1
2 PA HOUSE OF REPRESENTATIVES
INSURANCE COMMITTEE
3 PUBLIC HEARING
4 ---
Thursday, April 22, 2010
5 Ambler, Pennsylvania
6 ---
7 COMMITTEE MEMBERS PRESENT:
8 REPRESENTATIVE ANTHONY DeLUCA, Chairman
REPRESENTATIVE BRENDAN BOYLE,
9 REPRESENTATIVE GARY DAY
REPRESENTATIVE EDDIE DAY PASHINSKI
10 REPRESENTATIVE MARGUERITE QUINN
REPRESENTATIVE JOSH SHAPIRO
11 REPRESENTATIVE RICK TAYLOR
REPRESENTATIVE TOM HENNESSEY
12
OTHERS PRESENT:
13
KATHY McCORMAC, Republican Executive
14 Director
ART McNULTY, Democratic Executive
15 Director
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HELD AT: Ambler Theater
18 Ambler, Pennsylvania
19 REPORTED BY: SUSAN L. SINGLAR, Court
Reporter-Notary Public
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2 TESTIFIERS:
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4 JULIE S. MASSEY, M.D., Chief Medical
Information Officer, Albert Einstein
5 Healthcare Network
6 DARLENE KAUFFMAN, Associate Director,
Payer Relations PA Medical Society
7
ANN S. TORREGROSSA, Director, Governor's
8 Office of Healthcare Reform
9 PHILIP MAGISTRO, Deputy Director
10 KELLY LEWIS, President, The Technology
Council of Central PA
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MARTIN CICCOCIOPPO, Vice President,
12 Research, The Hospital & Healthsystem
Association of PA
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ROBERT GABBAY, M.D., Director, Penn State
14 Institute for Diabetes & Obesity
15 ELLIOT B. SLOAN, President, Executive
Director, Health Information
16 Management Systems Society
17 ERIC GERTNER, M.D., Associate Chief of
External Programs, Division of
18 Internal Medicine, Lehigh Valley
Health Network
19
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21
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1 REP. DeLUCA: Good morning,
2 ladies and gentlemen. Welcome to the House
3 Insurance Committee meeting here on House Bill 2106
4 sponsored by my good friend, Representative Taylor.
5 Before I continue, I'd like to ask everyone to
6 introduce themselves.
7 REP. PASHINSKI: Good morning,
8 Representative Eddie Day Pashinski, 121st District,
9 Luzern County.
10 MR. TAYLOR: Rick Taylor,
11 Montgomery County, Ambler, right here.
12 REP. DeLUCA: Who is our host.
13 I'm Representative Tony DeLuca.
14 I'm the Chairman of the Insurance Committee from
15 the 32nd Legislative District, and that's in
16 Allegheny County.
17 MR. McNULTY: Art McNulty,
18 Executive Director, House Insurance Committee.
19 MR. DAY: Gary Day, State
20 Representative, 187th District, Lehigh and Berks
21 County.
22 REP. DeLUCA: Coming down the
23 theater steps is Representative Marguerite Quinn.
24 Welcome, Marguerite.
25 We have Kathy McCormac, who is

1 the Executive Director of the Republican Insurance
2 Committee. And today it's a toss up between
3 Representative Quinn and Representative Day being
4 the chairman of the Republican Committee
5 representing the Chairman. So you two are going to
6 fight on who the chairman is today.
7 This Bill is the Health
8 Information Technology Act and it contains several
9 important features, including the creation of the
10 Pennsylvania Health Information Exchange Authority.
11 The Authority will consist of 17 members, which are
12 appointed by the governor and legislative leaders.
13 It will act as a governed structure under which the
14 Commonwealth's self information exchange system is
15 developed. In addition, the Bill creates the
16 Health Information Technology Fund. The Fund will
17 be administered by the Department of Economic and
18 Community Development, who will be responsible for
19 the Bill's loan and grant program so that the
20 health care providers can obtain funds for the
21 implementation of electronic medical records.
22 Electronic medical records are an important piece
23 of the puzzle for reforming the health care system
24 in the Commonwealth and nationally.
25 And I want to congratulate

1 Representative Taylor for introducing this
2 important piece of legislation. Certainly, it's on
3 the cutting edge and it's certainly appropriate,,
4 Representative Taylor, so I commend you very much.
5 The Authority will be in the best position to
6 implement a state-wide strategy that ensures that
7 its citizens enjoy all the benefits that electronic
8 medical records will bring to the health care
9 system. These benefits include better outcomes for
10 patients, better patient management for the
11 providers and eliminate the inefficient and
12 duplication services with an overall savings to the
13 system.
14 In addition, the Authority will
15 be able to ensure appropriate resolution of all the
16 issues surrounding implementation of electronic
17 medical records, such as adequate security of the
18 medical information, patients' privacy and the
19 creation of a fair and balanced system; wherein all
20 parties are timely sharing information that will
21 benefit the patients. The House Insurance
22 Committee is pleased to have the expertise and
23 knowledge based of the individuals that make up
24 today's agenda, and we look forward to the value
25 that all of you can add to this important issue.

1 Before I call the first witness,
2 I would like to represent our host, my good friend,
3 State Representative Rick Taylor, who has been
4 doing an outstanding job, not only on this
5 Committee, but in Harrisburg. He's been at the
6 forefront, as everyone on this table here, daises
7 here, on health care issues. He's been a fighter
8 for the cancer clinical trials, small group reform,
9 and also the very important piece of legislation
10 that we passed pertaining to hospital-acquired
11 infections. He's certainly been an asset to the
12 Insurance Committee.
13 Representative Taylor?
14 MR. TAYLOR: Thank you, Mr.
15 Chairman. Thank you for coming down to the
16 Insurance Committee. I really do appreciate it. I
17 also appreciate you coming to this wonderful
18 theater. I figured if there was an ideal location,
19 if someone could sit and watch a three hour French
20 film here, they certainly can do a three hour
21 hearing on insurance.
22 But anyway, I wanted to say that
23 I'm very passionate about this issue. Not only as
24 have you stated, Mr. Chairman, in this area that we
25 can improve patient outcomes and medical

1 efficiencies, but we can also bring jobs to our
2 communities. The health IT field is a growing
3 field and the infusion of federal dollars will help
4 spur the private investment. Based on what we've
5 seen in our states and other states that have
6 widespread use of health information exchanges
7 coupled with the amount of physicians, hospitals
8 and health systems in Pennsylvania, we could
9 potentially see the creation of 7,000 jobs in the
10 Commonwealth. But we have got to make sure we do
11 it right.
12 To do that we must have a
13 streamlined system. The federal investment is
14 critical to organizing and creating a workable
15 structure for Pennsylvania's Health Information
16 Exchange. Too often it can be a disjointed
17 approach and it can lead to failure of the entire
18 system. I believe that House Bill 2106 will
19 prevent that. House Bill 2106 will give the
20 stakeholders a seat on the Authority to make sure
21 that we are stringent with patient data but nimble
22 enough not to smother a budding industry in its
23 growing years.
24 Again, I thank Mr. Chairman for
25 realizing the importance of this issue, and I thank

1 all the testifiers and the members of the audience
2 for attending and helping to move this Bill through
3 the legislative process.
4 REP. DeLUCA: Thank you,
5 Representative Taylor. And let me just say for the
6 public that this Insurance Committee has been
7 working bipartisanly. We hear a lot of issues out
8 there, especially on the federal and sometimes even
9 with the State, about partisanship, but this
10 Committee, I have found, to be very nonpartisan,
11 working together on behalf of the citizens of
12 Pennsylvania, and I'd like to commend each and
13 every one of our members up here for a fine job
14 they do in trying to represent -- doing a good job,
15 not trying, doing a good job for the residents of
16 the Commonwealth of Pennsylvania.
17 The first person to testify today
18 will be Julie Massey, M.D., chief medical
19 information officer, Albert Einstein Healthcare
20 Network.
21 Welcome, Julie.
22 DR. MASSEY: I am Dr. Julie
23 Massey, Chief Medical Information Officer at Albert
24 Einstein Healthcare Network. Thank you for the
25 opportunity to speak with you today.

1 Einstein is around urban safety
2 net health care system. We have over 1,200 beds
3 and 100 outpatient facilities serving the greater
4 Philadelphia region. We employ more than 7,000
5 people and offer training programs for physicians,
6 nurses, pharmacists and other health care
7 professionals. As a community not-for-profit
8 organization we take seriously our responsibility
9 to understand and meet the diverse health care
10 needs of the patient population that is
11 predominantly covered by government payers, of
12 which 50 percent are covered by Medicaid and 34 by
13 Medicare.
14 Implementing an advanced
15 electronic medical record is critical to Albert
16 Einstein's ability to continue to provide the
17 highest quality and safest level of care to our
18 patients. In fact, our EMR initiative is the
19 largest single project in the nearly 150-year
20 history of our organization. We believe that
21 appropriate, secure sharing of clinical
22 information, both within the health care
23 organizations and with other providers, is an
24 essential component of advancing quality and
25 coordination of care while potentially reducing

1 costs.

2 Our electronic medical record

3 project was approved by our Board of Trustees in

4 the fall of 2008 prior to the adoption of the ARRA

5 and HITECH acts. At that time our Board of

6 Trustees approved the first phase of a ten year,

7 nearly hundred million dollar investment to

8 implement an electronic medical record in our

9 hospitals. This first phase of our project will

10 allow Einstein to meet the current proposed CMS

11 Stage I meaningful use definition. It's important

12 to know that Einstein will need to make an

13 additional investments to meet further stages of

14 meaningful use and to provide electronic medical

15 record solutions to our more than 300 employee

16 physicians in their offices. We believe these

17 additional investments will cost 30 to 40 million

18 dollars.

19 Einstein is very appreciative of

20 the government's significant investment in health

21 care IT through the American Recovery and

22 Reinvestment Act. We think it is important to

23 realize, however, that the HIT incentive program

24 will only offset about ten to 13 percent of our

25 total cost investment, assuming we meet the

1 definition of meaningful use. Therefore, we
2 believe it is important to take several items into
3 consideration as you move forward.
4 We understand that ARRA provides
5 states with discretion regarding how and when
6 Medicade HIT incentive payments are made both to
7 hospitals and eligible providers. Einstein, like
8 many health care organizations with large Medicaid
9 patient populations, is continuously challenged to
10 find capital for many worthy projects, including
11 HIT. We believe that the use of Medicaid HIT
12 incentive payments to health care providers should
13 be leveraged as quickly as possible by DPW. In
14 order to accelerate a statewide commitment to
15 meaningful EHR use, early access to funds will
16 incentivize (sic) hospitals and other health care
17 providers to move forward with these expensive and
18 complex projects.
19 By identifying the eligible
20 providers who are meaningful users or who are
21 working to become meaningful users, DPW can make
22 first-year payments as soon as January, 2011, which
23 will encourage rapid adoption. We also urge DPW to
24 exercise its discretion to pay high medical
25 assistance hospitals and eligible providers half of

1 their full multi-year payments in the first year in
2 order to accelerate adoption.
3 The Health Information Technology
4 Act, House Bill 2106, introduced by Representative
5 Rick Taylor, would establish the Pennsylvania
6 Health Information Exchange Authority, or PHIX, and
7 the Loans or Grants for Information Networks
8 Program. The measure creates a framework for
9 secure transfer of electronic health records and
10 other technologies that store, protect, retrieve
11 and transfer clinical, administrative and financial
12 information electronically within the health care
13 setting. The Bill will create the Authority to
14 govern and operate a state-wide electronic Health
15 Information Exchange. In addition, the Bill
16 prohibit using sensitive information submitted to
17 the Authority to compare health care providers. We
18 believe the establishment of a state-wide Health
19 Information Exchange structure is a crucial step to
20 achieving the promise of improved quality and care
21 coordination.
22 The Loans or Grants for
23 Information Networks will provide the framework to
24 financially assist providers, both large and small.
25 It is imperative for the long-term success of HIT

1 that individual and group physician practices and
2 hospitals have access to the technical and
3 financial assistance to successfully implement
4 health IT. As providers, we didn't learn about
5 health care IT in medical school. We know that
6 health care IT will greatly improve health care
7 quality, but we need expert assistance in order to
8 achieve adoption and to share best practices.
9 In March, the Governor's Office
10 of health care Reform sent the Pennsylvania Health
11 Information Exchange strategic plan to the office
12 of National Coordinator for HIT for review and
13 approval. This plan differs from the November,
14 2009 proposal in that it calls for the issuance of
15 an RFP for a technology partner to build PHIX. The
16 final PHIX strategic plan also does not include
17 dedicated funding for building and maintaining PHIX
18 beyond the initial 17 million dollars awarded to
19 Pennsylvania by the Office of the National
20 Coordinator.
21 A robust Health Information
22 Exchange system will create significant cost
23 benefits for payer organizations by improving
24 efficiency of the health care system. We believe
25 it is critical provider organizations should not be

1 burdened with the cost of creating and maintaining
2 the Health Information Exchange when we receive no
3 financial benefit from its deployment.
4 ARRA allows states to adopt
5 meaningful use definitions that vary from the CMS
6 Medicare meaningful use definition. Under the
7 proposed rules from CMS, a provider would be
8 eligible for Medicaid incentives if they meet the
9 Medicare definition of meaningful use. As we
10 understand DPW's vision, which was published prior
11 to the CMS proposed rules, Pennsylvania intends to
12 adopt CMS Medicare meaningful use definition and
13 establish additional electronic reporting
14 requirements: Electronic Quality Improvement
15 Projects. We are concerned that these additional
16 electronic reporting requirements for 2011 would
17 make it even more difficult for providers to
18 qualify for the HIT incentive payments in 2011 or
19 2012. Einstein desires one clear target for
20 meaningful use, which does not require us to meet
21 multiple standards.
22 Physicians in our offices and in
23 the hospital need better access to our patient's
24 data to improve the quality of our care and
25 coordination of our care. Today, much time is

1 spent in our offices collecting patient information
2 from multiple, different sources. This time could
3 be much better spent directly caring for our
4 patients. Health Information Exchange is a
5 necessary step to achieve this goal.
6 Einstein is deeply appreciative
7 of Representative Taylor's efforts to work with the
8 provider community on this legislation, which will
9 play a vital role in the PHIX strategic plan. We
10 believe the authority created by House Bill 2106
11 should govern the PHIX. We urge your support of
12 House Bill 2106.
13 In conclusion, Einstein is an
14 enthusiastic participant and supporter of the
15 implementation and adoption of health care IT. We
16 believe that HIT will enhance the quality, safety
17 an efficiency of care provided to our community.
18 We're making substantial investments in these
19 technologies and encourage the Committee to
20 consider our concerns to prevent providers from
21 being overly burdened with the cost of HIT, which
22 could slow down and weaken implementation efforts.
23 Thank you, again, for the
24 opportunity to talk with you today and to provide
25 Einstein's perspective on the implementation of

1 health care IT. We welcome the opportunity to work
2 with you on this important initiative. Thank you.
3 REP. DeLUCA: Thank you, Doctor,
4 and we look forward to working with you and a lot
5 of the stakeholders on this legislation, which is a
6 very important piece of legislation.
7 Doctor, you acknowledged the need
8 for funding at the state level for the
9 implementation of electronic medical records in
10 this State.
11 Now, what funding source were you
12 suggesting that the Pennsylvania -- it's a tough
13 one.
14 DR. MASSEY: It's a tough one.
15 REP. DeLUCA: -- adopt? And I
16 don't know if you have looked at that, if you've
17 thought about it. It may be some of the other
18 testifiers, if they would, while you're the
19 audience, think about that, we'd appreciate it.
20 DR. MASSEY: I think there are
21 important considerations to think about. We know
22 in our systems that we need to align the incentives
23 with where the efficiencies and the -- where you're
24 going to see things get better from a cost
25 perspective. So we need to look at aligning those

1 incentives so that we can improve both our
2 providers, they need to have the incentive and the
3 reason to want to make these investments, and we
4 need to find the funding in guilty the areas where
5 we're going to see the efficiencies improve.
6 REP. DeLUCA: Let me also -- I
7 see your summary here. Quality coordination of
8 care for the patient, which is what we're striving
9 for.
10 How do we -- and I have talked to
11 some of my physicians back home, and they're really
12 not too enthused about this type of -- having
13 medical records and the technology. They believe
14 that probably it will -- even with the incentives,
15 would cost them more money and take time away from
16 the practices because they're worried about the
17 reimbursements that they're not getting.
18 How would you suggest that we
19 sell this program to some of the -- well, a
20 majority of the physicians out there who are a
21 little leery about going into this?
22 DR. MASSEY: The cost and the
23 complexity of projects like this is daunting,
24 especially when it is so far out of what we
25 normally do and our focus is on our patients.

1 Lending the support to help with the technical
2 aspect so that we can be less worried to overcome
3 those challenges. And the adoption issue, when we
4 talk with physicians who have used medical records,
5 there is a period of time of adjustment, the design
6 process, where things are slower. But the improved
7 efficiency, when you start to ask physicians about
8 how long it takes to find the results of certain
9 tests when they're done in multiple, different
10 networks, particularly in the Philadelphia area,
11 there are so many of us close together, to actually
12 gather that information, to call and get the right
13 doctor on the phone, the right results, if they
14 could have that process at the touch of a button,
15 that time can be made more efficient to direct and
16 actually do things like the medical health, to do
17 things that are more focused on the coordination of
18 the care of our patients, if we didn't have to
19 spend so much time looking for the data or
20 potentially replicating the data because we can't
21 find it. It happens often.
22 I'm a primary care pediatrician
23 by training, and just having so many different
24 places to look and relying on our patients for the
25 results of the information and to drive the care,

1 we're the ones that are best to drive their care,
2 but we need the time to be able to do it. And the
3 tool properly implemented should assist us with
4 being able to find the time and decreasing this
5 unnecessary wasted time in our day.
6 REP. DeLUCA: Good. Good.
7 I want to recognize
8 Representative Tim Hennessy, who has joined us
9 today, too. Thank you, Tim, for showing up.
10 Any questions from the
11 Representatives?
12 Representative Pashinski?
13 REP. PASHINSKI: Thank you, Mr.
14 Chairman.
15 Thank you very much, Doctor.
16 It's a pretty exciting project,
17 isn't it?
18 DR. MASSEY: It is.
19 REP. PASHINSKI: Could you take
20 us through -- there's a couple of things I'd like
21 to touch upon.
22 First of all, you said that when
23 you're medical school you didn't receive any
24 training with respect to medical information
25 technology; is that correct?

1 DR. MASSEY: When I was in
2 medical school we actually were just on the cusp of
3 learning about some of what computers can do,
4 particularly in the education side and how you can
5 enhance training and education for physicians. It
6 was really the beginning of electronic records. As
7 a resident I trained. We did have some clinical
8 decision support on a computer that you could use.
9 But there's -- we don't learn about the technology.
10 We spend so much time focusing on what we do to
11 learn the medical care for our patients, the
12 technical aspects can be really daunting.
13 REP. PASHINSKI: I agree with
14 that. But the exciting part of all of this is that
15 once we get through the building process, the
16 accuracy, the real-time data and the speed at which
17 you can obtain proper information so that you can
18 then do a legitimate diagnoses and then being able
19 to then present a cure is pretty exciting. We
20 talked about going into doctors' office, dentists'
21 office and seeing walls of files, paper files. So,
22 essentially, what this is going to do is take those
23 paper files, put that into an electronic format.
24 That electronic format will then
25 be able to be transmitted to anybody that's

1 connected to this beltway, to this highway, and
2 instantaneously you will have access, with the
3 proper security codes, to gather that information
4 that you need to treat your patient; is that
5 correct?
6 DR. MASSEY: Well, our hope is
7 that -- particularly the key critical elements,
8 there can be volumes of information. But there are
9 key elements that we can identify that are
10 important to exchange. It's things as simple as
11 allergy information, medication lists, diagnoses,
12 key results, lab tests so they don't need to be
13 repeated, expensive tests, like some of our imaging
14 studies, when they have been done, they should be
15 able to be shared so that even different physicians
16 that are caring for the same patient are dealing
17 with the same information and can enhance the
18 communication between those specialists so that
19 they have that information.
20 REP. PASHINSKI: I appreciate
21 that.
22 Would you then say that the
23 likelihood of eliminating errors would be far
24 better?
25 DR. MASSEY: There are studies

1 that have shown improvements in errors. Certainly,
2 it's very difficult to make an accurate diagnosis
3 if you don't have all the information in front of
4 you, or if you're dealing with disparate pieces of
5 information that are not all in the same place. So
6 the other piece to this is not just the electronic
7 version of a record that's sitting, instead of
8 paper, but it's the ability to link to notable
9 guidelines to be able to improve the decision
10 support, provide rules and alerts. It's something
11 as simple as I'm seeing a patient that is coming in
12 for a sick visit and I know they're due for a
13 chronic care management, it's right there and can
14 alert me and help me connect with my patient.
15 But more than, it's bringing some
16 of the evidence-based medicine to the bedside where
17 a patient is being seen so that you can link to --
18 there's so much information that is appearing in
19 our literature everyday, it's impossible to keep
20 track of all of that and to bring it to read and
21 keep -- there's just not enough time in the day.
22 But to be able to use the power of a computer to be
23 able the filter those things and bring what I need
24 to take care of a patient to the bedside when I'm
25 caring for the patient to help me guide my care

1 should help that, as well.
2 REP. PASHINSKI: I appreciate
3 your testimony. I appreciate you giving up your
4 valuable time and the good work that you do, and
5 I'm glad that you're supporting this effort. Thank
6 you.
7 DR. MASSEY: Thank you.
8 MR. TAYLOR: Thank you for coming
9 to testify. And I hear you trying to keep up with
10 everything. So far the House has ventured 2,500
11 bills, so keeping up with your own professional
12 standards is hard to do. But when I look at this
13 Bill, and my hope is one of the things is to create
14 more efficiency within hospitals to drive down the
15 costs of health care.
16 What would it do on the
17 administrative side in your expertise as a chief
18 medical information officer at Einstein?
19 DR. MASSEY: I think there's a
20 few things. I think there is, just as a practicing
21 physician, the burden of exchanging even
22 administrative data. If we can streamline that and
23 make that easier, it reduces the time for my
24 support staff and reduces the time for even things
25 as simple as knowing which medication is on which

