Statement of Peter Basch, MD, FACP
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Good afternoon and thank you for the opportunity to address this committee. I see that I know many of you, which is reflective of one of the issues I will raise, for those I don't know, a few brief words of introduction. I am a practicing physician in Washington, DC and an early adopter of health information technology, using an electronic medical record in my practice for over a decade, which has included from the very beginning, the exceedingly valuable electronic receipt of most lab results directly into the record. And as Medical Director for Ambulatory Clinical Systems at MedStar Health, I am the clinical lead for our enterprise-wide implementation of a full electronic health record for our ambulatory practices. I thus will answer the committee's question re the speed of standards development as an HIT end-user, a health system clinical leader, and a physician contributing whenever possible, to this overall technical-political transformation.

First, to the question…In my view the Office of the National Coordinator <u>is</u> proceeding fast enough on standards development. That said, this statement is <u>not</u> a blanket endorsement of how ONC is doing its job; why meaningful standards development, in my opinion, probably can't proceed any faster than it is now occurring – and indeed might have to slow down; or why a narrow focus on standards development is likely to mislead us into believing our work is done, when <u>at best</u> we have developed highly advanced enabling infrastructure that may never be optimally used towards the IOM's laudable goals of STEEEP care.

<u>Point #1 –Standards development, use cases, and clinician volunteers</u>
Developing standards is hard work under any circumstances, and arguably more difficult when that development may have the unintended consequence of worsening care. To attempt to mitigate this downside, standards are conceptualized and then advanced in the context of use cases. And for use cases to provide meaningful context, they must be vetted before many individuals who understand clinical care and the importance and consequences of secure mobilization of information. Among those stakeholders who must be at the table, are practicing clinicians. And as use case and standards vetting takes more than a casual commitment, what we typically see as clinician stakeholders are those whose jobs permit them to engage in such activities, and those who no longer see patients. While it might appear then that the right people are at the table, I would posit that these individuals, as skilled as they are, don't have the same perspective as those who continue to see patients and thus must ultimately use whatever new paradigms are developed. Suggestions for improving this situation include:

1. **Limiting the number of use cases;**
2. **Focusing first on standards that have clear clinical significance;**
3. **While it has been an honor and a source of professional and personal satisfaction to work with exceptional people such as those on this committee, I also see this familiarity as symptomatic of a problem; this same small group of dedicated people stretched past their limits, on workgroup after workgroup. Limited participation by clinical experts results in incomplete and unworkable specifications. We cannot expect clinicians who have 50-60 hours a week "day-jobs" to take on the equivalent of a second part-time job. To get a sufficient number of qualified clinicians to commit to this necessary work, we should expect that these individuals will need to cut back on their patient care workload – and will thus need adequate compensation to be made whole.**
4. **And even when we find such people, the workload and unreasonably short deadlines are more suited for workgroup members who don't have a "day job."**

Point #2 - ONC process
The lack of effective and timely communication and coordination among the major groups working on these efforts has negatively impacted the standards development process. These groups (such as HITSP, AHIC, CCHIT and others) should be able to communicate directly with each other when clarification is needed, and should not have to go through ONC each time a question arises.

Point #3 – Standards development is not enough
Creating standards is not sufficient. They must be implemented. ONC has not developed a plan to support and facilitate implementation of specifications outside of pilot NHIN projects. I mentioned in my introduction that I have been fortunate in that my EHR implementation has always had a lab results interface. Our ability to receive such results as structured data has helped us to communicate such information to others, including our patients, and to having more useful and accurate clinical decision support. We were able to do this, because as a health system, we had the resources, including an interface engine and interface engineers. Thus, with sufficient resources, perfecting the standards for lab reporting was not necessary to achieve our ends. However, that luxury is not available for most clinicians, particularly those in solo or small practice, and the absence of "plug-and-play" interoperability for results has either added substantial cost, or resulted in EHR implementations with lesser functionality.

That said, what is a burden to clinician IT purchasers is a business model for others. As long as standards development is not tightly coupled to standards deployment, we are not likely to see the savings of this interoperability passed onto end-users. Additionally, even when some vendors do implement a usable standard or otherwise make connectivity inexpensive and easy, managed care contracting makes it impossible to use normal market forces to take advantage of this benefit.

Point #4 – Standard development and deployment are necessary but insufficient.
While standards need to be developed and uniformly deployed, their absence is not primarily responsible for the lack of rapid adoption of HIT. Likewise, more rapid promulgation of standards *per se* will not lead to HIT's universal adoption. Physicians and other clinicians will adopt whatever technology infrastructure is necessary to practice medicine, provided that the implications of that adoption does not result in a long term negative business case. And until our healthcare and reimbursement systems change such that there is a sustainable business case for clinicians for management and quality, HIT will continue to be adopted slowly, and used sub-optimally.