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To: The Environment, Technology, and Standards Subcommittee
U.S. House of Representatives
Committee on Science

From: Witness Diane Cecchettini, RN
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Thank you Mr. Chairman and Members of the subcommittee. My name is Diane Cecchettini. I'm the President and CEO of MultiCare Health System in Tacoma, Washington, and I'm also a registered nurse. Thank you for inviting me here today to discuss the benefits of Information Technology (IT) to providers and consumers of health care, the impact of IT on quality and costs, and the incentives and barriers that exist to the broader adoption of IT in the health care industry.

MultiCare operates two adult and one pediatric hospital and we serve as a Level II trauma center for both children and adults. We have 593 licensed beds, 5 ambulatory surgery centers, six urgent care centers, and a certified home health agency and hospice program. We also employ 200 physicians in our MultiCare Medical Group. Over the last eight years, MultiCare has invested 50 million dollars implementing an electronic health record in our ambulatory physician practices. Currently, we are implementing the electronic health record (EHR) in our 3 inpatient facilities which will cost another 50 million dollars. We believe this is a critical investment to support improvements we've seen in patient care, but the costs are truly monumental. With the EHR we have a much greater ability to track our care processes using evidence-based guidelines, communicate among different providers who care for the same patient, and improve patient outcomes because of our ability to track and study data trends. Our patients also see specific benefits. Most importantly, they can participate in their care through

secure electronic access to their medical record to view medical problems, see lab work results, make appointments, review educational materials specific to their diagnoses and even refill prescriptions.

In 2001-2002, MultiCare conducted a study of 5000 diabetic patients in MultiCare Medical Group and estimated that as a result of implementing specific physician practice guidelines, which included tracking and reporting of certain lab values like blood glucose and cholesterol, along with blood pressure, 33 heart attacks and 28 deaths were prevented in one year. This of course has the downstream effects of less Emergency Department (ED) visits, less Coronary Care Unit stays and fewer cardiac catheterizations to name a few, all of which can cost tens of thousands of dollars each. The potential annual cost savings in this group of 5,000 diabetic patients alone had an estimated downstream savings to Washington State healthcare of 4.3 million dollars annually (Reed and Bernard, 2005). The journal article describing the study is attached to my written testimony. We believe firmly that while terribly expensive on the front end, EHRs save lives and will save the national health care system significantly over the long run.

Our mission is quality patient care. Because, ultimately, it is the patient who owns their clinical data, our goal is to establish one health record that spans the continuum of our services. Physicians in our EDs have access to medications and past medical history via the ambulatory record. Our ambulatory physicians and home health nurses are able to see the course of treatment when a patient is in the hospital. Our community physicians are able to remote into our system using a secure connection. Now, instead of relying on just faxes and mail, our medical records department is beginning to work with physician offices to access patient information electronically. This is much more efficient to the physician and to our hospital. Secure access for our providers can even be extended to them at home, meaning they can see important lab and radiology results as soon as they are available, even at night or on weekends. This is good for care

continuity and it also saves money because duplicate lab tests or other interventions that might be repeated, are not. Another real advantage of an EHR is the ability to contact patients quickly when a drug is recalled or found to have ill-effects for certain populations. For example, as soon as we learned of the potential problems with the drug Vioxx, we were able to immediately contact our patients receiving the drug and schedule them to talk with their doctor. When concerns arose about hormone replacement therapy in 2002, information was targeted to 15,000 women. With traditional paper systems this would be extremely time intensive, if not impossible.

Our prevention programs have also seen tremendous improvements with the EHR. Childhood immunizations have reached 100% in some of our clinics. Our mammogram compliance rate exceeds 97%. In 2003, influenza administration reminders were mobilized in 7 days for new CDC recommendations.

We feel strongly that Information technology provides our health system with several specific benefits. In particular, it allows us to:

- Practice evidence-based medicine;
- Implement disease management programs that focus on prevention and care of the chronically ill;
- Lengthen lives and allow patient participation in care;
- Prevent costly hospitalizations; and
- Support public health and biosurveillance.

We equally believe that payment incentives are key for the adopters of technology in order to achieve successful expansion throughout the country. Specifically, we would encourage the state and federal government to:

- Adopt a common set of operating standards to support interoperability;
- Provide payment incentives for adopters of technology
- Ensure protection of consumer privacy by enforcing encryption, user authentication and audit trails;

- Encourage a common set of measures to audit performance among all of the payers for health care; and
- Support a common, agreed-upon, and detailed vocabulary for all medical terminology, such as SNOMED.

A significant barrier will continue to be how to pay for information technology, especially for small hospitals, rural providers, and individual physician practices. While some federal and private grant money has been available for Health Information Technology (HIT) adoption, there simply is not enough to go around. We would like to extend the use of our EHR to smaller physician practices, and even to hospitals through application service provider arrangements (ASP). I would encourage CMS to continue to examine its interpretation of the Stark Law, in order to encourage connectivity in regional networks at a fair market value. We would also encourage CMS and other payers to ramp up efforts to expand pay for performance and reimbursement incentives for organizations that adopt information technology. Once payment is tied to the use of technology, the urgency of adoption will increase. However, hand in hand with these efforts need to be a uniform set of standards that vendors must adhere to in order to achieve the interoperability needed to ensure patient records are always available when and where they are needed.

It is also important to consider the implications of the EHR on access to and recovery of data during a disaster such as hurricane Katrina. Hospitals, clinics and other care settings, along with the paper medical record information in those facilities were literally destroyed. As evacuees crowded into shelters with many in need of medical attention, doctors who treated the patients had to do so with only a rudimentary knowledge of their past treatments. However, area hospitals that already had electronic health record capacity lost virtually no patient data. Implementation of interoperability standards facilitating safe information exchange and appropriate redundancy planning in case of another disaster can

ensure that electronic patient information can be available much sooner, alleviating many of the challenges faced by care givers in difficult circumstances.

I have the honor of currently serving as the Chairperson of the Washington State Hospital Association. As a state, the health systems in Washington have actively embraced the Institute for Healthcare Improvement's 100,000 lives campaign. We firmly believe that technology can improve care quality in our hospitals and save money. While the return on investment is not immediate, EHRs are key to achieve the efficiencies and care management so crucial to patient safety in the hospital, and to address the needs of the chronically ill. The task of developing a National Health Infrastructure is extremely difficult and complex--it is a long term endeavor. However, it is imperative that it be done and I appreciate the leadership of the Subcommittee.

Thank you. Mr. Chairman, this completes my statement. I will be happy to answer any questions that you or other Members of the Subcommittee might have for me.