1 insurance formulary at the time when I'm writing
2 the prescription so it doesn't have multiple phone
3 calls going back and forth is critical. So just
4 the improvement on the administrative side is the
5 beginning.
6 And I think add to that the
7 potential for reducing duplications in care,
8 because we just don't have what we need when we
9 need it. Emergency room visits in one place and a
10 day or two later in another place in the middle of
11 the night and you don't have access to the
12 information, and so you have to care for the
13 patient in front of you and we know what we have to
14 do to secure the safety and security of the
15 patient, but if we knew they just had the same test
16 done the day before at another hospital, it's going
17 to reduce the need to have that kind of
18 duplication.
19 MR. TAYLOR: Thank you.
20 REP. DeLUCA: Representative Day?
21 MR. DAY: Thank you, Mr.
22 Chairman, and thank you for bringing the Committee
23 outside of Harrisburg out here in the communities
24 of Pennsylvania.
25 I'd like to thank you for your

1 testimony today. A couple of quick questions.
2 With a system like this, we would probably need to
3 standardize the method for recording PHI or
4 personal health records or information.
5 How do you believe the adoption
6 of that would be among our health care providers?
7 DR. MASSEY: The system we're
8 implementing, and most systems do have tools to
9 make it intuitive for physicians to use while
10 translating into standardized dictionaries and
11 technology. It does need to be codified, discreet
12 data that we need to exchange. And I think in the
13 key areas there's a learning curve that needs to be
14 overcome, but once you get past that, our job, my
15 job, as the Chief Medical Information Officer, is
16 to make sure that the things are intuitive, that we
17 have synonyms, that we have ways to make that
18 easier for the physicians to find things the way
19 they're used to finding them. But it needs to be
20 translated into a language that can be exchanged
21 and shared so that there's consistency.
22 MR. DAY: How do you feel about
23 -- I know section C7 and section E address
24 security of personal health information.
25 But how do you feel about maybe

1 the legislature drawing a line where everyone can
2 agree by putting it in the law, also, that would
3 require mandatory, either disposition of records or
4 mandatory hands-off archiving, you know, another
5 barrier to -- for the record so at some point
6 they're either disposed of or archived and only
7 accessed under another level of security?
8 DR. MASSEY: I think computers
9 are very smart today. They do have a lot of
10 auditing capability if you need to know who is
11 accessing different parts of the record. As a
12 pediatrician I have little limited back retro that
13 I need to look. There's only so long for the
14 lifetime. But for the lifetime of a patient and
15 towards -- they're much longer, and there could be
16 key pieces of information.
17 I think what's important to
18 exchange may not be that whole paper record that
19 you're talking about, but the key elements that we
20 can all agree on that should always be exchanged,
21 the things that will really help us, some of the
22 consultant notes, some of the things that help us
23 drive our decision making in diagnoses, allergies,
24 medication. If we can agree on those key elements
25 that are always readily available, we need to make

1 some distinction between what we have to read
2 versus the volumes. Just because it's on the
3 computer doesn't necessarily mean it's easy to read
4 if there's a lot of it, but we need to be able to
5 identify the key elements that are going to help
6 us.
7 MR. DAY: Thank you. I
8 appreciate that.
9 My last question is: Do you
10 believe this system could potentially evolve in
11 future years to a smart system that actually aids
12 in diagnosis where when have you certain components
13 of a person's history together with what we learn
14 in medical school and the computer actually making
15 recommendations and suggestions?
16 DR. MASSEY: The computer can
17 help guide us, but it's still a computer. There's
18 still a distinct component of hands on, of
19 understanding and talking with our patients of what
20 we understand and read between the lines. It may
21 help guide us on things we might not have thought
22 of because they weren't in our forefront to
23 consider, it's never going to replace what we do,
24 but it certainly will be a tool that will help
25 filter from the vast information out there, help

1 filter and guide us in our decision making.

2 MR. DAY: Thank you again for

3 your testimony.

4 REP. DeLUCA: Representative

5 Quinn?

6 REP. QUINN: Thank you. Thank

7 you all for being here. I came to learn about this

8 and to follow up. About two years ago I had the

9 privilege of sitting with the hospital I represent,

10 Doylestown Hospital, and I went through a whole

11 presentation. They have invested in electronic

12 medical records. And the benefits, everything that

13 you're saying, the benefits and being able to have

14 all of that information in such a timely fashion,

15 it's wonderful. However, it's still based on

16 compliance of the whole provider population.

17 And that's what -- what concerns

18 me then and continues to concern me in Pennsylvania

19 we have -- we have got more older doctors than we

20 have young doctors coming in. And it's the old

21 trick, tough to teach an old dog a new trick, and I

22 do have concerns that given the investment in this

23 systems, even if there's help with that, but the

24 investment that it would be in the offices that

25 have to feed in, so not the offices for the

1 hospitalists (sic) but for the ancillary offices,
2 how -- there's going to be training. That's staff
3 that's been around for a long time.
4 How do you address that? This is
5 only as good as the information it receives.
6 DR. MASSEY: And it's only as
7 good as the people who use it, absolutely. And
8 that is the major focus of why my organization has
9 committed to having me as a physician involved in
10 the design and deployment of that. Part of that is
11 the up-front design and the support in being able
12 to make the system as intuitive and consistent with
13 what we expect as physicians.
14 I have spoken with a number of
15 physicians, and it's interesting, we do make that
16 generational leap of older physicians may not be
17 wanting to use computers. And while there's some
18 component of that, I have often been struck by it
19 not only being generational, there are some
20 physicians in the younger generation that you would
21 expect adopting computers right away that are a
22 challenge.
23 We see computers permeate so much
24 of our world, our medical world and our own
25 education, going to the bank, doing our online

1 ordering. Even in the different generations we see
2 that more and more. And as that permeates more of
3 what we do in the rest of our lives, it helps the
4 adoption of using a computer. But the design is
5 not just the design of the computer screens. It's
6 having clinicians, nurses, physicians, office
7 managers involved in the work flow of what is
8 happening in their office. They need to
9 participate in the design of how they're going to
10 use the system, not just the design of the computer
11 screens. And if you go through that and have that
12 technical assistance and support, that sharing of
13 best practices so that we can all understand what
14 some of that guidance is and put that in the right
15 way, then you help to overcome those initial
16 barriers. There's still a learning curve.
17 If you've talked with physicians
18 who have used these for a number of months or
19 years, they can't imagine going back to not having
20 the tools that they need to take care of their
21 patients. But we need to get past that initial
22 reluctance and inertia. And some of the support
23 that we can get through having local experts that
24 we can turn to to help us in our offices will help
25 overcome that initial reluctance. But getting past

1 there and getting used to using it, it's got to fit
2 into their everyday world. It can't just be thrust
3 upon them by someone that's not involved.
4 REP. QUINN: I disagree with not
5 one part of your answer there.
6 But is there a mandatory
7 compliance element to this that I'm just missing,
8 or is it a peer pressure?
9 DR. MASSEY: I think it's a
10 combination. Part of the push and incentive
11 support is something that will truly help pull docs
12 along. They have to have a reason to go through
13 the difficulties and challenges to design and do
14 it. There has to be something to incentavize (sic)
15 them, to push them along. And that, I think, is
16 what we're seeing in some of the other legislation
17 that's sort of pushed a reason for us to do it. We
18 have penalties looming if we don't do it after
19 2015. Those are all reasons to make us want to do
20 it. Once we get past that initial -- it's hard to
21 make someone do something they don't want to do
22 simply by telling them it's mandatory, but you have
23 to align their needs with what the system will do.
24 And if can you do that and overcome that initial
25 reluctance, then we all have aligned what our needs

1 are for everybody.

2 REP. QUINN: Through your efforts

3 in educating your peers on this, have you received

4 any comments or indication that we'll actually lose

5 some docs who just say: The heck with it? By that

6 time, I'm not going to be practicing, and this is

7 just one more element that they say: I'm not going

8 to deal with it?

9 DR. MASSEY: When I have had

10 heard those kinds of pieces, often they have a

11 younger extender or another physician in their

12 office who is helping edge them on. When they have

13 given up totally, I don't see it as this being the

14 only thing. There are other things that are making

15 them make their decision. I have not heard the

16 push back that this is going to make people leave

17 medicine.

18 REP. QUINN: Two more questions,

19 if you can indulge me. I have a bill that requires

20 patients to get copies of certain test results.

21 Is there a patient portion of

22 this? You mentioned accessing codes.

23 What accessibility does the

24 patient have to their own electronic medical

25 records?

1 DR. MASSEY: Lots of the
2 individual vendors do provide and most do a portal
3 for the patient, should they choose to sign up to
4 directly access their records. One of the most
5 exciting things for me in that portal is not just
6 the receiving of my results but the ability to have
7 secure communication with the physicians. Some are
8 more advanced. That tends to be a later thing that
9 people add on. They have got the get the framework
10 in place, and then they can add that secure
11 messaging.
12 But the ability to improve the
13 way we talk with our patients in the way that they
14 communicate, our patients are working, they're not
15 always in the house when we're in the office. But
16 the ability to have that asynchronist communication
17 and secure messaging back and forth can enhance the
18 communication and better allow the patient to have
19 the information they need to manage their own
20 health care.
21 REP. QUINN: I have received
22 feedback on my bill, that it could be too much
23 information for a patient. And in that feedback
24 has been some push back, too, to moving it along.
25 Do you have concerns that the

1 patient is going to be freaking out at 11:00 at
2 night when they read this, not normal office
3 hours?
4 DR. MASSEY: What I think is
5 important that, again, the primary physician or the
6 physician who is taking care of the patient who is
7 getting those results can add communication to the
8 patient about what they need to do or don't need to
9 do. That allows that human filter to be able to
10 sigh: This is a message I can communicate to my
11 patient and they will get it at 11:00 at night, or
12 I have a relationship with my patient, I know I
13 need to call them during the day and have a phone
14 conversation. I'm reluctant to just sort of dump
15 all of the information immediately to a patient
16 without the ability to have that secure
17 communication with their physician who is going to
18 help guide them there. And that's what I find
19 exciting. It's a tool to help us enhance that
20 communication, not simply have access to things
21 that they may or may not understand the relevance
22 simply by a number that they see on a result or
23 what it means.
24 REP. QUINN: One other question
25 just to your direct testimony. You mentioned that

1 you'd urge DPW to exercise the discretion to pay
2 medical assistant hospitals and eligible providers
3 half of their full multi-year payments during the
4 first year in order to speed up the HIT adoption.
5 We're in a really bad budget crisis.
6 How do you envision DPW
7 accelerating these payments, with a push from the
8 feds, push meaning money?
9 DR. MASSEY: Yeah. That's where
10 the source of the finances are coming from, and to
11 be able to disperse them -- they have the
12 discretion in when they can disburse them, but it's
13 important they be dedicated for the projects that
14 they're aimed to support.
15 REP. QUINN: Could you be more
16 specific in terms of how you see that, and are you
17 also in communication with your federal reps to try
18 and encourage that?
19 DR. MASSEY: We do. We are
20 working on the federal level, as well. When those
21 funds are available, when they pass through the
22 Medicaid to disperse them. It's important they get
23 targeted to support the implementation as they are
24 through Medicaid.
25 REP. QUINN: Is it possible for

1 it to come down that fast from the feds? These
2 wheels turn awfully slowly.
3 DR. MASSEY: The promise so far
4 is we get the structure in place, and that should
5 be. We don't know, but we would hope that that
6 would be the case.
7 REP. QUINN: Thank you very much.
8 REP. DeLUCA: Representative
9 Hennessey?
10 REP. HENNESSY: Thank you, Mr.
11 Chairman.
12 Dr. Massey, thank you for your
13 testimony. You've indicated that Albert Einstein
14 is investing a hundred million dollars over the
15 next ten years, plus maybe another 30 to 40 million
16 to link your employee doctors, people that are on
17 your staff or work for your system. And I'm going
18 to guess that University of Pennsylvania is going
19 to be doing the same thing, and Jefferson and
20 Temple Medical.
21 Is there anybody that's
22 developing a uniform system? I realize the
23 computers -- the whole technology is evolving, but
24 it would seem to me to be a shame to do what we did
25 before in the video field when VHS was competing

1 with beta.
2 And is there anybody out there
3 that's watching to make sure that we don't create
4 systems that sort of compete with each other, as
5 opposed to compliment each other?
6 DR. MASSEY: There's a couple of
7 things. There are standards that are being
8 established that the vendors are matching to allow
9 that exchange, but that's one of the reasons that
10 legislation like this is so critical.
11 REP. HENNESSY: Where is that
12 standard being created, at the federal level, at
13 the state level, among yourselves?
14 DR. MASSEY: The standards are
15 being developed now at the federal level for what
16 those languages are so that they can talk to each
17 other and not be towers and silos that can't talk.
18 But it is critical to have the framework that sets
19 the standards. That's what a lot of it -- this
20 piece of legislation will help that framework
21 because it will set the standards that everybody
22 can agree for what that communication tool will be.
23 We can put the infrastructure and the framework and
24 say: You can create what you're doing with your
25 own vendor, but it must be able to talk in this

1 language to everybody else. That's one of the
2 reasons that at the state level I think it is so
3 critical to have the state involved, because that
4 standard setting, having the expert set the
5 standard will help keep us from having these
6 disparate systems that don't talk with each other.
7 We need, as organizations, to
8 meet the needs that we have within our
9 organization, but these key elements that we need
10 to exchange need to be on a framework that is
11 consistent for all of us.
12 REP. HENNESSY: Do we run the
13 risk of having the federal government set one set
14 of standards, the State try to refine it, and then
15 have regional standards develop, like, you've got a
16 cluster of different and often competing medical
17 systems here in the Philadelphia area.
18 Anybody that talks among the
19 group among all your systems to see whether or not
20 you can work on a unified approach, rather than
21 just trying to go about it -- everybody trying to
22 get the best system -- develop the best system on
23 their own and you find we have wasted a lot of
24 energy in the process?
25 DR. MASSEY: The good news is the

1 industry, as a whole, is participating in the
2 conversations around setting standards and being
3 consistent so they are abiding by the technologic
4 standards of those languages to exchange. But the
5 governance of the data that we're exchanging and
6 how that needs to be controlled at a different
7 level, as an industry, we're becoming more
8 consistent with those standards and participating
9 as providers, as well, to narrow down -- I think
10 it's not so much the standards around the
11 technology itself that concerns me, but it's the
12 potential that we have different reporting
13 requirements so we have to report these ten things
14 to one agency and a different matrix that we have
15 to report, and that's where I think we need to come
16 together to create the framework to have a more
17 consistent -- each time we need to create a new
18 report does involve resources on our side to be
19 able to report in a certain way.
20 We all have some sense of what
21 quality improvement and how we can care for our
22 patients, what's important matrix. Even our
23 medical side is coming to more consistency on what
24 needs to be reported. But if we can define those
25 matrix for our regions that we need to, we will be

1 -- it's not just the framework around the ability
2 to exchange the information but also the ability to
3 report it and interpret the data that we get.
4 REP. HENNESSY: I think it's
5 going to be important as these things develop that
6 we make sure that the systems, themselves, are not
7 rather parochial, that each system shares its
8 information so that other systems can refine it, as
9 opposed to each system trying to compete and
10 ultimately end up with the best system.
11 DR. MASSEY: And it's not just
12 the individual systems but the individual small
13 providers and what they can invest. Getting that
14 regional support, the technical advice, as well as
15 sharing those best practices, those standards so
16 that we're consistent is important.
17 REP. HENNESSY: Thank you very
18 much.
19 Thank you, Mr. Chairman.
20 REP. DeLUCA: Thank you,
21 Representative Hennessey.
22 Doctor, let me just ask you this.
23 We're still going to have some paper records.
24 There's no way that I feel that there's not going
25 to be any paper records. Let's be truthful about

1 it. As a doctor, you're going to have to put some
2 notes down. Me, as a patient coming in, you're
3 going to ask me questions that I have to write down
4 on the paperwork. So we're still going to have
5 some of that. And I would hope that the fact that
6 we wouldn't just text that information in without
7 reviewing it because we can make some mistakes and
8 it can be detrimental to us in the long run. So I
9 think we still need a little back up from the
10 doctor, but we also need to have that medical
11 records, electronic medical records.
12 In the meantime, let me ask you
13 this, because we do talk about duplication of
14 service, which will cut down on that. And I had a
15 personal situation where I had a test done and I
16 went to another doctor for a different procedure,
17 and the thing I find amazing was he didn't ask me
18 about whether I had the test done. If I did not
19 tell him, then I'd have a duplication of the test,
20 which all he had to do was call up, and he did call
21 up, the hospital did have the electronic medical
22 records on file, and they FAXed it right over to
23 him, and he said: I didn't need the test because
24 he already had the information. So I think that
25 shows the benefits of it.

1 But I'm wondering why, because
2 this is going to take us time to get up and
3 running, why some of our physicians are not doing
4 that, to make sure that the patients are not having
5 the tests, previous tests and ask them that
6 question: Have you had that test. They ask you
7 about everything else but they don't ask you about
8 the test.
9 DR. MASSEY: We're still in
10 transition. There are a lot of patients who do
11 know exactly what -- and collect those copies of
12 their tests and their records. And I have had
13 patients come in with a stack of -- here's my
14 records and my summary.
15 REP. DeLUCA: I'm not talking
16 about tests. I'm talking about CAT scans and MRIs.
17 I don't think you need to have a record to say that
18 you a CAT scan or MRI.
19 DR. MASSEY: And where you had it
20 done.
21 REP. DeLUCA: So I don't think
22 you need the record for that.
23 DR. MASSEY: Although, I
24 occasionally get a confusing response from my
25 patients, too, I may have gotten it here or there.

1 Yes. There's some of that.

2 But for a tool that could, with a
3 click of a button, reach out and say: Has anything
4 been done, reach out to the pharmacy benefit
5 managers: Have you had any prescription filled and
6 to bring that right to the doctor so that they see
7 it. They go through the same process every time
8 they're reaching for information from that Health
9 Information Exchange. Sometimes it will bring
10 nothing back. Sometimes it will bring all of that
11 back. Patients are a critical part of being able
12 to take ownership and participate in their own
13 health care.

14 REP. DeLUCA: Now, as far as the
15 older, as Representative Quinn stated about the
16 older ones a little leery about going into it, I
17 would imagine it would be their staff that would be
18 doing this kind of stuff that have the technology
19 and training to do that kind of stuff and work with
20 computers; am I correct?

21 It wouldn't be --

22 DR. MASSEY: Not necessarily.
23 Not necessarily. Some of the gathering of
24 information may be, but if you have a single record
25 that can reach out to an exchange and identify the

1 patient as having information that's out there, it
2 would be in the normal flow of what they're doing
3 in caring for their patient to gather that
4 information. Again, the trick is to make it as
5 intuitive and simple, using touch screens, drop
6 down lists, things that they need to participate in
7 the design.
8 And the other piece it is does
9 take some at-the-elbow support for a period of time
10 to get them used to how they're using it until it
11 becomes an ordinary part of their day.
12 REP. DeLUCA: Well, excellent
13 testimony, Doctor, and we look forward to working
14 with you, and thank you very much for taking the
15 time to come here today.
16 DR. MASSEY: Thank you.
17 REP DeLUCA: The next individual
18 to testify is Darlene Kauffman, Associate Director
19 of the Pennsylvania Medical Society. Welcome,
20 Darlene.
21 MS. KAUFFMAN: Good morning,
22 Chairman DeLuca, and members of House Professional
23 Licensure Committee. I am Darlene Kauffman. I'm
24 Associate Director of Payer Relations with the
25 Pennsylvania Medical Society. Along with Dr. Scott

1 Shapiro, I currently represent the Medical Society
2 on the Advisory Committee of the Pennsylvania
3 Health Information Exchange or PHIX. I am
4 presenting the Medical Society's testimony here
5 today on behalf of Dr. Shapiro and our president,
6 Dr. James Goodyear.
7 I want to thank you for the
8 opportunity to share with you today the Society's
9 thoughts on House Bill 2106 and on the issue of
10 health information technology in general. Let me
11 begin by saying that physicians wholeheartedly
12 embrace technological advancement in medicine.
13 However, for the most part, their interest in the
14 field of technology typically resides in the area
15 of clinical advancements, better and faster
16 diagnostic tools, more advanced surgical
17 instrumentation, and more effective drug therapies.
18 When it comes to health information technology, the
19 learning curve is a bit deep steeper for many
20 physicians. Having said that, I believe that the
21 vast majority of physicians support these changes
22 and fully recognize the critical role they have on
23 the overall quality of care delivered to their
24 patients.
25 The work of PHIX is a daunting

1 undertaking. For all intents and purposes, it is
2 the platform or information highway upon which
3 medical records, diagnostic images and lab results
4 will be shared with an individual's physician or
5 other health care provider. I cannot express to
6 you how valuable it would be for a cardiologist to
7 encounter a chronic heart patient suffering from an
8 acute cardiac event in the emergency room at 3 AM
9 and be able to view a cardiac echo done three
10 months ago in San Francisco or even the hospital
11 just across town, not to mention having the
12 patient's medical history at her fingertips.
13 Better care, faster care, more cost-effective care,
14 I hope we can all look forward to that.
15 Let me now turn to the details of
16 House Bill 2106 and share with you some of our
17 concerns. First and perhaps of most concern is
18 that House Bill 2106 proposes to place PHIX under
19 the Department of Community and Economic
20 Development or DCED The health insurers,
21 physicians and other providers, hospitals and
22 representatives from the legislature and executive
23 branches of state government that serve on the PHIX
24 counsel view this project as a separate
25 public/private authority. Ultimately, PHIX will

