To: Dr. Blumenthal
Chairman Reynolds
Members of the Executive Subcommittee

SJ: Testimony on the subject of “Meaningful Use” in EMR adoption

My name is Jack Callahan. I am Executive Vice President of Corporate Development at SRSsoft, which is headquartered in Montvale, New Jersey. SRS has over 4,000 practicing physicians as clients of our hybrid EMR product, mostly in specialist practices. Our clients are principally (though not exclusively) high-volume, high-revenue-per-visit practitioners in medium to large practices. We continue to enjoy a 100% successful implementation rate, a source of great pride for us and our clients. The reason behind that success rate, we believe, is highly relevant to the important work of the committee, and is the reason we wanted to present this testimony.

There are three important points that I would like to make. First, the government should focus on the ends, not the means; they are paying for outcomes, not for specific EMR products. Second, if widespread adoption is the goal, then the EMRs must be much more “usable”. There will be no “meaningful use” without actual use, and meaningful use by a small fraction of the provider population does not deliver the “meaningful use” sought by the legislation. Third, the there must be definitions of “meaningful use” that are relevant for all types of providers, specialists as well as primary care practitioners.

Testimony throughout the two days extended the amount of discrete data that “certified” EMR systems must gather. The discussion of the term “meaningful use” at the hearing seemed to center on the data that must be produced and shared by “certified” EHR systems. It is inferred that the end result of having such systems, will be improved outcomes, reduction of aggregated medical costs, fewer errors and enhanced patient rights and access to their health records.

But what about those who must GATHER that data—the providers and physicians themselves? The more discrete data that must be gathered and made reportable, the more burdens are placed on physicians and practices to enter this data.

There is no reason to believe that by adding the incentives of the Stimulus Bill, the problem of low adoption rate and poor success rate will be resolved. “Success” is unlikely to come from the same systems that are part of the poor track record to date. There is too much money at stake to make that assumption.

The track record of EMR installations has suffered from low adoption rates—as low as 4% of physicians use a “fully functional” EMR, and an additional 13% use EMR partially, according to a 2008 New England Journal of Medicine study. **Why has the adoption rate been so low?** Also, EMR installations have had a very disappointing success rate. By some sources, the number of EMR installations that have failed is greater than 50%. **Why is the success rate so low?**

I would suggest that the answer to the two questions above is the unacceptable decrease in productivity that results from the data entry demands on physicians.

Are there any studies that can document that the EMR adoption rate or success rate has improved since the advent of CCHIT standards in 2006? CCHIT now has nearly 500 functional requirements, a minority of which are applicable to ALL practices and specialties. Given the exorbitant cost of development and testing by CCHIT and the annual certification fees for vendors, it surely cannot be the government's intention to drive out the innovative, specialty-focused vendors who have resisted CCHIT-driven developments because their clients valued speed and productivity more? **Are CCHIT-driven requirements missing a key element?**

Providers who have resisted EMR up to now, by most studies, list **"it's too costly"** as the primary reason. Looked at closely, this "cost" objection has two components: first is the up-front cost (which providers will still have to bear under Stimulus Bill incentives); second are the operational costs of adopting EMR such costs as protracted training times, long learning curves, reduced patient volumes due to lost productivity and time spent by the provider doing detailed data entry into a computer. **What other industry asks its most highly-paid resources to do so much data entry/clerical work?**

The discussion of "meaningful use" has focused on primary care physicians, which is as it should be, given their role as gatekeepers and coordinator of care for patients with chronic illnesses. However, it is unrealistic to expect specialists to be subject to the same definitions of "meaningful use."

Regarding the CCHIT-model, none of the nearly 500 criteria deal with "usability" of the EMR product. Whether a product takes a doctor 3 mouse clicks and 10 seconds, or 20 mouse clicks and 2 minutes to accomplish, if the "function" can be demonstrated adequately, CCHIT passes it. Both products get the same credential.

I submit to this committee that the "usability" of these systems will be the key to better adoption, a higher success rate and ultimately lead to the "meaningful use" that is envisioned by all those who have worked so hard for healthcare reform up to this point. Do not get so focused on the "data output" and "data exchange" aspects of proving meaningful use that you forget the "data input" and "data gatherer" --the physicians and providers who are at the front lines of providing the care. Vendors will try to persuade you that "usability" is how they will compete for business. Specific metrics on usability are needed to validate usability.

There are alternative EMR products, the hybrid EMR, for example, that allow practitioners to continue to practice medicine in the most effective way. The legislation must be open to the meaningful use of these products as well. There is no sense to having certified products if a broad market of providers won't use them continually and completely, or simply can't "afford" them to due to productivity declines. Build "usability' metrics into the certification requirements and look closer at how hybrid EMR has solved many of the adoption/failure issues that traditional EMR has had for years, and probably will continue to have. Enable those who will be charged with "gathering" the data on which healthcare reform is relying. Meaningful Use will find its headwaters in the notion of "usability".

Thank you for your consideration…..Jack Callahan (jcallahan@srssoft.com)