe that portability and interoperability of health data are crucial to the improvement of quality and safety of health care in this country. This improvement will be realized primarily through increases in the continuity of digital information flow between providers and between providers and patients. This, in turn, holds great promise to create greater continuity of care delivery in our fragmented health care system. We believe that portability and interoperability of health information can, quite literally, save lives. And we believe that there is urgency to this effort.

As many of you know, the Academy has been an innovative leader in our quest to provide health-IT resources to our members and to transform the electronic health care system as a whole. Approximately half of our membership, in active medical practice, currently have an EMR from a commercial vendor to assist them in the delivery of quality primary health care services. Data portability and interoperability of these systems is mandatory if we are to avoid the creation of a disconnected set of "data islands" among our primary care providers in this country.

While we strongly support the efforts of the ONC to champion interoperability, we believe that there are challenges with the processes that the ONC has overseen, and we believe their resolution will greatly improve the efforts to realize a national health information exchange system that is affordable and effective.

First, we believe that the health-IT vendor community for ambulatory care products and services has been under-represented at the governance and committee levels for AHIC, HITSP, and ONC. The companies that serve the IT needs of ambulatory care medical practices are, for the most part, small firms. As a group they are quite distinct from the large hospital information system (HIS) companies that serve hospitals, large provider enterprises, and academic medical centers.

While small, these companies often provide excellent products and services matching the needs of the ten-and-under provider practices that represent over 70 per cent of the nation's community-based medical practices. Compared to several years ago, the products they offer are more affordable, innovative, and scaled to the needs of automating medical practices rather than hospitals. As a group they have been making solid progress in their ability to export and import standardized sets of patient summary health data. In short, they have grown to be an important and innovative segment in the national health information infrastructure as health-IT suppliers to physicians and medical practices.

Because of their small size and restricted budgets, however, most of these companies have not been able to participate in the time consuming and resource intensive meeting schedules and deliverables of HITSP, and thus they have been unavailable to help provide both input and perspective to counseling ONC on the development of the national use cases and the real world market demand for particular standards important in this sector.<sup>1</sup> While the entire ONC process has arguably been "open" to this group of stakeholders, they have nonetheless been under-represented and their voices not often heard.

Quite naturally, we at the AAFP are concerned that this group of vendors and health-IT manufacturers with whom we have worked closely over the past several years not be disadvantaged with respect to the opportunity to participate in what is deemed suitable for the nation as a whole.

Secondly, we believe that the definition of the criteria for selection of certain standards under consideration by HITSP has not been sensitive to the facts of real world adoption, nor to the business case demanded by physician users of EMR and EHRs, nor of the vendors/suppliers of these systems. This process has, instead, selected several standards that have achieved only normative status (that is, standards that have been balloted but not tested for usability nor subjected to the rigors of real world deployment)

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<sup>1</sup> The following comment is from the CEO of a small EMR company, and helps to explain the situation I am describing: "I really wish we could have participated in the ONC/HITSP meetings and process. Our primary mission has been to maximize EHR adoption. The upside of this is the size of our base of users which is approaching 10,000 sites. Over 80% of these are in small, independent practices that are very cost sensitive. If we participated in the policy meetings, our costs would have to increase. This would decrease the adoption rate in this very challenging but important group of constituents. Unfortunately, even though small, independent practices represent over 50% of practicing physicians, evolving policies appear to often be in conflict with their needs. This promises a continuance of the overall, low adoption rate for the industry." Randall Oates, M.D. President, SOAPware, Inc.

while passing over standards that have become both useful and popular among many customers.

In particular, the ASTM Continuity of Care Record (CCR) standard has shown itself "ready for prime time" in the real world. A majority of commercial EMRs in the ambulatory care space are already CCR compliant and capable of CCR exchange, a limited yet very useful form of interoperability. And yet HITSP has chosen instead to promote other standards that have only normative status on the part of a particular SDO and which are without any commensurate degree of testing.

Here again, this problem may be reflective of a "disconnect" between what is happening in the marketplace of products and services that serve customers in medical practices treating large numbers of patients with a focus on chronic illnesses, and what is going on with the much smaller number of large medical institutions, such as hospitals and large academic centers, with a focus on acute illnesses.

Both groups are equally important stakeholders. However, at times, HITSP's predominantly large institution bias seems to have prevented its members from having the awareness of the innovations occurring in the community-based environment with EHRs and PHRs. As a case in point, at the last HITSP Panel meeting on September 7th, 2007, the chair of HITSP and the ONC representative stated that the real need for HITSP was "to establish an interoperable patient summary," which is precisely what the ASTM CCR standard has provided since late 2005, and with which the market is far down the process of adoption and implementation.

This is a particularly important issue because of the linkage between the HITSP recommendations, CCHIT certification of EMRs, and the Stark health-IT safe harbor requirements that govern the donation of EMRs by hospitals to physicians. Our fear is that family physicians and other providers will face delays and significantly increased costs of their health-IT purchases should the vendors of these be required to meet compliance mandates that in turn require costly "upgrades" to untested and possibly overly complex standards that have not been proven in the real world.

Despite the urgency that is felt by ONC and AHIC, and which we at the AAFP share, with regards to speedy development and implementation of health data exchange in this country, we caution the wisdom of attempting to force un-ready or un-tested standards upon a market which we know to be very dependent on the willingness of providers, many of them in small and medium size medical practices, to purchase and utilize IT products that are the targets of these standards.

Given these challenges, we strongly encourage ONC:

- 1) To develop a set of requirements to follow that would appropriately balance the needs and use cases of the ambulatory care IT market and its customers, with those of the inpatient institutions and the large enterprises, their vendors and consultants.

2) To develop requirements that more fairly balance the normative status of a given standard with its responsible SDO, and real world adoption, demand, and market use.

3) To consider a methodology for testing and assessing the utility of all standards, but especially those like the CCR standard and the Clinical Document Architecture (CDA) Continuity of Care Document (CCD) that are relatively new and which hold great promise for increasing portability and interoperability of health information, prior to making those standards part of the certification processes of CCHIT, or, through linkage, de facto standards upon which products may be donated under the provisions of the recent Stark safe harbor rulings by OIG and CMS. We suggest that there may be a number of ways to provide rapid-cycle pilot projects and laboratories for taking standards through proof-of-concept quickly and efficiently.

I thank you for the opportunity to speak to you today, and I will be glad to take any questions you have.

(Attachments)

[CCR Compatibility List]

[CCR Acceleration Task Force Member List]

[HITSP Membership List Broken Down by Stakeholder Group]

[IHE Connect-a-thon Participation List]