1 provide services to the Department of Public
2 Welfare, the Department of Health and perhaps even
3 the Pennsylvania Health Care Cost Containment
4 Council. While I appreciate the potential economic
5 impact that PHIX may have, DCD has had little
6 involvement with PHIX thus far and does not have
7 the inherent knowledge to deal with the intricacies
8 of health information technology.
9 Other concerns include House Bill
10 2106 establishes a Health Information Exchange
11 authority that lacks private sector input. In
12 fact, the only private sector input on this
13 authority would be from hospitals and with only one
14 proposed seat to be filled by a physician;
15 private-practice physicians will have very little
16 input in a system that will directly impact
17 thousands of physicians and millions of their
18 patients.
19 House Bill 2106 would empower
20 this authority to, among other things, develop
21 clinical goals. Clinical goals or clinical
22 practice protocols are not within the scope of
23 PHIX. Again, the purpose of PHIX is to design,
24 build and maintain a Health Information Exchange.
25 A good analogy would be Pennsylvania's Department

1 of Transportation. PennDOT designs, oversees the
2 construction of and maintains our state highways
3 but they do not design cars, dictate what color
4 they are or determine whether the car was the most
5 appropriate or cost-effective vehicle for the trip.
6 This legislation would prohibit
7 the collection and analysis of deidentified data.
8 While we agree that the role of PHIX is not to
9 engage in data analysis, such data has immense
10 value in improving the quality of care.
11 Furthermore, deidentified data represents a
12 potential revenue source for PHIX, subsequently
13 lowering the subscription fees to physicians,
14 hospitals and other providers.
15 Prohibiting access to aggregated
16 deidentified protected health information to users
17 of quality care studies would be short-sighted at
18 best. Don't get me wrong, extracted data should
19 not be used to compare one physician against
20 another, or make the case that one hospital is
21 better than the next, but data should be used to
22 improve quality outcomes, disease management and
23 population assessments.
24 Lastly, House Bill 2106 would
25 establish a second role for PHIX, a mechanism to

1 finance health information technology. It would
2 establish a loan program that would receive funds
3 from the federal government and distribute them to
4 purchasers of electronic health record systems.
5 Under the American Recovery and Reinvestment Act,
6 the federal government may provide states with
7 funds to help -- to help health care providers
8 acquire EHR systems. The federal government,
9 however, has decided not to grant loan funds to
10 states for this purpose. More importantly, most of
11 the ARRA grant programs are already well underway
12 and many are granted directly to private entities,
13 rather than the state.
14 While we have concerns about
15 House Bill 2106, as it is presently drafted, I have
16 to applaud Representative Taylor, please excuse our
17 typing error here, for undertaking such a complex
18 issue. As you can see, the future of quality
19 health care does not rest solely on the clinical
20 skills of the physician. Rather, it rests with a
21 physician whose clinical skills are enhanced, not
22 encumbered by a limitless array of patient data.
23 The Pennsylvania Medical Society
24 supports the establishment of PHIX as a
25 public/private authority that would build and

1 maintain a state-wide infrastructure. Eventually,
2 PHIX will connect to similar systems in other
3 states and regions to enable electronic Health
4 Information Exchange throughout the Commonwealth
5 and beyond. We believe, however, that there are
6 certain principles that are foundational for the
7 success of such an endeavor.
8 First, the system has to be
9 accessible by all providers, even solo
10 practitioners. That means that the system must be
11 easily accessed -- as easily accessed as the
12 internet and use of the system must be completely
13 voluntary. Second, PHIX should be implemented and
14 financed in a fair and equitable manner.
15 Information technology is expensive and it is safe
16 to say that we will all need to participate in its
17 financing. We believe that those who benefit from
18 Health Information Exchange should pay for it.
19 State and federal government, insurers, hospitals,
20 and other health care facilities and physicians
21 will share the benefit and should share the costs.
22 Third, the scope of PHIX should
23 be limited. PHIX should have the authority to
24 build and maintain the Health Information Exchange
25 infrastructure and provide deidentified clinical

1 data that would be used for research and for
2 quality initiatives. Such data would be enormously
3 useful to organizations, such as quality
4 improvement research organizations, the Chronic
5 Care Commission, the Department of Health, and many
6 other public and private organizations.
7 Ultimately, as with any other
8 technological advancement, physicians' primary
9 focus is to provide the best quality of care to
10 their patients. We believe that if executed
11 properly PHIX can help us to meet that objective
12 more efficiently and cost effectively and with
13 better clinical outcomes.
14 Thank you, again, Chairman
15 DeLuca, for the opportunity to share with you some
16 thoughts we, at the Pennsylvania Medical Society,
17 have regarding PHIX and health information
18 technology in general. To the best of my ability,
19 I would be happy to answer any questions that you
20 may have.
21 REP. DeLUCA: Thank you, Mrs.
22 Kauffman.
23 Any questions from my right?
24 REP. HENNESSY: Philosophically
25 or physically?

1 REP. DeLUCA: Any way you want
2 it, Representative.
3 REP. HENNESSY: I would.
4 Ms. Kauffman, thank you very much
5 for your testimony. Two things I wanted to ask
6 you.
7 You're the director of Payment
8 Relations?
9 MS. KAUFFMAN: Payer Relations.
10 REP. HENNESSY: Tell me what that
11 is and tell me how that affects the distributions
12 to monies to doctors in the field, because when we
13 met last week with a group of our doctors over in
14 Chester County, they were rather upset with the
15 reimbursements they were getting. And this whole
16 concept, the project, seems like a wonderful idea
17 but it's going to be terribly expensive, and I'm
18 wondering at what cost to the doctors'
19 reimbursements because, understandably, that's what
20 they're concerned about on a daily basis, how much
21 money they're being able to make so they can
22 provide for their own families. You've got to
23 wonder how much we can afford.
24 MS. KAUFFMAN: Payer Relations,
25 I'm Associate Director of Payer Relations, and what

1 we do there is we do deal with reimbursement all
2 the time. I happen to be dedicated to a couple
3 projects in particular, and one of them has been
4 health information technology. So hence, I'm here
5 today on behalf Dr. Shapiro.
6 The issue of reimbursement,
7 particularly in this region of the State, has been
8 a challenge. Recently, for example, Independence
9 Blue Cross sent a letter to physicians revising the
10 standard fee schedule. I'm doing an analysis on
11 that right now. Some of our cardiologists have
12 expressed deep concern about the severe cuts in
13 payments for procedures. They have increased the
14 payment for evaluation and management services,
15 which is what is the bread and butter of primary
16 care physicians, but they have cut, so far in my
17 analysis, I can't say that this is how it's going
18 to end up, but it looks like almost 12 percent cut
19 in the procedure area.
20 It actually -- they're actually
21 paying less than Medicare. Across the country, you
22 can tell, if you read anything in the national
23 level, you will see that physicians are upset about
24 Medicare payment and they're thinking about
25 dropping out of the Medicare program. You have

1 heard this for a number years. In Pennsylvania,
2 you don't find that, and the reason you don't find
3 it is because Medicare pays better than some of the
4 actual insurers in Pennsylvania. So that is an
5 issue.
6 And subsequently, when we come to
7 health information technology, there's a real
8 challenge on the part of physicians to how they're
9 going to pay for this, especially in view of the
10 fact that although they gain some efficiencies in
11 the office, it doesn't nearly equate to the
12 investment that they're putting out. Most doctors
13 do not see a real financial return on investment
14 for the purchase of these systems.
15 Now, the federal government, as
16 part of this stimulus package that was passed last
17 February of 2009, has provided vehicles to address
18 some of the major barriers to physician adoption of
19 electronic medical records. One of them, as Dr.
20 Massey pointed out, is the incentive program,
21 which, although it will not cover all the costs, it
22 provides a significant amount, up to $44,000 under
23 Medicare per physician over a four-year period.
24 The other barrier is technology,
25 as she pointed out, that physicians aren't -- they

1 didn't to go school to be techies. They went to
2 school to take care of patients. And so, just
3 like you and I -- and I also liken it to when you
4 remodel -- I remodeled my kitchen last year, and I
5 know nothing about carpentry and I feel like a babe
6 in the woods talking to people on what kind of cost
7 they're going to charge me for this. Doctors feel
8 that way with technology. They're uncomfortable
9 there. And in their private practice they don't
10 really have, usually, the expertise on staff to
11 help them.
12 The federal government has
13 provided a vehicle called the regional extension
14 center, and we have received -- the Quality
15 Insights of Pennsylvania has been granted an award.
16 We're not -- they're not able to reach out yet
17 but the -- they're certainly having their operating
18 plan evaluated by the Office of the National
19 Coordinator of HIT right now. But what that would
20 do would actually provide for primary care
21 physicians' feet on the ground to go into the
22 practices to actually provide consulting services
23 at a very low, very low cost because it's
24 government subsidized. And in Pennsylvania,
25 Quality Insights of Pennsylvania plans to reach out

1 to thousands and thousands of primary care doctors
2 in the State.
3 So we talked about finance, and
4 then we talked about the technology barrier, and
5 then you address -- somebody asked about
6 physicians, would we lose physicians. And the
7 Pennsylvania Medical Society -- I have definitely
8 had many calls from physicians who are in their
9 early sixties or late fifties and they're thinking,
10 you know, it really isn't worth it to me to invest
11 in this. And I don't have any particular -- the
12 first thing that I'm going to get from the federal
13 government is 2015. It's a one percent reduction
14 in my Medicare fees. If I can hang in there until
15 retirement, I will do that.
16 So I think you're going to see a
17 transition, as time goes on, as physicians -- older
18 physicians retire. The younger physicians who come
19 out of medical school, they have been trained, the
20 more recent ones, have been trained, and they're
21 very, very interested of going into a practice that
22 has the kind of technology that they were trained
23 with.
24 But I do agree with you, the
25 reimbursement issues go hand in hand with the

1 barrier to doctors, but I do think there's been
2 programs out there, and I will point out in terms
3 of incentives, two years ago the government came
4 out with incentives for electronic prescribing, and
5 we have seen huge increase in numbers of physicians
6 who have adopted electronic prescribing as a result
7 of that incentive.
8 REP. HENNESSY: In your testimony
9 you had indicated the American Recovery Act
10 authorized the federal government to give money to
11 the states to make loans to the providers, and yet,
12 in your testimony you say they have gone a
13 different way, they haven't decided to bypass the
14 states.
15 Is that the $44,000 over the four
16 years you're talking about?
17 MS. KAUFFMAN: No. That is a
18 different program. That's the Incentive Program.
19 There was the possibility in ARRA that there could
20 be funds made available to the states that they
21 could develop loan programs and they would be the
22 middle man to disburse these funds within the
23 state; however, that did not -- we were hoping, and
24 I know that the Governor's Office of Health Care
25 Reform was hoping to get those funds, but that did

1 not work out.
2 REP. HENNESSY: Is that cut and
3 dried?
4 MS. KAUFFMAN: Well, it's not cut
5 and dried in that there's some kind of -- it's
6 still out there as a possibility; however, they
7 inserted the word -- the word in the legislation
8 says may and the Office of National Coordinator
9 decided not to. It doesn't mean they won't at some
10 future time, but at present, that's the way it
11 stands.
12 REP. HENNESSY: Thank you.
13 Thanks, Mr. Chairman.
14 REP. DeLUCA: Representative
15 Pashinski, any questions?
16 REP. PASHINSKI: Thank you very
17 much, Darlene. Good to be with you again. Let's
18 establish a few things here.
19 You indicated, when E
20 prescribing, that because of the incentives,
21 doctors have gotten on board much quicker?
22 MS. KAUFFMAN: Yes.
23 REP. PASHINSKI: Which was an
24 electronic system?
25 MS. KAUFFMAN: Yes.

1 REP. PASHINSKI: So many of these
2 doctors had to learn this new learning curve?
3 MS. KAUFFMAN: Yes.
4 REP. PASHINSKI: And did so, and
5 to the delight of everyone, it is successful.
6 MS. KAUFFMAN: Yes.
7 REP. PASHINSKI: And it is
8 proving to eliminate some of those errors, that
9 doctor's signature, and whatever that prescription
10 was. Now we don't have to worry about that.
11 In light of the fact that that
12 was one piece of this electronic puzzle, in light
13 of the fact that -- I believe you said in here that
14 you agree that this is the wave of the future and
15 it is something that we need to address.
16 MS. KAUFFMAN: Yes.
17 REP. PASHINSKI: But you've also
18 identified some of the shortfalls. So the first
19 one is the financial incentive. The second was in
20 the learning curve, the technical assistance, and I
21 heard Dr. Massey say the same thing about the
22 technical assistance.
23 The point that I'm simply trying
24 to bring forth and see if you will agree with me,
25 this is the wave of the future.

1 MS. KAUFFMAN: Absolutely.
2 REP. PASHINSKI: This is going to
3 definitely provide less errors, better diagnoses,
4 allow physicians to actually deal with the patients
5 a lot more than in the past, which is what they're
6 trained to do, and over time, let alone create the
7 jobs, you also are going to transfer jobs from four
8 assistants pushing paper to maybe one IT expert and
9 one person who is going to be involved with that
10 transcribing and so on.
11 Is that about correct?
12 MS. KAUFFMAN: Yeah. There's
13 certainly a total redesign. Office redesign is a
14 big part of implementing electronic medical
15 record. And the success that you envision is --
16 hinges on a good approach to office redesign. It's
17 not like buying off the shelf Word program and
18 plugging it into your computer. This changes the
19 way that you deliver care in a way that has never
20 been done before. So you definitely -- physicians
21 need to do that.
22 As far as the wave of the future,
23 absolutely. I think that the kind of questioning
24 is whether we're building something and will they
25 come. I think they will definitely come. There is

1 so much motivation, whether it be from the federal
2 government or payers, I think that other commercial
3 payers are going to follow suit with the federal
4 government. The meaningful use criteria that Dr.
5 Massey alluded to requires, even in 2011, that you
6 do a test, one test of Health Information Exchange,
7 as recommended. We can't be sure what the final
8 measures will be, but by 2015 they're looking for
9 every patient to have a personal health record that
10 they can access and have information about
11 themselves electronically.
12 So I think the push is on. We
13 have been in the industry. We have been well aware
14 of this for a long time. This is not an idea that
15 just came out this year. It's going to happen.
16 REP. PASHINSKI: It's an exciting
17 concept.
18 MS. KAUFFMAN: We just need your
19 folks' help to make it happen.
20 REP. PASHINSKI: These hearings
21 help define redesign, and I know Representative
22 Taylor is in tune to that and see what we have to
23 do to accommodate those needs. Thank very much.
24 MR. TAYLOR: Thank you for coming
25 to testify. I thought it was very thoughtful

1 testimony. Please forward my good wishes to Dr.
2 Shapiro and Dr. Goodyear. They're good friends and
3 I always respect their ideas.
4 And I want to echo what
5 Representative Pashinksi said is I certainly would
6 like to work with this. This is why we're doing
7 the hearings, to get input on some of the thoughts
8 that when we put this together may have not
9 considered some of the critiques that I think are
10 very valid concerns. So I would love to sit with
11 you in a future date and hear what you have to say
12 a little further in deep on this. Thank you for
13 coming out to testify.
14 REP. DeLUCA: Again, I want to
15 thank you, Ms. Kauffman. And the only thing I
16 would like to add to this, and I think
17 Representative Pashinksi and you said the wave of
18 the future, and I think as I have found out,
19 sometimes we don't have a vision, and we need to
20 have a vision for the future generation. The
21 status quo is not acceptable. As you know, you're
22 taking care of the payments and that they're -- the
23 records, we can't sustain the increases in health
24 care as they have been going, especially when we
25 have primary care physicians who are not making

1 that much and individuals who are losing their
2 jobs, health care continues to go up, that means
3 more and more physicians will not be able to
4 sustain, especially primary care physicians, be
5 able to sustain their families because they don't
6 make that much. And everybody has to have a little
7 bit of -- as they said, new ideas, meeting skin in
8 the game, and if we don't have that, then we're not
9 going anyplace. And I understand about it's a new
10 thing, but people adjust.
11 And I think the main thing that
12 your organization is concerned about the medical
13 profession is to make sure it doesn't eat all their
14 savings and profit. The incentive we know has to
15 be there, and so I want to commend you for your
16 testimony. And as Representative Taylor has
17 alluded, that's why we're having these hearings
18 because none of this legislation is in stone.
19 We're there educating ourselves. We don't know
20 everything. You're the experts. You've given us
21 that information. You make us better able to do
22 our jobs and we can relay this to our fellow
23 legislators.
24 So I want to thank you very much
25 for your testimony.

1 Representative Quinn? And before
2 I say that, we are joined by Representative
3 Shapiro. Thank you for coming.
4 REP. SHAPIRO: Thank you, Mr.
5 Chairman.
6 REP. QUINN: I appreciate the
7 analogy that you had to the PennDOT and the
8 vehicles that we drive.
9 Is there concern among your
10 members that once all this information is shared
11 there will be directives with regard to their
12 administering care, patient treatment?
13 MS. KAUFFMAN: I believe some
14 physicians, for the purpose here, which is sharing
15 among providers, for treatment purposes, I do not
16 believe anybody has any concerns about that, which
17 is what the purpose of this exchange is.
18 If you're referring to -- I'm not
19 sure quite what you're referring to, reporting
20 information to the federal government?
21 REP. QUINN: Just a general
22 share. There's a lot of questions out there
23 floating around, whether I'm food shopping or
24 anything else, people are coming to me with myths,
25 facts, concerns, I guess is the best word, with

1 what is coming our way from the federal level.
2 And I was just curious, when I
3 was reviewing your testimony and saw that analogy
4 with the transportation is if among the provider
5 community that concern exists once information is
6 shared?
7 MS. KAUFFMAN: Yeah. It depends
8 on the physician. I mean, just like the
9 population, as a whole, they have a variety of
10 political points of view, and so they're not --
11 they don't think as a single organism. So yes,
12 there are physicians that do have that concern and
13 there's some that do not.
14 REP. QUINN: I don't know if
15 you're the best one to ask this, or the prime
16 sponsor, or our next speaker, but do you have some
17 thoughts as to why there's only one physician on
18 the Board?
19 MS. KAUFFMAN: I can't speak to
20 that. I would recommend -- I would recommend
21 several physicians. I have no idea because I was
22 not involved in the creation of the Bill. It could
23 simply be an oversight, but physicians and other
24 health care entities do need to be involved in any
25 public/private partnership because we are the prime

1 users of this and we're the subject matter experts
2 on how this is used and how it could best function
3 in the hospital and in the practice environment.
4 REP. QUINN: Thank you.
5 REP. DeLUCA: Thank you very
6 much, Mrs. Kauffman.
7 MS. KAUFFMAN: Sure.
8 REP. DeLUCA: Let me say, as I
9 said before, before you leave, that we look forward
10 to your comments and certainly will take
11 Representative Quinn's comments into consideration
12 why there's only one on it.
13 So we will look at that,
14 Representative Quinn.
15 The next individual to testify is
16 Ann Torregrossa, director of the Governor's Office
17 of the Health Care Reform.
18 MS. TORREGROSSA: I have asked
19 Phil to join us.
20 REP. DeLUCA: We had a good
21 meeting yesterday. I think Representative
22 Pashinski put a good group together and it was a
23 good meeting.
24 MR. MAGISTRO: Absolutely.
25 MS. TORREGROSSA: Chairman

1 DeLuca, and members of the Committee, thank you so
2 much for having us here today, and especially for
3 getting us out of Harrisburg. It's wonderful to be
4 in Ambler and in such a beautiful theater. It's
5 just marvelous.
6 Also, thank you so much for
7 inviting us to testify today on House Bill 2106,
8 which would create an authority for the
9 Pennsylvania Health Information Exchange. Such an
10 authority is needed for at least two important
11 reasons, one, to provide a home for the continued
12 work that has resulted from two very successful
13 public/private partnerships, and two, to meet one
14 of the requirements for receipt of federal funding
15 from the Office of the National Coordinator, which
16 is to have a stakeholder involvement in the
17 governance of PHIX, and that's our federal grant
18 for 17.1 million dollars.
19 Let me tell you a little bit
20 about these two very exciting public/private
21 partnerships. The first came from an Executive
22 Order, which created an advisory committee to
23 assist the Governor's Office of Health Care Reform
24 in the development of PHIX. Two of the people
25 testifying today have served on that Committee.

1 You just heard from Darlene, who has been a very
2 active member of the Committee, and Martin, from
3 the Hospital Association, also has been a very
4 valuable member.
5 We have been diligently working
6 on an RFP to create the exchange with the passage
7 of the HITECH Act required all states to accelerate
8 their efforts to establish a Health Information
9 Exchange. And the time frames that they put in
10 place are just amazing.
11 For Pennsylvania, HITECH makes
12 the following substantial funding available. You
13 have heard about the incentive payments that
14 Darlene referenced. We estimate that there's about
15 1.5 billion dollars in incentive payments available
16 to hospitals, doctors and other health care
17 providers who have electronic health records that
18 meet the federal meaningful use definition. That
19 definition will include the ability to transmit
20 health information to health care providers outside
21 of their health system through a health information
22 exchange, and these incentives are available
23 starting January, 2011. So for our health care
24 providers to be able to get these incentives, we
25 have to have the exchange up and running very

1 quickly.

2 Darlene also referenced the 44.4
3 million dollars for two regional extension centers
4 that will work with small primary care practices to
5 assist them in selecting and implementing an
6 electronic health record so they can meet the
7 meaningful use criteria needed to receive the
8 incentive payments. And hopefully, they're going
9 to help some of those old dogs that Representative
10 Quinn talked about come up to speed. Then our
11 office received 17.1 million dollars for developing
12 the Health Information Exchange, which will then
13 allow health care providers to actually share
14 information over the exchange.

