Senate Communications & Technology Committee

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Good Morning.

I am from Lancaster General Health, a non-profit hospital system with a combined 689 beds and 40,000 annual discharges. Our annual emergency visit volume is about 109,000 and our annual outpatient volume is about 855,000 registrations.

We started our electronic health record implementation with Epic as our vendor in April 2006 and brought our first practice live in February 2007. After taking four years, we have almost completed the implementation of our employed physician practices and have implemented three independent physician practices for totals of 200 providers and about 220,000 patients seen actively using our electronic health record. Lancaster County's approximate census is just over 500,000 people. We plan to continue implementing the electronic health record in our hospitals later this year, but physician order management and clinical documentation in the hospitals will be available later in 2012.

Even though our large market share presents us with a unique opportunity to have everyone working on the same EHR, we face significant challenges ahead for our health system, physician partners, and health information exchange.

Just released last month, PricewaterhouseCoopers' Health Research Institute surveyed more than 300 provider executives and 1,000 consumers/patients. They found that the proportion of hospitals anticipating fulfillment of the 2015 Stages 1 through 3 Meaningful Use deadlines is falling, from 90 percent in spring of 2010 to 82 percent currently. This translates to extended delays in electronic health record implementation and penalties for those that fall behind the curve.

Lancaster General Health faces our own challenges during our EHR implementation. It has taken us 4 years to almost complete our physician practices. We have spent $10M on our ambulatory implementation and anticipate spending an additional $80M to implement the hospitals. We also anticipate a net add of $6-8M annually for ongoing information technology

operational costs. It is of note that 50% of these costs are in labor. To date, implementation costs and labor availability have posed the most significant challenges to Lancaster General Health.

We are also challenged to meet requirements for health information exchanges. At Lancaster General Health, we believe in the importance of exchange at a community level. As a result, we have created a Community Connect program to offer our electronic health record to our independent physicians on the Medical Staff. The program subsidizes the cost of the EHR and creates a platform for us to share medical information within the same record. Over the last 4 years of implementation, we only have 20% of our Medical Staff using the EHR. A majority of this percentage includes our employed physicians. Over 75% of the independent physicians on Staff do not currently use an EHR in their office. It has been a challenge to implement the EHR for these independent practices even though we are offering a 70% subsidy to join our EHR program. We see the same physician barriers to adoption as demonstrated nationally. Despite the subsidy, physicians, especially those in primary care, continue to worry about initial capital investment as well as ongoing maintenance costs at fair market value when the Stark subsidy ends. Small practices also worry about bringing in additional resources and spending the time needed to achieve a return on their investment. Our physicians have concerns about long-term productivity loss and illegal record tampering through the sharing of a common record. Finally, many practices are still skeptical that EHRs can even deliver improved quality.

While we have preferred using our Community Connect program to share patient data, we recognize that not all of our surrounding practices will seize this opportunity. As a result, we have created our own local exchange to interface medical data. We have several pilot practices and are currently exchanging lab orders and results. Within our exchange, we can establish connections with providers we want to network with rather than be limited to a primary referral network as proposed in the Stage 2 Meaningful Use criteria.

Our current model of exchange comes with its challenges. Due to immature standards, clinical data is more challenging to exchange among different EHRs. Consequently, exchanged information may be in a different area in the EHR and difficult for the clinician to access and incorporate into the main allergy, medical history, or result section contained within their EHR. Furthermore, physicians are questioning us regarding this exchange, "If this information is stored in another area in the EHR, which is harder to access, am I still liable for not reviewing it?" Having every progress note from the primary care physician and a patient's specialists in one system, could easily triple or quadruple the amount of information available for review at a patient's admission. Physicians are worried about missing the key document among all the additional information available. Alternatively, they have concerns that with so many interfaces a key document may get lost and would not available for review.

We believe that demonstrating a connection with the National Health Information Network (NHIN) or NHIN Direct should satisfy Meaningful Use objectives. NHIN Direct is a project to create the set of standards and services that, with a policy framework, enable simple, directed, routed, scalable transport over the Internet to be used for secure and meaningful exchange between known participants in support of meaningful use. This connects healthcare stakeholders through universal addressing using simple push of information. Built on common Internet standards for secure e-mail communication, this exchange is secure as users can easily verify

messages are complete and not tampered with in travel. This works on the Internet with no need for central network authority. It starts with standards as minimal as possible to support a basic exchange and keeps implementation costs as low as possible. We think this is a reasonable first step for exchange. This will improve clinical handoffs and increase physician acceptance of document exchanges. For Lancaster General Health, this would also allow us to concentrate on efforts in our community but still supply information to an exchange in case our patient goes anywhere in the nation.

When I discuss exchange with our Medical Staff, I usually get a reluctant response to "share my patient's information on the Internet or a government's computer." Our doctors are not interested in health information exchange or protocols for secure messaging. However, when I discuss how much we fax from our offices to the emergency room, they begin to understand the power of NHIN Direct. This is not the whole solution, but a place to start. It solves the transfer of information when the end receiver is known and is similar to how we fax or mail information today. This "push" transaction also provides security to ensure consent and legal transfer.

If Pennsylvania was to proceed with a statewide exchange, its main purpose should be to facilitate information availability to the NHIN. The most effective statewide HIE will have a way to create a master patient index that can securely integrate data and make it accessible to the NHIN. A master patient index would provide a solid way to identify patients and subsequently minimize security and privacy concerns. We struggle with supporting an opt-in model for patient authorization as we believe that this will slow meaningful incorporation of data into the exchange and thereby slow physician adoption.

We believe that the Commonwealth should work closely with those that have had successful pilots for exchange and engage key stakeholders in technical architecture as well as legal agreements. In this way, we can quickly move from strategies to tactical, proven solutions while being fiscally conservative with ARRA funding.

Clinicians need to be involved early to influence how HIE data will be accessed to make informed decisions about patient care. Clinical use will drive successful adoption over financial/insurance gains within the exchange. As mentioned earlier, our physicians fear data overload and require the HIE to display data in a clinically-friendly, easily-indexed manner. This design not only needs to be easily digestible, but also capable of generating decision support to influence patient outcomes.

In conclusion, Lancaster General Health has had our challenges with EHR implementation costs, and labor availability. Our physicians are equally challenged with several barriers to EHR implementation despite a subsidized cost. We appreciate the opportunity to share our thoughts on a statewide health information exchange. Thank you for the opportunity to provide testimony to the Committee.