15 One of the criteria for receipt
16 of the 17.1 million dollars from ONC was to submit
17 a strategic plan containing a plan for governance
18 that includes participation by all major
19 stakeholders. That's a condition of the grant. As
20 part of the plan development process we submitted a
21 strategic plan for public comment. The draft plan
22 proposed that PHIX be governed by an authority,
23 similar to that in House Bill 2106, with the Board
24 of Directors be made up of state officials and
25 other important stakeholders, including health care

1 providers, consumers, employers, insurance
2 companies, et cetera. We received only positive
3 comments about this proposal. There was not one
4 negative comment against the staffing of such an
5 authority.
6 The biggest concern that we have
7 had thus far before the Authority is set up is
8 whether there is a common understanding about how
9 the Authority and the work of building the Health
10 Information Exchange will be funded. We think that
11 our Health Information Exchange can be completed
12 over the next four to five years building the
13 backbone this year and adding health care providers
14 as the electronic health records can be connected
15 with PHIX. We have a variety of funds to build
16 PHIX. We, obviously, have the 17.1 million dollars
17 from ONC, and we also believe that Medicaid will be
18 allowed to use 90 percent federal funding to pay
19 for its pro rata share for health care in
20 Pennsylvania, which is about 17 percent.
21 Once we have entities connected
22 to PHIX, those entities will pay some subscription
23 payments that will help with the operating costs.
24 But despite all these revenue sources, we estimate
25 that we will have a total revenue shortfall, that's

1 a total, of 11 million dollars over the five year
2 build-out period, which can be met in a number of
3 ways.
4 First, we are talking to
5 insurance plans about voluntary contributions, as
6 was done in Rhode Island. Insurance companies may
7 feel they have a good business case to make these
8 donations, given the potential for large savings
9 once PHIX is operational. Secondly, to address
10 this shortfall we could have health care providers
11 pay more of the cost to connect. We want to try to
12 avoid that. Also, other revenue sources could be
13 identified. To put this shortfall in perspective,
14 it's less than one dollar for every Pennsylvanian,
15 and it should be something we can figure out,
16 particularly given the benefit that this will have
17 for citizens.
18 As you have heard, we have an RFP
19 on the street and will not know the final cost
20 until the negotiation process is finalized, but it
21 should be important to note in these tough budget
22 times that we are not seeking any additional money
23 this year for PHIX. It's the same funding that's
24 in the budget. And should the Authority be
25 created, we would then transfer the federal grant

1 to the Authority for its administration.

2 The other public/private

3 partnership that we are urging you to include in

4 this Authority is the one that has been involved in

5 transforming how health care is delivered and paid

6 for, and that involves patients in promoting their

7 own wellness. This public/private partnership came

8 out of an Executive Order creating a Chronic Care

9 Management Reimbursement and Cost Reduction

10 Commission. The Commission has been implementing

11 its strategic plan for over two years and has

12 involved insurers, provider organizations, state

13 agencies, quality improvement experts and

14 consumers. I think a really neat thing about this

15 is that all major payers, except Medicare fee for

16 service, have sat down together with primary care

17 practices in a remarkable collaboration to figure

18 out, on a region-by-region basis, how they might

19 provide financial rewards to primary care practices

20 who participate.

21 The State supervision of the

22 discussions on payment provided antitrust

23 protection, which makes these agreements possible.

24 Obviously, payers can't sit around and collude

25 about what they're going to pay doctors. That's an

1 antitrust violation. The exception to that is if
2 the State supervises those discussions and it's to
3 improve the public health.
4 Payers and practices that have
5 been involved in this have signed a three-year
6 participation agreement. Primary care practices
7 commit to sending a multi-disciplinary team to
8 seven days of educational sessions in the first
9 year to learn how to transform their practice,
10 provide monthly clinical data and narrative
11 reporting, participate in monthly conference calls,
12 work with practice coaches and expert faculty and
13 apply and receive accreditation as a
14 patient-centered medical home from the National
15 Committee on Quality Insurance or NCQA, as it's
16 known. Practices started by focusing on patients
17 with diabetics and pediatric asthma are now going
18 out onto other chronic diseases.
19 The first regional learning
20 collaborative started in May of 2008 in southeast
21 Pennsylvania. Nearly two years later, we now have
22 seven learning collaboratives operating in six
23 regions of the State with two more planned this
24 year. A total of 918 primary care practitioners
25 and 173 practices are caring for 1.1 million

1 patients involved in this quality improvement
2 effort. It is by far the largest such effort in
3 the country. Insurers have committed to pay 30
4 million dollars in additional dollars for
5 qualifying participating primary care practices.
6 Preliminary results show that
7 patients are healthier, need far fewer
8 hospitalizations, and doctors and other providers
9 are energized and costs have been reduced. Two of
10 our energized physicians will be testifying today,
11 Dr. Gertner and Dr. Gabbay, about the importance of
12 including this type of initiative in the Authority.
13 So, what do these two initiatives
14 have to do with one another? Just as CMS is not
15 giving the 1.5 billion dollars in incentive
16 payments that I mentioned earlier to health care
17 providers just because they have adopted an
18 electronic health record for their patients.
19 Rather, providers must demonstrate that they are
20 making meaningful use of that EHR to improve
21 quality and reduce costs. Similarly, Pennsylvania
22 should not have an authority that just allows
23 transmission of clinical data without providing the
24 structure to health care providers and payers to
25 improve quality and contain costs. Rather,

1 Pennsylvania should have an Authority that allows
2 payers and providers to work collaboratively under
3 the State's antitrust protection to create
4 voluntary payment incentives and quality outcome
5 measures that improve quality and reduce the cost
6 of health care.
7 The financial impact of combining
8 these two initiatives is tremendous. Just one
9 example. The Pennsylvania Health Care Cost
10 Containment Council, PHC4, reported that in 2009,
11 20 conditions resulted in 2.5 billion dollars in
12 hospital readmission charges. Work done in both
13 the Geisinger and Penn showed that having a care
14 manager work with patients within 48 hours of
15 discharge can significantly reduce readmissions.
16 Getting the Discharge Summary to the primary care
17 practice can be done through the Health Information
18 Exchange. Effectively using that information
19 requires the practice to follow a new care delivery
20 model and have a care manager work with the
21 patient.
22 If we have learned anything
23 through our learning collaborative work, it's that
24 practices cannot respond to eight to ten different
25 paper performance measures from eight to ten

1 different plans. Similarly, I think the insurance
2 companies have learned that individually they
3 cannot make a big difference in quality, but that
4 if all of them are aligned, we can then really
5 begin to transform health care. Agreement among
6 payers on quality improvement measures will make it
7 much easier for health care providers to focus and
8 achieve the goals established for change. The only
9 way we're going to be able to move the cost curve
10 down and quality up is to move away from a payment
11 system that rewards health care providers for the
12 volume of services provided. Instead, we need to
13 construct a payment system that rewards providers
14 for performance or value, including delivery of
15 care in a coordinated way.
16 When we discuss with the Office
17 of the National Coordinator the possibility of this
18 combination of functions in one authority, they
19 said we would be the poster child for the country.
20 It is exactly that combination of facilitating
21 clinical data exchange, but facilitating its use
22 for health care transformation and payment reform
23 that they think is necessary to make health care
24 more efficient and improve the health status of our
25 citizens.

1 We urge you to amend House Bill
2 2106 to allow inclusion of work to have
3 consumer-based quality improvement and voluntary
4 repayment efforts included under the Authority.
5 The vast majority of stakeholders representation on
6 our PHIX Advisory Committee and the same for our
7 Chronic Care Commission through the same groups on
8 both of the Boards. One Board making sure that the
9 exchange of clinical information is coordinated
10 with voluntary quality improvement and cost
11 reduction efforts makes sense.
12 It's critical that this
13 legislation be enacted before the end of this
14 fiscal year so the Authority's Board can be
15 appointed and assume its responsibilities as soon
16 as possible.
17 Thank you for your invitation to
18 testify. Both Phil and I are available to answer
19 your questions.
20 REP. DeLUCA: Thank you, Ann.
21 You mentioned the fact that you are asking us to
22 amend this piece of legislation.
23 Would you submit language to that
24 amendment to us?
25 MS. TORREGROSSA: We absolutely

1 would, yes. We are circulating through our two
2 Commissions, through the PHIX Advisory Board and
3 through the Chronic Care Commission draft language.
4 We want to make sure it has consensus with both of
5 those Commissions and they think it's a good idea,
6 and then we'll be submitting it to you.
7 REP. DeLUCA: Very good. Thank
8 you.
9 Representative Pashinski?
10 REP. PASHINSKI: Thank you, Mr.
11 Chairman.
12 Thank you, Ann, and thank you
13 both for being here. I'm going to address this to
14 Phil first. There was some question by
15 Representative Hennessey and others I know have the
16 same question.
17 When we're talking about IT, are
18 we going to be reinventing the wheel and spinning
19 our wheels? So Phil is a, I'm going to say
20 expert, in the area of IT talk. Most of us aren't
21 IT wonks. And, Phil, if you don't mind, I'm going
22 to give that you label. You're going to be our IT
23 wonk. But it is important for everyone to know.
24 And the concern that Representative Hennessey
25 brought forth is a serious one. There is no money

1 to waste, and the idea is let's do it right from
2 the beginning, and that is the new paradigm of
3 medical process.
4 Ann had indicated we are going to
5 try to remove ourselves from volume forcing doctors
6 to see and to treat an enormous amount of
7 individuals. It's overbearing to imagine. Instead
8 of doing that, try to allow them the time to truly
9 diagnose and have the tools to diagnose correctly
10 so that we don't make the errors. This eliminates
11 potential insurance problems, suit problems, and we
12 reduce the tort concern dramatically.
13 So my question to Phil is: Could
14 you, in our language, in nonwonk language, assure
15 us that the technical capabilities of this system
16 will be able to be integrated, interpretable, be
17 able to be shared, and the key word is share, so
18 that that doctor can then diagnose properly?
19 Phil?
20 MR. MAGISTRO: Sure. It actually
21 is a legitimate concern. And a few years ago, or
22 several years ago, we had a lot of proprietary
23 systems out there that did not speak to each other.
24 But what we have maintained in our position here is
25 that we would follow any rules or standards

1 promulgated by the federal government. We don't
2 want to change anything specific to Pennsylvania or
3 even have a region change that would impact the
4 interoperability between a region, the state and
5 the state to the national level.
6 Our issue is not having
7 standards. Our issue is having too many standards.
8 ZIP codes are a standard. We have disease
9 standards. We have procedures standards, code
10 sets, communication standards. And the federal
11 government has had a lot of time invested in either
12 themselves or in groups that they authorize
13 reviewing standards and determining which ones
14 should be applied. And I can get you a list of all
15 those that we would incorporate, but it's a
16 comprehensive list that's working towards
17 finalization where I think right now most vendors,
18 state governments and other entities have all
19 agreed to use a common set of protocols for
20 exchanging data.
21 REP. PASHINSKI: What about the
22 security? Everyone's concerned. This is vital
23 information, very personal.
24 And what safeguards have taken
25 place in order to prevent stealing vital

1 information?

2 MR. MAGISTRO: Well, there's a

3 number of things. First of all, I'd have to say

4 that a paper record is not that secure. Anybody

5 walking past a chart laying on a table could open

6 it and look at it. In a computer world there are a

7 lot of safeguards and technologies that exist.

8 They start with the system that the data is housed

9 in and they extend to other systems that would

10 connect with that.

11 In our project or our initiative,

12 we're not proposing a central repository of any

13 information. We're proposing a system that

14 actually can link to existing sets of data. So if

15 a provider types my name into the system, it

16 wouldn't go out to a central database and pull in

17 all my information. It would have the ability to

18 go find my information wherever it exists in other

19 databases; similar in a way to the way Google works

20 where when you type in a word in Google looking for

21 something, it doesn't have a database at Google

22 that it searches, it goes out and finds all the web

23 sites that have that information and then lets you

24 link out to all those web sites. That's a similar

25 structure to what we're doing. So it is secure in

1 that regard, that anyone that could get into the
2 system wouldn't have access to a set of records
3 stored in a repository.
4 REP. PASHINSKI: So if we were
5 going to connect Geisinger with another system,
6 explain how that would work. Because when you say
7 Google, I think we are a little apprehensive
8 because Google gets us to a whole bunch of places.
9 But in the medical records systems there's going to
10 be several locked doors that you have to get
11 through, and without the proper passwords, it's
12 impossible to penetrate.
13 Is that correct?
14 MR. MAGISTRO: Yes. There's a
15 number of levels. HIPPA requires that providers
16 have role-based access. So an office manager
17 doesn't have the same level of access to a patient
18 record that a physician does. There's other levels
19 of access that are provided for, as well. In
20 connecting to health systems, we would connect them
21 through a couple of different ways.
22 There could be a direct exchange
23 of data from one system to another that's enabled
24 by an interface. There could be what is called a
25 continuity of care document exchanged, which has a

1 set of specific information on that patient
2 record. That's a standard that's applied now and
3 systems are working towards being able to create
4 and receive that standard. And we would enable the
5 exchange of that through our pipeline, through the
6 Health Information Exchange, not touching the
7 record as it goes, merely transporting it from
8 Geisinger physicians to UPMC physicians, or even
9 local physicians. It doesn't have to be across the
10 State. It could be within a community.
11 REP. PASHINSKI: Now, correct me
12 if I'm wrong. The ultimate goal would be, let's
13 say, for example, for anybody that may have heard
14 the medical spot or the fact that the technology is
15 there where you could have your entire medical
16 record on a credit card. Let's just use that as an
17 example.
18 So the ultimate goal would be
19 able to have this credit card be accessed if you
20 have an emergency. That could be in the
21 ambulance. That could be on the way to the
22 emergency room. That could be whether you're in
23 California, or in Harrisburg, or anywhere in the
24 United States, or anywhere this electronic system
25 is connected. We are no where near that point yet.The

1 point that we are at right now, which is historic,
2 is that we can begin building the foundation
3 electronically for this sharing of data, which is
4 so critical for the medical profession.
5 And is there anything else, as
6 far as the chronic care model? I like to use that
7 the cavity in the tooth. And we have heard so much
8 about the fact that health care costs so much.
9 It's unsustainable. We know that. And that's why
10 a lot of these new innovative and very well tested
11 pieces of information are now being put forth as a
12 way to actually solve some of the medical concerns
13 that we have. So the preventative care model was
14 very important in the fact that if you have a tiny
15 tooth decay, tiny cavity, the pain is less and so
16 is the cost. If you allow that cavity to continue
17 to decay, you end up with periodontal disease or
18 extraction, et cetera, and that disease goes into
19 the body, which causes other grave consequences.
20 This whole idea is to let's find
21 ways that we can prevent this, and when we identify
22 it early, it saves us literally billions and
23 billions of dollars. So diabetes, type II diabetes
24 discovered early is -- can easily be treated. You
25 can have quality of life, proper diet, medication,

1 and the cost is minimal compared to when the
2 diabetes begins to affect all other parts of the
3 body, which creates chronic care, which creates
4 hundreds of thousands of dollars for that patient,
5 millions of dollars.
6 Could you expand on that a bit?
7 MS. TORREGROSSA: Certainly. As
8 part of our working with the participating
9 practices, they agreed to put all their diabetic
10 patients into a patient registry. And, of course,
11 they all thought they were providing the best care
12 in the world. But when they actually put their
13 patients in the diabetic registry, they saw that
14 they were only getting about 50 percent of the
15 evidence-based care that they should be getting to
16 keep them healthier. And so, they started getting
17 people in, you know, for the appropriate things
18 they should be doing. And low and behold, one
19 medical assistance HMO found that in ten months of
20 operation, getting their doctors to work in this
21 way, using electronic records to manage care, they
22 had reduced hospitalizations for diabetics by 26
23 percent.
24 And that's just the beginning of
25 what we can begin to achieve if we align payment,

1 we assist practices in transforming, we use
2 clinical support. So the kinds of things that I
3 think this combination of Health Information
4 Exchange and the opportunity to align incentives
5 and help practices transform the practice is just
6 going to be amazing, as far as improving the
7 quality of health care and reducing the costs.
8 And Pennsylvania is so far out
9 ahead of other states on this, we have been invited
10 to talk all over the country about it. People just
11 are amazed at what we have been able to do. And,
12 again, it's not this office. It's this wonderful
13 collaboration, public/private collaboration that
14 has made this work possible, and it's that same
15 kind of collaboration that we need on a board to
16 continue to work.
17 The Board is going to have to be
18 a manageable size. Everyone's going to want to be
19 on the Authority Board. It's going to have to be a
20 manageable size. But we found that by having
21 advisory groups underneath, where you get the broad
22 consensus, you work through the issues, you can
23 have a lot of participation that then can help
24 inform the Board in its operations.
25 REP. PASHINSKI: Thank you.

1 Thank you very much for your testimony.
2 REP. DeLUCA: Representative
3 Shapiro?
4 REP. SHAPIRO: Thank you,
5 Chairman DeLuca. Representative Taylor, thank you
6 so much for hosting us here today in the theater.
7 My wife and family and I enjoy coming here often,
8 although sometimes the entertainment is a little
9 more stimulating than an insurance meeting.
10 Nevertheless, we appreciate it.
11 And, Ann, thank you so much for
12 your testimony. I think your final point there
13 about how Pennsylvania is way ahead on these issues
14 is spot on. And I think, as you would agree,
15 Representative Taylor's Bill is just a key part of
16 allowing that to go forward. So I think it's
17 important that we get that going. I have two sort
18 of technical questions, I guess.
19 The first one would be: On the
20 RFP process to get this rolling, where are we?
21 What is the timing?
22 What can we expect as we look
23 down the pike, assuming we, in the legislature, get
24 our jobs done and pass 2106, which I hope we will?
25 Where are you guys on the RFP

1 process?
2 MS. TORREGROSSA: The response to
3 the RFP has been incredible. I think they had the
4 largest number of people come out for the hearing
5 about this in a long time. So we're expecting a
6 lot of response on this RFP. Bids are due back in
7 May. Obviously, depending on the number bids, it
8 may take a short time or a longer time. Part of
9 the review process will be to actually see in
10 operation how their exchange works, their product
11 works. We don't want something that hasn't been
12 tested and used and shown the ability to be able to
13 securely and safely exchange information.
14 So we'll then go pick a bidder
15 and we'll go through the negotiation process, and
16 we're hoping to have something in place before
17 Labor Day as far as the final. We will then, you
18 know, depending on how much start-up time we need,
19 we want to get operational as soon as possible.
20 The Authority, of course --
21 REP. SHAPIRO: How long after,
22 say, Labor Day would it take to go operational?
23 MS. TORREGROSSA: Phil, what
24 would you say?
25 REP. SHAPIRO: I'm not going to

1 hold you to it. I'm just trying to get a ballpark.
2 MR. MAGISTRO: Once we begin
3 work, to build out the infrastructure will take
4 anywhere between six and 12 months. That's
5 creating table for master patient indexes, or
6 provider directories, or record locating service,
7 all that core infrastructure product. And we'll
8 work with early adopters to do that, some large
9 health systems, some hospitals, a regional Health
10 Information Exchange, we'll get that in place over
11 the first 12 months and then we'll begin to expand
12 out into the communities for the next three or four
13 years after that.
14 MS. TORREGROSSA: But we want the
15 Authority in place so we can begin transfer the
16 work of this. It's very important that -- as you
17 heard, that doctors and hospitals and other people
18 are involved in rolling this out and understanding
19 how it's going to work and making sure that it
20 works for them. So we would urge you, please,
21 before the end of this fiscal year, before June
22 30th, to pass this legislation as amended.
23 REP. SHAPIRO: I would hope we
24 would. Representative Taylor is a bit of a bulldog
25 up there, so he'll be pushing this hard, I'm sure.

1 It sounds like the timing will be right on, if we
2 can get this done, even in conjunction with the
3 timing of the budget around June 30th. Then, if
4 the RFP is complete around Labor Day, that really
5 does put us in a strong position.
6 MR. MAGISTRO: There's even more
7 to it than that. There are a number of initiatives
8 that are funded by federal money that we coordinate
9 with, not only Medicaid, but also, there's the
10 Regional Extension Center Program that's working
11 with the doctors to get the HRs in place. There's
12 the broadband grants that are out there. There's
13 work force development. There's a lot of different
14 activities going on that this Authority would be a
15 central figure in pulling all together so that
16 we're all on the same page.
17 REP. SHAPIRO: Let me ask one
18 other question, if I may, also on a technical side.
19 You went through a series of revenue sources that
20 are available, be it the federal level, state
21 level, what have you. One of the concerns that I
22 have is that in the process of having so much money
23 out there for electronic medical records and
24 putting mandates on physicians and hospitals to go
25 out and do this that some of the smaller physician

1 practices may qualify for a loan. I think Taylor's
2 legislation talks about loans up to $50,000, if I'm
3 not mistaken.
4 How do we ensure that enough of
5 that money, or money available from the Governor's
6 Office, if there is going to be money available
7 from the Governor's Office, makes it to independent
8 practices so that they -- the primary care doc with
9 two or three docs and eight or nine secretaries, a
10 few nurses are in a position to not just maybe have
11 the sort of economic burdens of putting the system
12 on -- obviously, they have great benefits of it,
13 but how do we make so it they get the benefits, as
14 well as not being saddled with the economic
15 burdens?
16 Where's the money going to come
17 from to help those guys and gals?
18 MR. MAGISTRO: Actually, you
19 bring up a very good point, because the stimulus
20 money that's out there, even though it's a billion
21 and a half dollars, is probably 20 percent or less
22 of what the providers and hospitals need to spend
23 to get the money.
24 The loan fund that you are
25 talking about, there was a loan fund that was

1 discussed earlier in the original legislation that
2 was never funded at the federal level. They may
3 fund that some day. Senator Kerry put in a bill to
4 provide some money for funding in that section of
5 the stimulus bill, but it hasn't moved yet.
6 Representative Taylor's
7 legislation didn't identify a source of funding, I
8 believe, for the loan fund. We'd have to come up
9 with some way to do that. And we have to, I think,
10 look at creating incentives based on the savings
11 that are achieved once the information exchange is
12 established because we know we can save money. If
13 we can identify those savings and redirect them, we
14 can continue to provide incentives to providers.
15 We can help fund the IT activities, and maybe we
16 can return money to the premium payers or the
17 citizens of Pennsylvania through the insurance
18 companies.
19 REP. SHAPIRO: I think as we look
20 at how we roll out the system with priority in
21 terms of who gets the first, second, third, et
22 cetera, we have to be very cognizant of the small
23 practices in terms of asking them to put up money
24 up front. Asking them to put up tense of thousands
25 of dollars up front is something that may be very

1 difficult for them to achieve. Maybe as we achieve
2 some savings consistently as a result of it we can
3 use that to create some type of a grant program or
4 some other program that is going to help these,
5 particularly these primary care docs in private
6 practices that I think are going to benefit a
7 great, great deal from this electronic medical
8 records, but they're going to have a hard time
9 coming up with that money up front.
10 MS. TORREGROSSA: I think if you
11 look at the funding that's been available through
12 HITECH, we only got 17.1 million dollars to build
13 out this whole information exchange. But you look
14 at what the regional extension centers got, they
15 got 44.4 million dollars to work with the small
16 primary care practices to help them figure out what
17 system would work best for them, provide a hands-on
18 assistance, help them figure out how they can
19 qualify for incentive payments. So there's a lot
20 of money out there to help those very physicians
21 that you're concerned about. We just have to make
22 sure that that happens.
23 The other thing is you may not
24 have to buy a big electronic health record. I know
25 that IBM and other companies are talking about

1 having something that's available over the
2 internet. So just like your cable, you pay so much
3 a month depending on what the features are, do you
4 want the Phillies network, you pay a little bit
5 more, you want this, and they may not have to
6 invest in a whole big electronic health record.
7 They may be able to subscribe to an electronic
8 health record like. And one of the bid components
9 that we have in our RFP, again, looking to get
10 volume, would be to have them tell us if they have
11 an electronic health record like.
12 REP. SHAPIRO: A final point, Mr.
13 Chairman. We have to all work together, and with
14 Representative Taylor's leadership, to communicate
15 with the medical societies on the county level and
16 State level and these practices to make sure they
17 have access to all of this information. Many of
18 them are very, very excited about the prospects of
19 what this new IT is going to do for them in their
20 practices, and most importantly, for the patients,
21 but they're very concerned about the up-front
22 costs. So we look forward to working with you on
23 that.
24 MS. TORREGROSSA: And it's very
25 confusing, and so much information is coming from

1 so many different directions that it's going to be
2 important that we do work together.
3 REP. SHAPIRO: Thank you.
4 REP. DeLUCA: Representative
5 Quinn?
6 REP. QUINN: Thank you.
7 Thanks for being here, and thank
8 you for saying it's very confusing because there is
9 a lot of information. Trying to assimilate it and
10 come up with a good analogy, I'm finding it
11 difficult. But I totally agree with the concept of
12 where we're going, where we need to go with this.
13 But the practical side of me,
14 especially in this economic environment, I'm just
15 trying to get my arms around the cost in total and
16 the penalties, if any, if we don't -- I see that at
17 the tail end of your testimony you said it's
18 critical that we do this by the end of fiscal year,
19 but I know that I don't understand what if we
20 don't.
21 What is the downside, other than
22 this sliding a couple of more months?
23 Are there dollars tied to it?
24 This is a couple of questions.
25 Then, Phil, you caught me off

1 guard when you said there's no funding in this
2 Bill, there's not a funding source for the loan.
3 Could you please expand on that
4 and tell me, within the context of this Bill, are
5 there any other absences of funding sources because
6 we've seen relatively recently, on more than one
7 occasion, where we have gone forward with something
8 and not been able to -- the funding is not there.
9 MS. TORREGROSSA: Let me talk a
10 little bit about costs, and I know people are
11 concerned about that. We do have 17.1 million
12 dollars, and that's going to get us started with
13 the backbone.
14 REP. QUINN: That doesn't go
15 away if we don't do this by the end of the fiscal
16 year?
17 MS. TORREGROSSA: A condition of
18 the grant is that we have a way of governing with
19 extensive public/private input. The way we have
20 suggested to do that is through an adori
21 (phonetic). I think that's probably the preferred
22 way from the Office of the National Coordinator.
23 Would they accept another way?
24 They probably would, a nonprofit, which doesn't
25 have the same kind of accountability that an

1 authority would have with the Sunshine laws, with
2 right to know, with that kind of thing. They may
3 accept keeping it in a state agency, but there
4 would have to be -- it would have to be a very
5 unusual relationship so that the ability to have
6 private input into this -- more than input, really
7 participatory decision making, and that's why we
8 think an authority is so important. It has the
9 accountability, the transparency, and it continues,
10 I think, the public/private partnership that we had
11 to date.
12 It's very, very important that as
13 this is built out it works for people. It protects
14 consumers most. You think about your health
15 information and how that absolutely needs to be
16 secured. And so we think that the appropriate
17 entity to really help establish the business rules
18 and things that we need to go forward is this
19 partnership with the transparency that it would
20 have.
21 Will our money go away if we
22 don't have it? Probably not, as long as we have
23 enough significant involvement of the private
24 sector.
25 The cost, so we have got 17.1

1 million, and we can build the backbone, and the
2 backbone is what connects to everyone else. Phil
3 talked about the master patient index. That's one
4 of the first things we would build. What that does
5 is if someone Googles, you know, secure medical
6 Google Ann Torregrossa, it goes out and they come
7 back with 15 Ann Torregrossas, they have got to
8 figure out which Ann Torregrossa information to
9 give to the physician.
10 So the master patient index puts
11 fourth a bunch of algorithms that let you sort
12 through so that the right patient information with
13 that name gets to the right clinician that's doing
14 it. That's the kind stuff that we're building in
15 the backbone. Now, once the backbone is
16 established, then we'll start connecting those
17 providers who are ready to connect, like Geisinger,
18 who is already -- UPMC, and we'll go for kind of
19 the low-hanging fruit, the ones that are already
20 connected to a lot of hospitals and a lot of
21 doctors. And that's just one connection in. It
22 doesn't cost a lot. And then we'll connect as
23 practices and hospitals and other health care
24 providers are ready to be connected.
25 The big expense here, and you can

1 probably do this much better, but I had to
2 translate this to lay language.
3 REP. QUINN: I love lay language.
4 MS. TORREGROSSA: The big expense
5 here are the edge servers. Now, a lot of hospitals
6 may not want people to be able to Google into their
7 medical system and their medical records. They
8 want a firewall. They don't want anyone coming in
9 and getting information out. So what we're
10 proposing for them is to have a big edge server,
11 and they put their information out on that and they
12 still keep their firewall so no one can get into
13 their information and mess with their -- mess is
14 not a technical word, inappropriately disturb their
15 health information. These edge servers are quite
16 expensive. And, obviously, we'll connect as -- the
17 Authority will have a budget and they will connect
18 as they have the resources to do so. It's just
19 like any other entity has to live within a budget
20 that it has.
21 And we think that between the
22 Medicaid portion, which is 17 percent, the 17.1
23 million dollars, which we think will more than
24 build the backbone, we have had indications from
25 some larger insurers that they are willing to make

1 voluntary contributions because they want to jump
2 start this and they think they will get more than
3 their return on investment; that we can get this
4 together. The shortfall is only 11 million
5 dollars. And as I said, that's less than $1 per
6 Pennsylvanian. So we should be able to figure this
7 out, but obviously, no one's going to do something
8 that we don't have the money for. We're going to
9 build it out as the funds are available.
10 What we could do is to have some
11 of the providers share an edge server and help pay
12 a prorated portion of it if we don't have the money
13 to do those edge servers.
14 REP. QUINN: Is the 11 million
15 dollar shortfall what you're looking for in terms
16 of voluntary support for the insurer support?
17 MS. TORREGROSSA: Yes.
18 REP. QUINN: So that's the total
19 sum?
20 MS. TORREGROSSA: That's over
21 five years. So we're not saying: Cough up 11
22 million dollars today. That's not what we're
23 asking for. So if you think of an over five years,
24 and obviously, most -- ONC wants us to spend most
25 of the 17.1 million dollars in the first two

1 years. And so we're going to need that additional
2 money after the first year. We have enough for the
3 first year.
4 REP. QUINN: Thank you.
5 Phil, to the part about --
6 MR. MAGISTRO: Actually, I'd like
7 to go back just one second to the why the sense of
8 urgency. I was involved in running the chronic
9 care work for two years until I switched over to
10 this full-time, and I can tell you, just from that
11 perspective, there's always been concern about the
12 fact of the longevity of the program. Our office
13 was created by Executive Order, and the
14 administration changes at the end of this year, and
15 there's no guarantee that our office will maintain
16 itself. And we're a critical component in managing
17 and directing all those activities that take place
18 between providers and payers to the tune of 30
19 million dollars worth of activities. So they want
20 some reassurance that there's a plan in place for
21 how that goes forward.
22 And on the Health Information
23 Exchange side, there's a lot of activity that's
24 going on out there. Doylestown Hospital is one of
25 the premier examples in Pennsylvania of how a

1 hospital connects with community physicians to
2 share records. But a lot of the activities that
3 are in preliminary stages are being held back to
4 see what happens at the State level, what is the
5 guidance going to be on Health Information Exchange
6 at the State level going forward. So the sooner
7 that we can put something in place and reassure
8 people that there's a plan and a solid approach,
9 the faster things will move.
10 Now, about the funding issues.
11 The only funding issue that I see potentially is
12 the one where the loan fund does haven't a revenue
13 source. I mean, there are other funding issues but
14 not tied to 2106. We have a lot of shortfalls on
15 money that's available to payers -- or to providers
16 to purchase and implement systems. But directly
17 back to 2106, it's the same issue as with the
18 federal stimulus legislation where they created a
19 fund, opportunity, and then there's no money behind
20 that to support the fund, itself.
21 REP. QUINN: So, correct me if
22 I'm wrong, but the loan fund is dollars
23 specifically to the physicians to help them get up
24 and running? And just like mess is not a technical
25 term, neither is old dog.

1 MR. MAGISTRO: At the federal
2 level, the original intent was Medicaid has
3 eligibility requirements for providers to receive
4 money. Medicare has some requirements to receive
5 money. And some people don't fit into either
6 category, nursing homes, all the long-term care
7 facilities, home health. They're key pieces in
8 this.
9 The transitions of care are very
10 costly in Pennsylvania. Coordinating care across
11 those transitions costs us a lot of money, and they
12 aren't involved in getting incentives to do
13 anything. That loan fund was ideally targeted at
14 people like that that could receive something to
15 help them out while they're not called out
16 specifically in the legislation. I can see that in
17 2106, if we have a loan fund at the State level, it
18 would follow the same pattern as the federal level,
19 where it goes to those providers that aren't
20 getting anything but need something.
21 REP. QUINN: My concern is just
22 simply in the last couple of years the doctors have
23 been -- well, disappointed by the support they have
24 received from the State, and I would hate to lead
25 them along, have them say: Yes, yes, there's a

1 loan and have it unfunded. So I don't know if
2 we're able to address that, to shore that up and
3 have a level of certainty.
4 Because that loan, that would be
5 for them to implement, not to reimburse; correct?
6 MR. MAGISTRO: That would help to
7 offset the costs of the system. That's my
8 understanding, and that's the way I would look at
9 it.
10 REP. QUINN: Thank you for
11 coming.
12 MS. TORREGROSSA: You may want to
13 keep the ability to have a loan fund in the
14 legislation so that if the federal government
15 decides that it wants to make money available you
16 have the authorization for that.
17 Additionally, I think in the next
18 year or two we're going to see how many physicians
19 take advantage of the incentive funding, how many
20 just can't -- hopefully, we're going to have better
21 economic times, as far as the State is concerned.
22 And by allowing that possibility, you would have a
23 vehicle if, in fact, a lot of physicians were
24 unable to afford this to do so.
25 REP. QUINN: I'm not suggesting

1 in any sense to take out, but what I'm suggesting
2 is to make sure in it's going in there, that
3 there's a funding source.
4 REP. DeLUCA: Representative
5 Hennessey?
6 REP. HENNESSY: Thank you, Mr.
7 Chairman.
8 Ann, Phil, thank you for your
9 testimony. I just want to try and see if I can
10 nail something down. We're talking 17-one million
11 dollars, which the Office of National Coordinator,
12 or whatever, is making available and we're saying
13 there's 11 million dollar shortfall on top of that,
14 so we have got to make that up figure over five
15 years.
16 Is that a hard figure that -- can
17 we rely on that, because otherwise --
18 MS. TORREGROSSA: It's our best
19 estimate. Obviously, we have an RFP out. We're
20 going to try to get the most efficient and
21 effective bidder through that process, but we just
22 don't have the go-to-the bank figures yet. We have
23 talked to other states, comparable size who have
24 gone through a bid process to try to figure this
25 out. It's our absolutely best estimate at this

1 point.
2 REP. HENNESSY: But we're talking
3 about building the backbone and making it available
4 so that everybody --
5 MS. TORREGROSSA: Can connect.
6 REP HENNESSY: -- can connect to
7 it for 28 million dollars. And that seems to be --
8 in the numbers, we're talking about a 29 billion
9 dollar budget and 28 million dollars seems to be a
10 doable and reachable goal.
11 MS. TORREGROSSA: Again, Medicaid
12 is potentially going to use 90 percent federal
13 funding to pay 17 percent, so that's on top of the
14 28, and it would depend on how many edge servers we
15 need or want, the providers want. One way to make
16 up the 11 million dollars, as I said, is to have
17 them pay a portion of the edge servers' cost.
18 REP. HENNESSY: That leads me
19 into the next question, which you identified
20 Medicaid as the driving 17 percent of our budget
21 here in Pennsylvania.
22 What about Medicare? With an
23 elderly population, it seems to be crazy to leave
24 them out of that loop, because if they can
25 contribute, that would help close the gap, as well.

1 MS. TORREGROSSA: You said
2 exactly what I have been saying to Washington,
3 every time I have a meeting with the officials from
4 CMS or ONC.
5 REP. HENNESSY: You listen better
6 to me than they listen to you?
7 MS. TORREGROSSA: Particularly
8 for a state, such as Pennsylvania, where so many of
9 our population is on Medicare, you know, just as in
10 our Chronic Care Commission, they're getting a free
11 ride. They're not one of the major payers that are
12 participating in the enhanced reimbursement, but
13 they're getting all kinds of savings. So that's
14 definitely a concern, and I share that with you.
15 REP. HENNESSY: But are they
16 saying no, they're not going to be involved, or is
17 it still up in the air?
18 MS. TORREGROSSA: They put out
19 all this incentive money, the 1.5 billion dollars,
20 and that's kind of their share.
21 REP. HENNESSY: When we spoke
22 yesterday at that meeting that Tony has been
23 referencing, one of the things I mentioned is in
24 our meetings with doctors -- my meetings with
25 doctors, they're complaining they're not getting

1 reimbursed by the insurance companies. I'm a
2 little concerned that we're -- even though we're
3 talking doable numbers here, we're relying on some
4 possible future authorization from the federal
5 government to allow Medicaid to kick in, and maybe
6 Medicare.
7 We have got a lot of other issues
8 on our plate at the State level, given our
9 budgetary crunch that have been in. In some sense
10 we have created them because we have built past
11 budgets on assumptions that haven't now come true
12 and now the chickens are all coming home to roost
13 at the same time. So this is a good idea and a
14 terrible time for us to try to wrestle with it.
15 But bringing you back to the
16 doctors, if the doctors are complaining now that
17 they're getting squeezed on their reimbursement
18 rates or payment rates by the insurers and now
19 we're asking the insurers to kick in some millions
20 of dollars, my first reaction is that the doctors
21 are going to be saying the two things are tied
22 together, that we're asking the insurers to kick in
23 money, therefore, that's driving even further
24 reductions in their payments to doctors, and how do
25 we manage to keep the doctors from recoiling and

1 trying to fight this or resist it because they
2 think that they're being unfairly targeted and the
3 insurance companies are taking it out of their pay?
4 MS. TORREGROSSA: The insurance
5 companies will more than make up whatever voluntary
6 contributions they make.
7 REP. HENNESSY: I understand what
8 you said, and you said that a couple times.
9 But how can we get that message
10 across to doctors and convince them when the next
11 reduction comes that it's not related to this?
12 MS. TORREGROSSA: I think you can
13 point to the work of the Chronic Care Commission to
14 show that when you create the opportunity that I
15 hope you will allow in this authority for payers
16 and providers to come together and look at
17 reimbursement, and look at how to improve quality,
18 and look at how to get the win-win situation where
19 the providers are working to increase quality while
20 reducing costs, and then the providers get, and
21 primarily primary care providers in our Chronic
22 Care Commission, get substantial incentives for
23 doing so.
24 We have to create the environment
25 where they're not just getting -- they're having

1 their fee for service reduced so they have to do
2 more and more and more services, instead of having
3 it be based on the value that they're providing,
4 which is increasing health care quality while
5 reducing costs. And I think you're setting up a
6 mechanism here to change that paradigm and to
7 really have them be at the table, talking about
8 this, working together with payers to get a much
9 more equitable reimbursement.
10 We have two physicians that are
11 going to be talking today who participated in this
12 and they can give you a different perspective.
13 MR. MAGISTRO: If I can just add
14 one more thing. I can give you a brief example.
15 If we work with insurers voluntarily to identify
16 measures -- Geisinger has done this well with
17 physician practices that aren't part of Geisinger
18 where they have identified measures and the
19 practices perform against those measures and
20 there's some savings attached to that, and some
21 practices have seen significant savings. One
22 practice, a five-physician practice, with only 450
23 Geisinger patients saved $600,000 in the course of
24 one year based on Geisinger's health plan estimate,
25 not the doctor's estimate. So once the physicians

1 see that there's that kind of savings, and if we
2 can find some way to allocate that back to the
3 providers, then I think we will get their
4 attention.
5 MS. TORREGROSSA: But we need
6 this mechanism so we can have the antitrust
7 protection and the ability to do that kind of
8 thing.
9 REP. TAYLOR: I want to quickly
10 thank you for coming out to testifying. We've been
11 working on this for a while.
12 The question here for me is, and
13 I think, Phil, you just hit it, beyond good medical
14 outcomes, reducing the cost through redundancy, et
15 cetera, there is a solid return on investment.
16 We're not just putting this investment up and just
17 hoping for the best. There is a return on
18 investment.
19 Is my assumption correct?
20 And what do you think the
21 magnitude of that is, or is that hard to say?
22 MS. TORREGROSSA: I think it
23 depends on what the initiative is. As I said, the
24 one Medicaid HMO, when it looked at our target
25 population, I believe we saved, in the first ten

1 months, 10 percent for pediatric asthma and for
2 diabetes, although there was a 26 percent reduction
3 in hospitalization, prescription costs went up
4 because people are being more compliant. ER use
5 went down, and I think they were saving $40 per
6 member per month in reductions for diabetic
7 patients.
8 So I think it's going to depend
9 on, again, the target population, what the
10 initiative is. But we have so much waste and
11 redundancy in our system that for a state budget
12 perspective to not do this is crazy. When we look
13 at the costs in our Medicade program, there are
14 going to be huge savings. When we look at the
15 costs in our EMMPTF, there are going to be savings
16 there. As just a payer of health care, we should
17 be doing this.
18 MR. TAYLOR: How about reduction
19 on medical errors?
20 MS. TORREGROSSA: No question.
21 No question. As you have clinical support, as you
22 don't rely on bad handwriting of clinicians, as you
23 get reminders, you think bar coding, using E
24 prescribing, this is the way to significantly
25 reduce those.

1 MR. MAGISTRO: I can't give hard
2 numbers but I can give a sense of scope. On the
3 chronic care side, PHC4 reported that there's about
4 3.7 billion dollars a year in hospital --
5 potentially avoidable hospital charges for just
6 four chronic illnesses. Our chronic care
7 initiative is really taking those on and addressing
8 that. So there's a lot of money out there where a
9 small percent of savings means a significant amount
10 of money.
11 On the Health Information
12 Exchange side, we talked in the testimony about the
13 two and a half billion dollars worth of hospital
14 readmissions. The percent that didn't show there
15 was work at Geisinger and at Penn showed that you
16 can reduce those admissions up to 40 percent by
17 having the right processes in place. And 40
18 percent of two and a half billion dollars is a lot,
19 but that's only 20 conditions. Look at the entire
20 State for all the reportable conditions. There
21 might be three to four billion dollars worth of
22 readmission charges that you could have an impact
23 against. And then there's all the other savings
24 that takes place throughout the system, all the
25 redundant testing that's eliminated and other

1 savings that you'd realize.

2 It's hard to put a number on it.

3 People have tried. States have tried. There's

4 numerous studies that have shown significant

5 savings. But just looking at the scope, a small

6 percent means a lot of money.

7 MS. TORREGROSSA: We are in the

8 process of doing a business case and having a

9 consultant who is helping us with this, and we will

10 be happy to share that with you, where we are

11 trying to quantify, looking at the number of lab

12 tests, so on and so on, exactly what the

13 anticipated cost is by payer, what should Medicaid

14 pay, what should States save, what should IBC Eye

15 Mark. So we are working through that process right

16 now.

17 REP. DeLUCA: Thank you very

18 much, Ann, and thank you, Phil, for your excellent

19 testimony. We look forward to working with you.

20 I want the remind the members

21 that we're an hour late, and I know some of the

22 individuals out there want to testify have other

23 things to do, too.

24 Kelly Lewis, president of the

25 Technology Council of Central Pennsylvania and

1 former member. Welcome, Kelly. Good to see you
2 here testifying on the other end, instead of the
3 House of Representatives.
4 MR. LEWIS: Good morning, Mr.
5 Chairman, Representative Taylor, members of the
6 Committee and public. I am pleased to have the
7 opportunity to offer written testimony regarding
8 House Bill 2106 on behalf of the technology
9 industry and our many members and partners. We
10 strongly support the establishment of an open,
11 interoperable and affordable Health Information
12 Exchange in Pennsylvania.
13 Without question, health care
14 information technology is poised to unleash
15 tremendous savings of time, resources and costs
16 while saving lives, improving health care quality
17 and patient safety. With so many benefits and
18 opportunities, it is crystal clear we need to do
19 the right thing the first time and do it the right
20 way. The technology industry and many partners are
21 very interested in making this Health Information
22 Exchange legislation and the resulting integrated
23 health care systems world class, best in class
24 because Pennsylvania is more than capable in doing
25 so and our citizens deserve the very best.

1 To improve the legislation, we
2 suggest your consideration on the following
3 amendments or modifications under a theme that we
4 have incorporated from medical science known as do
5 no harm. Many organizations, physicians and
6 hospitals have invested millions of dollars into
7 their existing health IT systems and we're very
8 interested in interoperability platforms, as the
9 basis for this health information exchange
10 technology.
11 I have listed 17 of those
12 suggestions, Mr. Chairman, and in the interest of
13 time and everyone's bellies growling, maybe I will
14 just go through these quickly. We require -- we'd
15 like the legislation to require all contracts and
16 outside contractors to bid in accordance to DGS
17 procurement rules leaning toward open, transparent
18 and fair procurements. As the hospital
19 associations identified to recommend three board
20 member position for the Authority, we believe at
21 least two licensed physicians should have permanent
22 board positions, as well, and at least two of these
23 named physicians should be recommended by two
24 associations; to wit, maybe one from the
25 Pennsylvania Medical Society and the other position

1 from a rotation among several physician specialty
2 practice associations.
3 In addition to number two, we
4 believe a Board appointee should be recommended
5 from the health information industry from an
6 organization like the Technology Council of Central
7 Pennsylvania or the Pittsburgh Tech Council or the
8 Northwest Technology Council. In addition to
9 number two and three, we believe a Board appointee
10 should be named from the nursing administration
11 industry representing the nursing industry, which
12 are very critical players in Health Information
13 Exchange, also recommended by an industry
14 association.
15 Like most authorities, the
16 technology industry believes that the Act should
17 have a sunset clause at ten years or some time
18 certain. The Authority legislation should include
19 provisions that make the Authority subject to the
20 Sunshine laws and the Pennsylvania Right-to-Know
21 Act. All the technology purchases under the
22 Authority should be subject to the rules and
23 regulations of the Office of Administration, which
24 has a time honored procurement for technology. We
25 believe the legislation should be more defined as

1 to the sustainability of the Authority, including
2 more definition on the revenues needed to support
3 the Authority because presently the Health
4 Information Exchange is not mandatory.
5 We believe the best way to deploy
6 an effective Health Information Exchange is through
7 the establishment and sustainable funding mechanism
8 of ten regional Health Information Exchanges in
9 Pennsylvania based on existing medical referral
10 regions that promote and reinforce the business
11 case of the exchange of health information. That's
12 very important. The legislation should better
13 define the relationships with regional Health
14 Information Exchange and provide for their initial
15 and their operational funding and set governance
16 language for the regional health information
17 exchanges and the interconnections between the
18 state-wide HIE and those regions and hospitals and
19 physician offices.
20 In addition to the loan and grant
21 provisions, I heard questions earlier that
22 identified specific funding guidelines for rural
23 Pennsylvania; we also believe there should be a
24 delineation for small health care providers.
25 Perhaps some language that would reserve 25 percent

1 of the funding for organizations of 25 licensed
2 physicians or less. That would match the rural
3 provisions and also make sure funding gets out to
4 physicians that need it. They don't necessarily
5 have the government relations staff that knows how
6 to navigate the waters of Harrisburg grant and loan
7 funding.
8 We don't understand Section 305
9 on prohibited use. We recognize there's many state
10 and federal privacy laws and regulations in place,
11 but we're concerned about not using the HIE data to
12 protect the public against pandemic disease and
13 other identified health issues via regional or
14 subregional situations, like we have had in
15 Selinsgrove for cancer, higher incidence of
16 cancer. An HIE could potentially project that out
17 with the data; certainly recognizing privacy laws.
18 And we believe the Committee and the sponsors
19 should weigh those issues against the public good
20 and also with the Center for Disease Control
21 guidelines.
22 Also, instead of creating yet
23 another form for loans and grants in the
24 Commonwealth, we beg the legislation to use the
25 existing single-use application put out by DCED.

1 We have too many different forms. It's already
2 confusing, and we shouldn't need to hire
3 professional help to get this funding out to the
4 health care provider community. Also, both DCED
5 and the treasurer have existing health care loans
6 with low interest that also could be used by the
7 Authority that we call attention to the Committee.
8 The terms for health care
9 provider, the definition should be expanded to
10 include visiting nurse associations, which have
11 pretty much the most touch with the Pennsylvania
12 public on a daily basis, and they need technology
13 as much as any organization. They fill out forms
14 that take over an hour to fill right now and they
15 would be greatly enhanced by technology out at
16 their fingertips. Likewise, nursing homes, which
17 have a great interaction or interrelationship
18 between hospitals and elder care, and our jails and
19 correctional facilities in the Commonwealth.
20 A definition we believe should be
21 included and incorporated into the legislation that
22 also includes schools K through 12 so our children
23 get the best care in emergency situations. Having
24 schools interconnected to Health Information
25 Exchange systems is an ideal use and a great reason

1 for Health Information Exchange.
2 On a technical basis, the
3 definition of health information registry or index
4 should be added to health care provider definitions
5 so that the technology aspects of the actual
6 deployment are realized. Phil had mentioned the
7 term master patient index or unique patient
8 identifier. This is very technical. It's very,
9 very important to a Health Information Exchange
10 technology, and we need that in that definition, if
11 possible.
12 The definition of qualified
13 electronic health record, we maybe can better be
14 restated to say that the health information should
15 be generated by a health care provider, not by the
16 federal stimulus package. The legislation
17 references the health information technology plan.
18 The technology industry, with all public plans,
19 believes that the legislation should call for all
20 plans to be subject to a 30 day public review
21 period that provides for written input that is
22 reviewed and considered by the Board before the
23 plan is adopted for use.
24 I wanted to amplify that the
25 Authority should help coordinate career pathway and

1 training needs for Health Information Exchange and
2 health IT in the Commonwealth. It will be a
3 growing field. We have a shortage already of IT
4 professionals in the Commonwealth, and as this
5 industry develops, we'll need to amplify career
6 pathways and training needs. And I would just
7 emphasize, again, that the HIE right now is not
8 mandatory, so we definitely need some language on
9 sustainability.
10 Thank you, Mr. Chairman.
11 REP. DeLUCA: Thank you, Kelly,
12 and certainly, you made a lot of good suggestions
13 here. You certainly haven't lost your touch from
14 the House of Representatives. I will say that to
15 you.
16 With all these suggestions here,
17 let me ask you this: How would you -- what
18 recommendations would you make for us to pay for a
19 lot of these things that you are adding into the
20 Bill?
21 What recommendation would you
22 have for how we fund this legislation, if we
23 adopted all your suggestions and add them into the
24 legislation?
25 Where do you feel that we would

1 be able to come up with the funding for this?
2 MR. LEWIS: We believe the RFP
3 process going out to this open procurement is going
4 to provide some very competitive pricings, which
5 may supply some extra dollars from the original
6 budget. There's the 17 million dollars coming in
7 from the federal government and whichever other
8 dollars we can draw down through the regional
9 extension centers and other funds.
10 Our industry supports a
11 streamline funding system for the whole
12 Commonwealth, and we believe the General Fund
13 should pay for the operations of the Commonwealth,
14 which you know from my days in the House, that's
15 where I come from; that we need to find savings by
16 the use of technology and use those savings to fund
17 the next generation of where Pennsylvania goes in
18 public/private partnerships, including Health
19 Information Exchange sustainability funds.
20 REP. DeLUCA: You believe the
21 General Fund should be paying for it. Now, as you
22 know, you're familiar because you've been up in
23 Harrisburg long enough, you're familiar there is a
24 shortage in the General Fund. To take money, and
25 we're short right here, they need 11 million

1 dollars. To take more money out of the General
2 Fund we would have to cut programs, which programs
3 have ramifications. I mean, you mentioned jails in
4 here, we should use the technology in the jails,
5 too.
6 So some of our programs that we
7 say we want the cut actually cost us more money in
8 the long run, because the fact is if we cut drug
9 and alcohol programs for people on the street, the
10 court systems, and we also put them in jail at 20,
11 $36,000. So I don't know where we would be able
12 to -- unless you are -- and I know you're not
13 telling us to raise taxes. I know you're not going
14 to do that.
15 So I'm just wondering how you're
16 going to -- there's a lot of good suctions in here,
17 I'm not saying that, but these suggestions cost
18 money. So I'm asking you -- I understand about the
19 RFPs. I hope they would come in that low that we
20 wouldn't have to need that 11 million dollars they
21 say that they need.
22 MR. LEWIS: The original plan
23 called for some type of excise tax on health care
24 policies in the State, which whether you call it a
25 health care excise tax on your health insurance,

1 however you call it, it's a tax. Someone's going
2 to have to pay it, usually that's people or it's
3 companies. So however you slice this, there's a
4 cost to running this technology. This is not going
5 to be free in its operation, just like the billion
6 dollar budget that Pennsylvania already spends on
7 technology.
8 So our side is this is an
9 important technology. It should be a priority,
10 whether that comes through the existing billion
11 dollars spent in the Commonwealth technology budget
12 or some other facet, this is a priority. This is
13 long overdue. There's other states that have
14 already bought their technology and are deploying
15 it. They are ahead of Pennsylvania. So we need to
16 pull our resources together and fund important
17 technology that improves the lives of
18 Pennsylvanians.
19 REP. DeLUCA: I can't agree with
20 you -- I agree with you tremendously on that. And
21 if you could, from your organization, give us a
22 statement to the effect of how you want to fund
23 this, because I want to make sure that people who
24 are telling us about funding resources, that they
25 come up with some type of funding plan and not just

1 say: Take it out of here, take it out of there,
2 cut this program, cut that program, because even
3 though this is something we need, our programs out
4 there are beneficial, too, to a lot of people. And
5 you take cancer research and all that kind of stuff
6 that we fund, too, we certainly can't afford to cut
7 those programs short.
8 But I want to commend you for
9 your testimony. It's fine testimony.
10 MR. LEWIS: If I could also add,
11 Mr. Chairman, our organization is notorious that we
12 will not propose a spending increase in the
13 Commonwealth without an equal but opposite revenue
14 that covers that. What we have identified are cost
15 savings that need to be incurred to pay for that,
16 just because I also served in the House and I
17 recognize that it's great to come up and ask for a
18 billion dollars in new spending, but where are you
19 going to coming up with the revenue. Our
20 organization does not do that.
21 REP. DeLUCA: That's good. I'm
22 glad to hear that, because we do have gubernatorial
23 candidates who are going around and campaign, and
24 they haven't come up with one proposal yet where
25 we're going to cut the almost billion dollars out

1 of the budget. So, I mean, we have a lot of
2 programs, and as you know, when you campaign, you
3 say a lot of things.
4 Representative Pashinski?
5 REP. PASHINSKI: Thank you, Mr.
6 Chairman. Thank you very much.
7 You have heard earlier that the
8 insurance companies are willing to fork over some
9 dollars to try to help get this program up and
10 running.
11 Since the technical industry will
12 probably profit by all of this, to what degree
13 could the technical industry participate in
14 providing equipment, tech help, anything and
15 everything that will help get this program up? I
16 think you recognize how important it is, and you've
17 also identified that other states have legitimately
18 taken an active role to get this in here.
19 So how could the tech industry
20 become more benevolent?
21 MR. LEWIS: Well, the best way
22 for the technology industry to level any
23 benevolence on this situation is to keep all the
24 procurements open, transparent and fair, and not go
25 out to state-sole source contracts. Now, we were

1 successful putting that out to an RFP so our
2 industry gets to bid and compete on the process.
3 That should happen in all the processes going
4 forward so our industry can sharpen their pencils
5 and offer competitive proposals.
6 Our industry is very, very
7 interested on this, not only in Pennsylvania, but
8 around the nation and world on incubating this
9 health information technology so it gets deployed.
10 Right now it's in its infancy. When this gets
11 fully operated it's going to be a brand new
12 industry sector in the tech sector. So we're
13 interested in helping it move forward.
14 The health insurance industry may
15 be willing -- I mean, I don't know where all that
16 is going to go in terms of the final say. They may
17 be willing to fund this, but again, it comes back
18 to whether this is mandatory or not. And if it's
19 mandatory and only a few early adopters do this,
20 it's not going to work. This requires -- there's
21 600,000 physicians that need to get convinced this
22 is good for them, and there's no money for them
23 right now to do that. And these interoperability
24 bridges between physicians and hospitals and the
25 state HIE are expensive, and you have to do the

1 initial expense to do it and then you've got to
2 manage it and pay the operational expenses every
3 month every year. You adopt new technology at your
4 office, you need to do a new patch on your
5 technology. That's expensive, especially when you
6 aggregate it across the whole State.
7 REP. PASHINSKI: What is the
8 profit margin of a company that would, let's say,
9 provide the server or provide the tech in order to
10 maintain it?
11 MR. LEWIS: Are you talking about
12 the HIE side?
13 REP. PASHINSKI: I'm talking
14 about the actual equipment.
15 MR. LEWIS: I'm not sure what the
16 profit margin is at Dell, but I'm sure that it gets
17 smaller each year as global competition makes them
18 do what they do. I mean, I can't imagine that the
19 server side of this is going to have that much of a
20 profit margin, whatsoever. And, again, if you keep
21 these procurements open and transparent, there's
22 going to be a ton more competition than if you
23 don't do it that way.
24 REP. PASHINSKI: The RFP process,
25 as Ann Torregrossa indicated, I think had over 100

1 and some different applicants. So obviously, it's
2 working.
3 MR. LEWIS: Correct. And I would
4 remind the Committee that is not the original plan.
5 Originally this was going to go sole source to the
6 State of Delaware, and many, many folks in our
7 industry worked together to get this to an open and
8 transparent procurement, which went out on the
9 street April 1st, and those bids will be due May
10 24th.
11 REP. PASHINSKI: Correct. Thank
12 you.
13 MR. LEWIS: Thank you.
14 REP. DeLUCA: Tim?
15 REP. HENNESSY: I'm fine. Thank
16 you.
17 REP. DeLUCA: Thanks a lot,
18 Kelly, for your testimony.
19 MR. LEWIS: Thank you, Mr.
20 Chairman. Thank you, Representative.
21 REP. DeLUCA: The next individual
22 to testify is Martin Ciccocioppo. If I
23 mispronounced that, I apologize. Thank you for
24 taking the time to comment this afternoon.
25 MR. CICCOCIOPPO: Chairman DeLuca

1 and members of the Committee, I am Martin
2 Ciccocioppo. I'm the Vice President for research
3 at the Hospital and Healthsystem Association of
4 Pennsylvania. And HAP has been very active across
5 a broad spectrum of health technology initiatives
6 and programs to support Pennsylvania's hospitals
7 and health systems and their effective use of
8 health information technology.
9 I appreciate the invitation to
10 present the hospital community's views on health
11 information technology and offer support for House
12 Bill 2106. My written testimony outlines an
13 overview of the hospitals and health systems
14 information technology in Pennsylvania, the
15 benefits of health information technology,
16 opportunities and challenges related to health
17 information technology, and our support for health
18 information technology act, House Bill 2106.
19 In the interest of time, I will
20 refer you to my written testimony, and I'd be happy
21 to answer any questions you have.
22 REP. DeLUCA: Representative
23 Hennessey, do you have any questions?
24 REP. HENNESSY: Thank you,
25 Doctor.

1 My questions, I guess, are going
2 to be how this is going to filter down. I think
3 Kelly Lewis just talked about how the doctors in
4 the field and individual small practitioners, how
5 they're going to be able to -- how they will be
6 affected by it positively, but also, what it's
7 going to cost them, because last week in the
8 meeting we had with doctors, doctors were
9 complaining about the costs being ratcheted down or
10 their reimbursements being ratcheted down by the
11 insurance companies, and now we're going to be
12 asking them to go out and purchase some levels of
13 equipment.
14 Can you give us some idea how the
15 small practitioner out in the rural areas, or
16 somewhere outside the Philadelphia, Pittsburgh, or
17 metropolitan areas, how are they going to be
18 affected by this and what can we do to make their
19 lives a little bit easier as this goes through the
20 legislative process?
21 MR. CICCOCIOPPO: I'd be happy to
22 speak to your question from the hospital and health
23 systems standpoint. Many of the physicians who are
24 practicing in Pennsylvania, we estimate is between
25 60 and 70 percent of the physicians, are closely

1 aligned with hospitals and health systems. So the
2 hospitals have been actively working with both
3 their own and their voluntary medical staffs to
4 help them understand the benefits of health
5 information technology, to help them underwrite the
6 costs of health information technology. Hospitals
7 and health systems have created internal systems
8 for sharing health information.
9 What the Pennsylvania Health
10 Information Exchange is about is about exchanging
11 information among unrelated organizations, so two
12 different health systems who might already have an
13 EHR in place and are sharing information with their
14 -- within their institution, or multiple campuses,
15 or their an affiliated physicians, or physicians
16 who are on their medical staff. The PHIX is going
17 to create an opportunity or a mechanism by which
18 that sharing of clinical health information will be
19 able to move between unrelated organizations.
20 REP. HENNESSY: I understand that
21 the Hospital Association does not necessarily favor
22 the combining of the Chronic Care Commission, which
23 we have heard some testimony about today with the
24 PHIX initiative.
25 Is there a reason that they

1 should be running parallel to each other and not
2 combined or interfaced?
3 MR. CICCOCIOPPO: We believe
4 there are a number of issues that come up or will
5 arise whenever you try to combine both of those
6 initiatives under the one authority. One is you
7 end up with an authority thats Board becomes too
8 big or unyielding; that it bifurcates the intent or
9 the effort of the Authority to effectively oversee
10 the deployment of the PHIX. I mean, PHIX doesn't
11 exist today. There is a whole lot of work that
12 needs to be done in order to create PHIX, and it
13 needs the undivided attention of this
14 public/private partnership in order to make it work
15 and make it effective.
16 There are already other
17 opportunities within State government that could
18 offer the support or the continuity of support for
19 the chronic care initiative. The Department of
20 Health could be one home for that initiative. The
21 Pennsylvania Health Care Cost Containment Council,
22 as it was reauthorized last year, is currently
23 undergoing a review by the Act Review Committee to
24 develop what priorities the Health Care Cost
25 Containment Council ought to be focusing on during

1 its five years of its current authorization. So
2 this is something that, actually, if you look at
3 the title of the proposed act coming from the
4 Governor's Office on Health Care Reform, it almost
5 mimics the Health Care Cost Containment Council Act
6 title, and may more effectively fit within that
7 construct in State government.
8 REP. HENNESSY: So your idea
9 is -- or the House Cost Association, their idea is
10 to keep separate people with separate focuses, to
11 see if these things can move more efficiently or
12 more fluidly along -- on a parallel track?
13 They can get their objectives
14 accomplished better, you think, by not combining
15 them but by keeping separate people separately
16 focused on individual initiatives?
17 MR. CICCOCIOPPO: We believe
18 there needs to be a concerted effort right now to
19 focus on the deployment of Health Information
20 Exchange across Pennsylvania.
21 REP. HENNESSY: Thank you.
22 Thanks, Mr. Chairman.
23 REP. DeLUCA: Martin, I really
24 didn't want you -- if you want to expand on your
25 testimony -- when I said --

1 MR. CICCOCIOPPO: I could
2 highlight, certainly --
3 REP. DeLUCA: You went through a
4 lot of work putting this together, and if you want
5 to elaborate on it, please do. I don't want you to
6 think -- that was not meant --
7 MR. CICCOCIOPPO: If you would
8 like me to highlight the written testimony, I'd be
9 happy to do that.
10 REP. DeLUCA: I would appreciate
11 that. Thank you.
12 MR. CICCOCIOPPO: Again,
13 hospitals are an important economic engine in
14 Pennsylvania. Hospitals drive 90 -- nearly 90
15 billion dollars of economic activity in this State.
16 We employ or are responsible for the employment of
17 nearly 600,000 people in Pennsylvania. Hospitals
18 believe that health information technology is going
19 to be key to be able to be a viable industry going
20 into the future.
21 We have adopted and put hundreds
22 of millions of dollars in health information
23 technology. To one degree or another, about 84
24 percent of the hospitals have some form of
25 electronic health record in their institutions and

1 largely are deploying that within their affiliated
2 or their own physician practices, as well. For
3 example, in a recent survey that we conducted in
4 conjunction with the American Hospital Association,
5 about 84 percent have EHRs, but 41 percent of the
6 hospitals are using E prescribing for some part of
7 their patient population. Fifty-four percent have
8 electronic lab order or computerized physician
9 order entry systems. That's not everybody, and
10 that's not necessarily universally employed within
11 those hospitals that have those capabilities. This
12 is an expensive technology that we're talking
13 about. So there's a huge obstacle to further
14 adoption electronic health record technology, and
15 the biggest obstacle is cost.
16 We're going to also face issues
17 relative to work force and having informed
18 individuals who are able to help individual
19 practitioners not only implement and understand the
20 implementation of an EHR, but also how to do that
21 work force redesign. And to that end, HAP has been
22 very supportive and engaged with the applications
23 in Pennsylvania for the regional extension centers.
24 There are two regional extension
25 centers that have been funded in Pennsylvania.

1 Because we got two funded in Pennsylvania at almost
2 45 million dollars, Pennsylvania has actually got
3 the largest amount of federal money to help primary
4 care providers to understand the implementation
5 process, go through this selection process and
6 implementation process of an EHR with the goal of
7 having them be meaningful users of electronic
8 health record technology so those providers can get
9 some reward on the back end for their investment in
10 health information technology. But, again, that's
11 expensive, and how an individual provider is going
12 to pay for that isn't all worked out in this
13 legislation.
14 And to some extent, the benefits
15 of that investment that a provider is making don't
16 accrue to the provider. Better coordination of
17 care and reduced tests that are being performed,
18 those savings don't accrue to the provider. So a
19 provider may have less business as a result of the
20 effective implementation of technology. Those cost
21 savings are not accruing to the provider. They're
22 really forgone payments to a provider. And that's
23 why whenever we talk about who should be funding
24 Health Information Exchange, for example, I think
25 that the bigger benefactors of Health Information

1 Exchange are the payers. And the payers, in the
2 original recommendation for the PHIX, was that
3 there be a very small assessment on unpaid claims
4 in Pennsylvania to help underwrite the costs of the
5 Health Information Exchange, not to underwrite the
6 cost of the HIE. Hospitals and physicians are
7 bearing that cost today. They have the potential
8 of getting some of that cost reimbursed from the
9 federal government and through the Medicaid program
10 if they become meaningful users of electronic
11 health record technology. But right now, the
12 proposed hurdle and the proposed bar for being a
13 meaningful user is set way too high by the federal
14 government.
15 Again, in my testimony I talk
16 about the legislation that was -- the regulations
17 that were proposed and that hospitals would have to
18 meet 23 different objectives for their use of an
19 EHR to be considered a meaningful user. And if you
20 don't meet any one of those completely, you're not
21 a meaningful user of electronic health record
22 technology. And your potential incentive payments
23 of 700,000, a million dollars, six million dollars
24 over the course of three or four years would be in
25 jeopardy and there are penalties that would kick in

1 in 2015 if you aren't a meaningful user.
2 So at the federal level, we're
3 working very closely with the American Hospital
4 Association and other stakeholders to ensure that
5 the requirements for meaningful use are achievable.
6 There needs to be a stretch and there needs to be
7 some effort to get to them, but they can't be so
8 high that they're out of reach because then nobody
9 is going to be able to reap the reward of that 1.5
10 billion dollars that could be coming to providers
11 in Pennsylvania, if they're meaningful users of
12 electronic health record technology.
13 So we're working to make sure
14 that Pennsylvania providers get the support that
15 they need for implementation of electronic health
16 records. We're working to make sure that the
17 requirements are set in a manageable way for
18 providers to be phased into meaningful use.
19 We're also looking at the
20 infrastructure in Pennsylvania and for the sharing
21 of text information in Pennsylvania that might be
22 in a clinical record. You don't need as robust of
23 an infrastructure as you to share diagnostic
24 images. So one of the things that is severely
25 lacking in Pennsylvania in terms of infrastructure

1 for effective clinical Health Information Exchange
2 is broadband capability, and many of our providers
3 are practicing in areas that don't have access to
4 sufficient broadband, and what broadband they can
5 get access to is at too high of a cost. So the
6 Hospital Association worked with the higher
7 education community in Pennsylvania and secured a
8 100 million dollar broadband grant to deploy a
9 1,700 mile fiber optic network throughout 39
10 counties in Pennsylvania that will be available for
11 health care providers to use for clinical data
12 exchange.
13 So there are a lot of moving
14 pieces. This is complicated. We're trying to keep
15 all of those issues at the forefront and make sure
16 that they're manageable. Health information
17 technology is going to be funded through Medicare
18 incentive payments and Medicaid incentive
19 programs. The Medicaid program is going to be
20 administered by the Department of Public Welfare in
21 Pennsylvania. We have heard that the loan program
22 was a may provision in the American Recovery and
23 Reinvestment Act, and right now it's not being
24 funded by the federal government.
25 Similarly, the Medicaid Health

1 Information Technology Incentive Program is a
2 program that is optional for states. So a state
3 doesn't have to put in place a Medicaid HIT
4 incentive program. We have been working very
5 closely with the Department of Public Welfare and
6 actually very pleased with how proactive
7 Pennsylvania has been in committing the needed
8 resources to develop an IT plan. We're listening
9 to the industry on how that plan might be deployed.
10 We heard from Dr. Massey at the
11 beginning of the day that it was important for
12 Medicaid to make payments to high Medicaid
13 providers for health information technology at a
14 higher level in the first years than -- they have
15 some latitude in what they can do with those
16 payments, and the federal legislation allows the
17 Medicaid program to pay a fixed dollar amount per
18 provider over the course of four years or five
19 years.
20 It also says that they can pay up
21 to 50 percent of that total amount in the first
22 year for a high Medicaid provider, as long as
23 they're becoming a meaningful user of electronic
24 health record technology. So that's a significant
25 sum of money could be deployed early on at no cost

1 to the State that would help a provider be able to
2 become a meaningful user for year two and year
3 three, and be eligible for the Medicare incentive
4 payments that you can only get once you already
5 demonstrate that you are a meaningful user of
6 electronic health record technology.
7 Now, another organization that
8 HAP is affiliated with and is instrumental in
9 starting was the Pennsylvania E Health Initiative.
10 The Pennsylvania E Health Initiative was started
11 five years ago, really, by Quality Insights of
12 Pennsylvania, which is the lead organization on the
13 regional extension centers in Pennsylvania,
14 Pennsylvania Medical Society and the Hospital
15 Association. It grew rapidly by -- with
16 participation from a broad array of stakeholders,
17 not unlike the type of board that we're looking at
18 creating for the PHIX Authority. PAEHI already is
19 a public/private collaborative that has a single
20 mission of advancing the use of electronic health
21 record technology in Pennsylvania through the
22 adoption of standard EHRs and standardized Health
23 Information Exchange.
24 As it relates to House Bill 2106,
25 we worked with Representative Taylor in drafting

1 2106. We believe that as has already been
2 identified, there probably is a change that needs
3 to be done in terms of using deidentified data for
4 health improvement. The prohibition that's
5 currently in the Act probably needs to be recrafted
6 a little bit, but we are supportive of House Bill
7 2106 and applaud Representative Taylor's efforts in
8 making that available.
9 Health information technology is
10 a critical component of any effort to reform our
11 health care system. In addition, health
12 information technology will move us to real-time
13 access to information and advanced communication
14 within the care team and between caregivers and the
15 patient, just as investment in railroads, air
16 traffic control. Just as roads facilitated the
17 economic development of national prosperity in the
18 20th century, so, too, will the spread of health
19 information technology help to improve the health
20 care system in the 20th century.
21 Again, I thank you for the
22 opportunity to testify, and again, I'd be happy to
23 answer any questions from the Committee.
24 REP. DeLUCA: I want to thank
25 you. I didn't want to cut you short, because I

1 think your testimony is very interesting and that's
2 what these hearings are about, to try to get that
3 on the record so that we can give that transcript
4 to our members there and educate them who are not
5 here. So I want to thank you for taking the time.
6 I know Representative Pashinksi
7 has a couple questions, but before I turn this
8 microphone over to Representative Taylor, I want to
9 thank you, again. I want to apologize to the next
10 three testifiers that I will be leaving because I
11 have got a six and a half hour drive, and I have a
12 meeting tonight. So I want to thank each and every
13 one of you for coming out today and testifying.
14 And I want to thank Representative Taylor for being
15 a host here at this beautiful facility in Ambler.
16 And I'm going to turn this microphone over to
17 Representative Taylor to chair the rest of the
18 meeting. Thank you very much.
19 MR. TAYLOR: Representative
20 Pashinksi?
21 REP. PASHINSKI: In the view of
22 time, we'll do this real quick. I know your
23 concern was on the advisory committees.
24 Do you believe that there could
25 be a model whereby you would have a main Advisory

1 Committee and subsets so that you would deal with
2 the various technical aspects of the operational
3 aspects, or do you feel as though you must have a
4 total separation between the PHIX Advisory
5 Commission and, let's say, the chronic care?
6 MR. CICCOCIOPPO: We don't
7 believe that initially there needs to be that dual
8 focus for this Authority.
9 REP. PASHINSKI: Based upon
10 strictly that you feel as though you need more time
11 to just get the PHIX operation up and running?
12 MR. CICCOCIOPPO: Yes.
13 REP. PASHINSKI: But you,
14 obviously, like the coordination between the
15 chronic care and the PHIX and it goes hand in hand?
16 MR. CICCOCIOPPO: One of the main
17 objectives of the Chronic Care Commission
18 initiatives for the southeastern part of this State
19 or the other six initiatives had to do with
20 implementing electronic health records in the
21 practices and Health Information Exchange, and then
22 using care coordinators to mind those systems.
23 We're looking at not doing that on a pilot basis in
24 various pockets of the statement. We're looking at
25 being able to ensure that that's a reality for

1 every practice in the State.
2 REP. PASHINSKI: Thank you.
3 MR. TAYLOR: Thank you very much
4 for your testimony.
5 MR. TAYLOR: In the interest of
6 moving this along, it's about time to get ready to
7 go.
8 Is Dr. Gabbay available?
9 DR. GABBAY: Yes.
10 MR. TAYLOR: Thank you, Doctor,
11 for coming today. You can start anytime you want,
12 and I sure the members will rejoin, but in the
13 interest of moving along, and I know your time is
14 precious, let's get rolling.
15 DR. GABBAY: Thank you for the
16 opportunity to provide testimony in support of
17 House Bill 2106, and specifically in regards to
18 establishing an authority and creating the
19 governance structure for the continuation of the
20 Commonwealth's Chronic Care Initiative. This
21 critical initiative represents a shining example of
22 how primary care can be transformed to improve
23 healthcare outcomes for patients and containing
24 health care costs. As the faculty chair for the
25 Initiative, I have had the opportunity to see

1 firsthand the extraordinary benefits that this
2 program has brought, not only to providers in
3 practices but to patients around the Commonwealth.
4 I'd like to take a few minutes
5 and maybe abbreviate the overall testimony I have
6 and hit some of the high points of the rationale
7 for the Initiative, what the Initiative is a little
8 bit so that you can more clearly understand it, and
9 then, ultimately, why this Bill is important.
10 Why do we talk so much about
11 chronic disease and why is it the Chronic Care
12 Initiative? It's because of statistics like
13 these. Half of Americans live with one or more
14 chronic illnesses, and it is the single most
15 significant threat to the health of Pennsylvanians.
16 Seventy percent of the mortality in Pennsylvania,
17 70 percent of all deaths are related to chronic
18 illnesses. And the number of people with chronic
19 illnesses is growing as the aging of our society
20 increases and the greater longevity.
21 Despite how important chronic
22 care is for Pennsylvania, unfortunately, care is
23 suboptimal, not just in Pennsylvania but, really,
24 nationally. So as was mentioned earlier, only
25 about half the people with chronic illnesses get

1 the necessary chronic care recommendations that
2 they need to. As an example, for a disease like
3 diabetes, which is hugely costly, we know that we
4 can prevent complications by getting good blood
5 pressure, cholesterol, and glucose blood sugar
6 control.
7 But despite knowing that, only
8 seven percent of people with diabetes are at goal.
9 Ninety-three percent are not doing well, and that's
10 pretty poor outcomes as a result of that. And
11 those outcomes, unfortunately, translate to huge
12 health care costs, which, as you know, is not
13 something we can afford as a society. For example,
14 80 percent of all health care costs and
15 hospitalizations are related to chronic illnesses.
16 Seventy-six percent of all physician visits and 90
17 percent of all prescriptions are all related to
18 chronic illness care.
19 So if you look at avoidable
20 hospitalizations, as was mentioned, for diabetes,
21 alone, this is almost one billion dollars a year in
22 Pennsylvania. So when you think about the
23 potential for health care savings, it's
24 astronomical.
25 So why are we not doing better?

1 Why is care suboptimal? It's
2 really not about bad providers or bad patients, but
3 it's realty the system of care that we have. The
4 system of care developed in the last century when
5 most people died of infectious diseases. It's an
6 acute care system. You get sick, you go to the
7 doctor, you get medicine and you come home. And
8 that worked well in the past, but now most people
9 have chronic illnesses and that kind of system
10 doesn't work. You need regular follow-up,
11 coordinated care to be able to prevent the costly
12 complications and long-term complications of
13 various diseases.
14 Fortunately, there is an
15 effective model that can retool primary care to
16 meet these challenges, and that's something that
17 was alluded to, the chronic care model. It's been
18 used in a number of different health care
19 situations, in the VA system, all around the
20 country in different environments, but the
21 challenges, despite the widespread recognition of
22 the value of the chronic care model to improve
23 outcomes, it's generally only been adapted in large
24 health care organizations, and that's in part
25 because there's been a mismatch between who bears

1 the cost for implementation of this chronic care
2 model and who receives the financial benefit. And
3 so, the needed changes in reimbursement necessary
4 to promote team-based care, to have the appropriate
5 health IT available has really not been available
6 in the past.
7 So, really, when you look at
8 where are you going to solve the chronic care
9 disease problem in terms of high costs and poor
10 quality, the only place it's going to happen is in
11 the infrastructure where we already have in primary
12 care. So somehow, primary care has to get better
13 at doing this, and again, retooling them and
14 educating them on how do to this better is the
15 answer. This is also very much aligned with a
16 concept called the patient center medical home,
17 which is essentially an operational way of applying
18 the chronic care model to primary care.
19 Over time it's very clear, from a
20 number of studies, that you can really bend the
21 cost care curve by implementing better chronic
22 illness management because of the high cost of the
23 illness and because most of the cost is for the
24 end-stage complications that occur because the
25 evidence-based goals have not been met.

1 So what is happening in
2 Pennsylvania and how are we addressing this? I
3 think the Commonwealth can be quite proud that we
4 have a unique initiative that in the last two years
5 has transformed primary care across the State. The
6 Initiative has brought together practices,
7 providers, purchasers of health care, third-party
8 payers and patients to develop an innovative
9 solution to how to improve care and meet these
10 challenges of high cost and poor quality.
11 The Initiative basically involves
12 learning collaboratives, where practices, 25 or 30
13 at a time, are brought together and they're taught
14 how to change and deliver care more effectively to
15 be more chronic disease focused. They're practice
16 coaches that go out and visit practices and help
17 them problem solve locally. The monthly report on
18 their data through health information technology to
19 see how are they doing and measure themselves
20 against the benchmark and be able to see where
21 they're falling behind and then develop strategies
22 to improve that.
23 And then one of the truly
24 innovative things that has been done is that there
25 are consensus-based payment reform that are

1 infrastructure payments that are paid to practices
2 to transform the way they deliver care. And these
3 are aligned with the National Center for Quality
4 Assurance certification for being a patient center
5 medical home. As practices achieve various levels
6 of certification, they get increased infrastructure
7 payments for them.
8 The problem with previous payment
9 reform and pay for performance types of initiatives
10 that have happened around the country in the past
11 is that, one, they basically ask providers to do
12 better, do better and we'll give you more money,
13 but they don't really tell them how to do better.
14 And the problem is that practices are mired in the
15 current system. They don't really know how to
16 change. They're just trying to work harder,
17 instead of smarter, and no one's teaching them how
18 to do that. One of the unique things about this
19 initiative is, as I mentioned, we bring practices
20 together, they share with each other their
21 experiences of how they're tackling these problems
22 and develop real-world solutions that work for
23 them.
24 As was mentioned, there are
25 almost 1,000 providers already involved in this

1 Initiative across the State and it's effecting a
2 total of one million Pennsylvanians. And it is, by
3 far, the largest initiative of its kind in the
4 country. There's nothing even close to this
5 happening anywhere.
6 I can tell you, just from
7 watching the practices, and you will hear from Dr.
8 Gertner some examples, but I can tell you
9 providers, many are saying for the very first time,
10 they're really enjoying the practice of medicine.
11 This is why they went into medicine. They're here
12 to help people, and they now have the tools to be
13 able to do that. Practices are operating as a team
14 where all the members are working together for a
15 common goal to improving the health of the
16 individual patients. And teams are empowered to do
17 the right thing as the natural thing to do for
18 patients.
19 One of the unique features, as I
20 mentioned, is the wide scope of this Initiative.
21 So it's happening across the State of Pennsylvania
22 in all the different regions. It's involving
23 community health centers, academic practices, many,
24 many small practices of one to three providers, so
25 we have several practices, just a single provider,

1 that's being able to retool their practice. As you
2 know, in Pennsylvania, we have many small
3 practices. That's one of the things that's really
4 quite unique about what we're doing and it's also
5 addressing health disparities. African-Americans,
6 Hispanics are having their care approved as a
7 result of the Initiative. Once of the practices in
8 Philadelphia serves primarily a homeless
9 population, and they're already seeing profound
10 outcome improvements as a result of changing this
11 kind of care delivery and using these innovative
12 approaches.
13 Just to give you an example of a
14 few things, one practice in the Philadelphia area
15 realized that there weren't healthy foods available
16 locally, so they actually worked to bring a
17 farmer's market in their practice to bring healthy
18 food choices to the people within their practice.
19 Other practices have been engaging patients
20 directly to help redesign and inform practice
21 changes. Really, this is the first time for many
22 of them that they have asked patients what their
23 needs are and how to meet their needs most
24 effectively. And although in the business world
25 asking your customer how to do things better is

1 very common, that doesn't happen in medicine up
2 until now, unfortunately, and I think these
3 practices are really to be applauded for what
4 they're doing.
5 We're already demonstrating
6 robust improvements. If you look at the NCQA
7 certification, National Center for Quality
8 Assurance certification, the patient center medical
9 homes practices are all achieving that in the
10 benchmark time that they were given. I was just at
11 a recent presentation about the patient center
12 medical home where it was acknowledged that
13 Pennsylvania has the most NCQA certified patient
14 center medical homes in the country.
15 We're also improving
16 evidence-based goals. There are measurements of
17 improvement in clinical measures, in the use of
18 appropriate medications. And you heard some of the
19 early cost data, 26 percent decrease in
20 hospitalizations, 30 percent decrease in emergency
21 room visits, and 16 percent decrease in overall
22 costs. That's a decrease in costs. That's not
23 bending the curve, it's pointing it downwards.
24 So what is unique about what
25 we're doing? In the past, where these things have

1 happened and where the patient center medical home
2 is being applied in many states and around the
3 country, it's typically one or two payers. And the
4 reason that matters is that if a provider has many
5 different payers and it's only a subset of their
6 patients where they need to make these changes,
7 they tend not to make big system changes within
8 their practice. They do small, incremental things,
9 and care ends up being even more fragmented because
10 one care is for one group of patients and another
11 care for another.
12 Here, because of the antitrust
13 protection that this Authority would continue to
14 offer, 17 different payers are all involved in this
15 initiative. So every practice that's involved,
16 it's the vast majority of their payers that are
17 involved. In fact, only Medicare CMS is the only
18 group that's not part of this. So it really
19 becomes in their interest to do this for all
20 patients, and that's what they have been doing.
21 I mentioned that I've been
22 speaking around the country at various conferences
23 about this work. It's quite clear that there's
24 literally no one in the United States that's doing
25 anything close to what we're doing, and we really

1 are a model that we can be proud of. I can say
2 that the effort is something that is really
3 transforming care throughout the Commonwealth and
4 we have an opportunity to spread this even further.
5 So why do we need this
6 legislation? Well, we need ability to bring
7 together purchasers of health care, third-party
8 payers and providers to collectively develop
9 innovative reimbursement models. We have one
10 already present. There are a number of other
11 available models, like accountable care
12 organizations that can be explored, and this can
13 only happen in this public/private partnership that
14 this Authority helps to support.
15 This work is really too important
16 right now to let die, and the urgency of the
17 timing, as was sort of brought up earlier, is that
18 the current Commission is ending and this work
19 needs to continue. I mean, this is something that
20 everybody in the country is following, when I go to
21 conferences, and it would just be a tragedy to let
22 this die right here and now. The insurers have
23 stepped up and helped to provide the funding for
24 this. I think they're interested in continuing to
25 see this perpetuate because, again, the savings

1 may, in large part, go back to them. But they need
2 a structure where this can be housed, and honestly,
3 I don't think some of the other suggested
4 environments for this, like the Department of
5 Health or PHC4, would be as powerful a group as a
6 separate authority that would have the ability to
7 bring people together, because getting the payers
8 together has really been something that, as far as
9 I know, only Pennsylvania has been able to
10 accomplish with a number of different payers that
11 are here.
12 So as successful as this
13 initiative has been to date to improve the lives of
14 those in the Commonwealth and control spiraling
15 health care costs, establishing a proposed
16 authority through a public/private partnership will
17 be essential, not only to continue the spread of
18 the current approach, but also to capitalize on new
19 opportunities for innovation that we know will be
20 available from CMS and others in the near future.
21 So with that, I'm glad to answer
22 any questions.
23 MR. TAYLOR: Questions?
24 REP. PASHINSKI: It's a shame
25 that we're running out of time. You're a terrific

1 testifier, and we truly appreciate it, but there's
2 two others we have to go through here.
3 REP. HENNESSY: I don't think I
4 need that.
5 Doctor, are there any websites
6 that we can direct our local physicians to so they
7 can get information about the potential for the
8 PHIX program, this Initiative? Because as I
9 mentioned to Ms. Torregrossa, a lot of our doctors
10 seem to be resistent and they think of it as
11 another way for the government to force them to
12 spend money on equipment or software and they don't
13 -- at least right now they're not seeing the
14 benefit of it and I sense a lot of resistance. And
15 if they could -- if there's somebody who has put
16 something together, hopefully Penn State has, that
17 can say: This is how it's supposed to work, this
18 is what it's going to do in terms of streamlining
19 the program, and this is how it's going to actually
20 affect your bottom line in a positive way, we might
21 break down some of the resistance.
22 DR. GABBAY: That's a great idea.
23 I'm less familiar on the health IT side of those
24 kind of resources, but certainly there's a research
25 showing the benefit of that, and I could work to

1 try to gather some of that information. On the
2 chronic care Initiative there is a website with
3 information, as well as we're publishing some of
4 our work in academic journals. And probably the
5 best way for people to get an appreciation is to
6 talk to practices and listen to practices that have
7 gone through this transformation.
8 Finally, there's a lot of
9 information from the developers of the chronic care
10 model and there's a web site that really describes
11 that model quite well and how to start implementing
12 it.
13 REP. HENNESSY: Thank you.
14 MR. TAYLOR: Thank you.
15 REP. PASHINSKI: Doctor,
16 piggybacking on what Representative Hennessey just
17 mentioned, how many other doctors locally are
18 involved in this?
19 DR. GABBAY: Locally, in
20 southeastern Pennsylvania?
21 REP. PASHINSKI: Yes.
22 DR. GABBAY: So there are roughly
23 30 practices in the first run through and then an
24 additional 30 practices in a second run through.
25 So total number of providers, probably about a

1 couple of hundred, off the top of my head.
2 REP. PASHINSKI: You gave us some
3 percentages, and they are very impressive.
4 Do you have any hard numbers that
5 go with those percentages?
6 DR. GABBAY: Hard numbers in
7 terms of --
8 REP. PASHINSKI: Instead of a
9 percentage, an amount, a dollar amount?
10 DR. GABBAY: A dollar amount of
11 the cost savings?
12 REP. PASHINSKI: Yes.
13 DR. GABBAY: That data was from
14 one of the insurers, and I suspect that they
15 probably have some more specific data. I don't
16 have access to that. But I suspect that that
17 exists somewhere.
18 REP. PASHINSKI: And do we have
19 that data?
20 MS. TORREGROSSA: I can check and
21 see.
22 REP. PASHINSKI: The reason I'm
23 saying that is, again, you are promoting all your
24 good work and all the advances you've made through
25 medical journals. That doesn't help us try to get

1 things passed. We need to have the people
2 understand that. We need to have our legislators
3 understand the success that's actually been created
4 through this great work. So that's what I'm
5 looking for in order to help answer questions from
6 folks that haven't understood this or participated
7 in this effectively as you guys. I appreciate it.
8 DR. GABBAY: I think one of the
9 challenges we have had is we have been so busy
10 doing it, we haven't had enough time to get the
11 word out, and absolutely. My world, as an academic
12 person, is certainly to get things out in academic
13 journals. But I, and I'm sure the other people on
14 the Commission and other people involved, are more
15 than glad to go out and talk to others because
16 we're all, as can you imagine, quite passionate
17 about all this. This is the future. This is it.
18 REP. PASHINSKI: You just started
19 the in the northeast?
20 You didn't get it up and running
21 yet in the southeast part?
22 DR. GABBAY: No. It's all around
23 the State. So we started in southeast, went to
24 south central, southwest, northwest, northeast and
25 north central.

1 REP. PASHINSKI: I'd be
2 interested in knowing who I could connect with in
3 the northeast. Thank you very much.
4 MR. TAYLOR: Thank you, Doctor.
5 You've certainly made some compelling arguments why
6 the Commission should be continued through
7 legislation, and we'll definitely keep that in mind
8 as we go forward. Thank you for your testimony and
9 time today.
10 DR. GABBAY: Thank you.
11 MR. TAYLOR: Calling Elliot
12 Sloane, Health Information Management Systems
13 Society.
14 Mr. Sloane, thank you for coming
15 today. You may begin when you're ready.
16 MR. SLOANE: Thank you,
17 Representative Taylor, Committee members, staff,
18 ladies and gentlemen. Thank you for the
19 opportunity to speak today regarding the benefits
20 of the Health Information Exchange and the proposed
21 legislation and House Bill 2106.
22 My name is Dr. Elliot Sloane. I
23 reside right here in Penllyn, next door to Ambler,
24 and am President of a 501(c)(3) nonprofit Center
25 for Health Care Information, Research and Policy.

1 I have lived in Pennsylvania for 35 years working
2 as a health technology computer and patient safety
3 specialist, and for the past ten years I have also
4 been a university professor.
5 Since 2004 I have served as a
6 consultant to the Federal Office of the National
7 Coordinator of Health IT that, under executive
8 orders and legislation from both the Bush and Obama
9 administrations and have provided HIEs, REC, CMS
10 incentive payments and HIT work force funding and
11 leadership for Pennsylvania. I also play an active
12 role in the HIPPA and HITECH national personal
13 health data privacy, security and interoperability
14 standards that affect our Pennsylvania HIE
15 activities.
16 Pennsylvania's Health Information
17 Exchange will allow the secure and reliable
18 exchange of health data between providers, payers,
19 consumers, public health agencies and other
20 stakeholders. This will make health care delivery
21 in Pennsylvania more cost efficient and consumer
22 friendly.
23 There are 193 Health Information
24 Exchanges across the U.S. in some stage of
25 operation, including one in Pennsylvania, the

1 Keystone Health Information Exchange. A recent
2 survey of benefits by those participating in Health
3 Information Exchanges revealed higher than expected
4 benefits even in the early stages of an adoption.
5 The perceived value of a Health
6 Information Exchange in terms of improved quality
7 and timeliness of clinical decisions and diagnosis
8 increased 300 percent among those surveyed. The
9 value of the Health Information Exchanges in terms
10 of improved access to accurate patient data
11 increased 12 percent from initial expectations.
12 I am here today as a Board member
13 on behalf of the Pennsylvania Health Care
14 Information Management Systems Society, HIMSS. Our
15 members strongly believe a strong HIT authority is
16 key to establishing the financial and operational
17 model for a successful HIE and the fulfillment of
18 obligations associated with the Commonwealth's
19 recent commitment from the federal government of 17
20 million dollars in ARRA funding.
21 Pennsylvania is comprised of
22 nearly 2,000 health care -- Pennsylvania HIMSS is
23 comprised of nearly 2,000 healthcare professionals
24 from medical centers, health systems, health
25 information technology vendors and consulting firms

1 representing some of the largest employers in
2 Pennsylvania.
3 House Bill 2106 puts forward the
4 establishment of an authority to govern HIE. We
5 support the Bill and we agree that there needs to
6 be governance and authority in place to establish
7 policies, procedures and management of its
8 operations. We would also encourage some
9 modifications be made that would strengthen the
10 Bill, modifications that we believe will further
11 improve the quality and reduce the cost of care
12 while at the same time protecting the privacy
13 rights of citizens. These modifications will allow
14 the ability to aggregate health data and conduct
15 analysis of the data. Analytics of aggregate data
16 can help provide clinical and business intelligence
17 for utilization management, which is critical in
18 order to drive down costs and improve quality of
19 patient care.
20 Other states can serve as an
21 example to the Commonwealth. The Greater Rochester
22 Regional Health Information Organization is part of
23 New York State's HITECH research consortium that
24 includes Columbia University, University of
25 Rochester, Cornell University and SUNY Albany.

1 This consortium conducts qualitative and
2 quantitative research using patient-protected
3 deidentified clinical information and claims data
4 that flows through the Exchange. Studies underway
5 include, one, the effects of electronic prescribing
6 alerts on physician prescription behavior; two, the
7 changes to clinical work flow efficiency and
8 quality outcomes in stand-alone versus
9 interoperating electronic medical records systems;
10 three, the effect of patient information exchange
11 on ordering patterns and quality outcomes.
12 Pennsylvania HIMSS strongly
13 supports the use of deidentified health data for
14 quality improvement initiatives. Another
15 modification we encourage be made relates to the
16 proposed loan preferences for providers. The
17 current language appeared give preference to
18 applications which provide direct patient access to
19 health care information, which Pennsylvania HIMSS
20 interprets as personal health records or PHRs.
21 We recognize that a key component
22 of health care reform must include patient directed
23 care management and that PHRs are one way that
24 consumers are beginning to get more involved in the
25 care process. However, we believe the loan program

1 would have a bigger impact on reducing costs and
2 improving quality if providers were encouraged to
3 submit loan applications that included a convincing
4 cost-benefit analysis that did not necessarily
5 require a PHR component.
6 PHRs are not yet a proven method
7 for improving quality and reducing the costs of
8 health care. There are many ways a provider may
9 use health information technology that are more
10 proven. Examples include computerized physician
11 orders and electronic prescriptions to reduce
12 medication errors, or the use of telephony
13 integration CTI systems to monitor patients with
14 chronic conditions at home to reduce hospital
15 readmissions. Pennsylvania HIMSS supports a focus
16 on loan incentives, which are benefits driven.
17 Most Health Information Exchange
18 is a critical piece -- Health Information Exchange
19 is a critical piece of the health care reform
20 puzzle. Most health care delivery occurs in the
21 physician office and the typical primary care
22 physician works with 229 other physicians in 117
23 different practices in care coordination issues.
24 We encourage the Committee to
25 seriously consider amending House Bill 2106, as we

1 have suggested today, in order to position the
2 Commonwealth for the greatest potential benefits
3 that an HIE has to offer.
4 Thank you.
5 MR. TAYLOR: Thank you.
6 Representative Pashinski?
7 REP. PASHINSKI: Thank you very
8 much, sir, for your testimony. One quick thing.
9 You mention here that you support loan incentives.
10 MR. SLOANE: Correct.
11 REP. PASHINSKI: Where do you
12 acquire those loan incentives and what kind of
13 percentage rates?
14 MR. SLOANE: Well, the loan
15 incentives are actually identified in the Bill.
16 Those are not loans that we're specifically
17 expressing a desire or need separately.
18 REP. PASHINSKI: I misunderstood
19 that. Thank you.
20 MR. TAYLOR: Thank you, Mr.
21 Sloane, for your time. Thank you for offering your
22 thoughtful critiques of the legislation, and we
23 certainly will be taking them on and we will be
24 reaching out to you to further expand upon them.
25 MR. SLOANE: Thanks.

1 MR. TAYLOR: Dr. Gertner,
2 associate chief of External Programs, Division of
3 Internal Medicine at Lehigh Valley Health Network.
4 DR. GERTNER: Mr. Chairman,
5 members of House Insurance Committee, and fellow
6 Pennsylvanians, thank you for inviting me here
7 today to testify on House Bill 2106, and more
8 specifically, on the benefits of amending it to
9 include not only the Pennsylvania Health
10 Information Exchange, but also the Chronic Care
11 Commission.
12 I have been fortunate to have
13 served on the Clinic Care Commission as the
14 Co-Chair of the Committee on Community Practice
15 Redesign, and I take great pride in the
16 accomplishments to date of our collective work here
17 in Pennsylvania. I am also one of the over 900
18 primary care practitioners involved in one of the
19 learning collaboratives. As a primary care
20 generalist in Allentown affiliated with the Lehigh
21 Valley Health Network, my practice participates in
22 the South Central Pennsylvania collaborative. So
23 the insight I can provide comes both from my active
24 participation on the Commission as well as my
25 in-the-trenches care for patients in Pennsylvania

1 who daily struggle with chronic diseases, such as
2 diabetes.
3 So why are we concerned about
4 chronic diseases? Simply put, chronic diseases,
5 such as diabetes and asthma, congestive heart
6 failure, hypertension, rheumatoid arthritis all
7 have an enormous impact not only on an individual's
8 physical health, but also their quality of life,
9 their sense of well-being, their ability to go to
10 work each day, contribute to society and provide
11 for their families. The burden of chronic disease
12 from a financial standpoint is great and is borne
13 not only by the individual who can't afford to
14 purchase her medications, but also by the rising
15 costs of health care.
16 Overall, you have seen the
17 statistics, but they bear repeating, and Bob Gabbay
18 and others have done a very nice job in summarizing
19 some of this data, so I won't repeat it here. As
20 Bob also mentioned, the data doesn't begin to
21 address the disparities that may exist in health
22 care of the care of patients with chronic disease
23 based on race, ethnicity, gender or geography.
24 As a primary care physician, this
25 data is my reality. Patients come in to see their

1 physician. We take a history. We perform a
2 physical examination, order tests and prescribe
3 medications, and at the end of the day, what have
4 we done to improve health?
5 How have we provided are that
6 meets the needs of the patient or her family? As
7 we run on the hamster wheel of primary care, we
8 suffer from the constraints of a system that was
9 not intended to care longitudinally for patients
10 with long-term conditions, but rather, a system set
11 up to treat acute illnesses. Another way of
12 stating this comes from Dr. Ed Wagner, who is the
13 creator of the chronic care model, who has been a
14 consultant to the Commission. He wrote: The
15 current system cannot do the job. Trying harder
16 will not work. Changing the systems will.
17 In Pennsylvania, that's exactly
18 what the Chronic Care Commission has done. It has
19 promoted, facilitated and overseen changing the
20 system of care in the outpatient setting to improve
21 health. We have create teams of healthcare
22 professionals in offices and clinics focused on
23 practice transformation. Through learning
24 collaboratives, providers have learned about best
25 practice methods what has worked elsewhere. We've

1 shamelessly shared our work so that the patient
2 education I use in Allentown was adapted for a
3 practice in New York. And the office protocols
4 developed in Hershey were adapted for practices in
5 Pittsburgh. Practices are linked together through
6 face-to-face meetings and through lists service.
7 We have expanded use of
8 electronic medical records and developed robust
9 patient registries with data that is meaningful to
10 both providers and patients. Importantly, making
11 the data we generate meaningful to improve patient
12 care, not just an EMR as a glorified word
13 processing program, that's how this collaborative
14 can change patient care and patient lives.
15 The data that helps at the point
16 of care is, in many ways, different from the data
17 that's collected regarding hospitalizations and
18 hospital care. It's the data that allows you to
19 see your practice from the population level, not
20 only on a patient-by-patient basis. It's the data
21 that helps you integrate the care you provide for
22 your patients with the most recent and
23 evidence-based medical recommendations. A very
24 meaningful example for me early on was our use of a
25 patient registry data looking at our rate of

1 documenting dilated retinal exams for our primarily
2 Medicaid clinic population in Allentown. As well
3 trained physicians, of course, we know the evidence
4 related to this, and the recommendation clearly is
5 for an annual examination. We truly thought we
6 were recommending this for our patients, but we
7 were very wrong.
8 When we put together our first
9 patient registry, we found that we were only
10 screening about eight percent of our diabetic
11 patients annually for retinopathy, a leading cause
12 of blindness among diabetics. And I mention this
13 not to highlight a problem, but rather, a solution.
14 We would never have recognized how great a problem
15 this was without the use of a patient registry. It
16 turned out that the reason for a such a low rate of
17 screening was simply that there was no
18 ophthalmologist on the city's bus route. So a
19 simple intervention, bringing an ophthalmologist to
20 the clinic once per month resulted in increasing
21 our in screenings over 50 percent in just a few
22 months.
23 How many cases of blindness did
24 we prevent? Anecdotally, every time we did a
25 screening, we found not only a few patients with

1 early retinopathy, but also cases of glaucoma and
2 cataracts. Or the example of the integrated team
3 approach to the care of our diabetic patients.
4 When a patient came to our office having returned
5 from Iraq 30 pounds lighter, we could very easily
6 have attributed it to his military service. But
7 our heightened awareness led us quickly to
8 recognize that he had new onset diabetes. Through
9 coordinated care efforts and a proactive team
10 approach, we brought his diabetes under control,
11 not in the usual matters of months, but within
12 several weeks. His fasting glucose levels were
13 under 100 and his hemoglobin A1c, a measure for
14 diabetes, went from 15 to just over seven, just
15 about at goal.
16 One of my pediatric colleagues
17 told the story of a little boy who missed many days
18 of school each year due to asthma, so he was
19 falling behind in class. Also, his family was
20 hoping to go to Disney World, but decided they
21 couldn't, given his symptoms. Their care team got
22 together, taught the boy and his family how to
23 monitor his symptoms more carefully, checked in
24 with him consistently and modified his
25 medications. That little boy didn't miss a day of

1 school throughout this winter and he did make it
2 down to Disney. Another success. Every one of the
3 173 participating practices has similar stories,
4 similar achievements, integrated, team-based care
5 made these possible, and the work of the Chronic
6 Care Commission facilitated these stories.
7 The work of the Chronic Care
8 Commission has crossed the State, but has also been
9 very local. While there are seven collaboratives
10 up and running, using the same basic format and
11 education, in many ways, each is guided by the
12 needs of the local health care communities. What
13 works for a pediatric practice in Montgomery County
14 may not work for a family medicine group in Adams
15 County. The incentives provided to practices in
16 Danville might not work for practices in
17 Philadelphia. The Pennsylvania collaboratives are
18 unique around the country in their ability to
19 innovate based on regional needs and regional
20 realities to adjust, when necessary, to new
21 information and new data, to introduce new concepts
22 at a pace that assures practices can implement
23 them, all while providing guidance and oversight.
24 This could not have occurred on the scale it has
25 without the public/private partnership forged by

1 the Chronic Care Commission.
2 Another important innovation in
3 Pennsylvania has been our focus on care
4 management. Making a correct diagnosis is just the
5 beginning. Managing that patient, coaching them
6 through the daily care that's needed is essential
7 to not only improve but maintain their health.
8 Each of the practices in the collaboratives now has
9 or will have an individual in the practice that
10 focuses on helping patients meet their goals of
11 care. A care manager that helps with the
12 transition from inpatient to outpatient settings,
13 that ensures enhanced access for high-risk
14 patients. Practices have care managers that can
15 help educate patients about their conditions, not
16 forced within the confines of a 15 minute office
17 visit, but a care manager can take her time with
18 the patient to provide that disease-specific
19 education that's necessary to become a better self
20 manager.
21 The care manager can ensure
22 proactive care takes place, not just reactive
23 treatment complications. Patients are also taught
24 skills that can help them cope with their
25 conditions, to live everyday with a chronic disease

1 beyond the disease-specific specific education they
2 receive. Patients will have a greater stake in
3 their own health care as a result, and the data
4 suggests this will improve health outcomes.
5 You've heard today about the
6 importance of the Chronic Care Commission as a
7 convener and as a facilitator of practice change.
8 The Chronic Care Commission has provided leadership
9 and a forum for discussion and education and
10 opportunity for stakeholders to come together to
11 focus on quality improvement for everyone, not just
12 your patients or my patients, but for everyone, for
13 all Pennsylvanians.
14 You have heard about the
15 transformation of our practices, a transformation
16 toward a more patient-centered approach consistent
17 with the ideals of the patient centered medical
18 home. You won't be surprised, then, to have
19 learned from Bob that Pennsylvania is home to the
20 most practices certified as patient centered
21 medical homes by the National Committee on Quality
22 Assurance, and the most that are certified at level
23 three, the highest level of certification. And
24 Pennsylvania is truly considered a model state
25 regarding its efforts at quality improvement, cost

1 containment and reform. You can't go to a medical
2 home meeting anywhere in the country without seeing
3 someone from Pennsylvania presenting their work
4 that started as a part of this effort. Continuing
5 this work, continuing to engage our many
6 stakeholders, continuing to transform our primary
7 care programs is in our compelling interest.
8 Amending House Bill 2106 to
9 include the Chronic Care Commission, along with
10 Pennsylvania Health Information Exchange under one
11 authority makes sense. Both require multiple
12 stakeholders from insurers and provider
13 organizations to consumer advocacy groups and
14 concerned citizens and adequate state presence for
15 continued spread and success. The representation
16 is similar and the need to exist as a partnership
17 is similar. Both focus on collecting data from
18 multiple sources and using the data to improve
19 patient care, especially in the outpatient setting.
20 The additional potential for integration and
21 coordination will serve to enhance the work of both
22 groups and ensure the sustainability of the
23 Authority.
24 The transformation of primary
25 care facilitated in Pennsylvania by the Chronic

1 Care Commission continues to be a model nationally,
2 a testament to the results of collaboration,
3 innovation and integration. Amending House Bill
4 2106 to allow the Chronic Care Commission to join
5 the Pennsylvania Health Information Exchange under
6 one authority will ensure the continuation of the
7 work not only of the Commission and the 900 plus
8 activated providers around the State, but also of
9 the over one million Pennsylvanians who are
10 becoming better self managers of their diseases who
11 are waking up every morning feeling a little bit
12 better than they did the day before.
13 For my colleagues, for my
14 patients, thank you for the opportunity to testify
15 before you today, and I would encourage all the
16 members of the Committee and the legislators to
17 visit the practices that are in your districts that
18 have implemented this model for a real hands-on
19 view of the trenches. Thank you.
20 MR. TAYLOR: Thank you, Doctor.
21 REP. PASHINSKI: Do you think you
22 and Martin can get together and we'll work this
23 out? Doctor, thank you very much for your
24 testimony. We appreciate it.
25 The AMA, the PMA, have you had

1 any collaboration with the PMA relative to the
2 results of your efforts?
3 DR. GERTNER: The PMA or PMS?
4 Pennsylvania Medical Society?
5 REP. PASHINSKI: Yes.
6 DR. GERTNER: PA Med, as it's
7 called now. That's actually one of the real
8 strengths of this collaboration. And as a
9 primary-care doctor, I will tell you that it's
10 often -- it's often difficult to get all the
11 specialties to agree. Internist won't talk to
12 family physicians. Family physicians won't talk to
13 pediatricians. Pediatricians want nothing to do
14 with the internists. In Pennsylvania this
15 collaborative came together with the support of the
16 Pennsylvania Medical Society, the Pennsylvania
17 Chapters of the American College of Physicians,
18 which is the internal medicine branch, the
19 Pennsylvania Chapter of the double AP, the
20 pediatricians and the Pennsylvania Academy of
21 Family Practice. So all four groups have been very
22 involved and very active in supporting this
23 program.
24 REP. PASHINSKI: Is it a good
25 cross-section of age relative to the physicians, or

1 is it primarily younger physicians that are
2 actively in this?
3 DR. GERTNER: There's a fairly
4 good cross-section. In fact, one of the stories
5 that really rings true for me was a pediatrician in
6 the southeast collaborative, who may actually be
7 here in Montgomery County or Bucks County, who went
8 into the collaborative thinking: I'm not doing
9 this. I'm doing this because someone told me I
10 should and maybe I will make a little money on the
11 side through the collaboration effort, but by the
12 end, after the year he was sold.
13 Again I made the point earlier
14 about how a registry, a patient registry is
15 critical for taking care of patients
16 longitudinally. Electronic medical record helps
17 facilitate that. They're not necessarily one in
18 the same. Having electronic medical records and
19 just inputting the data and never looking at it and
20 using it at the point of care truly is, to me, a
21 glorified word processor. I see some of our
22 residents who are trying to train and they will
23 just dictate in using voice-recognition software
24 into a field in the electronic medical record, but
25 it doesn't allow you to really capture the data.

1 It doesn't allow you to do surgical field and find
2 out what you need to know about how to care for
3 your patients.
4 So integrating those two
5 together, a registry, as well as electronic medical
6 record, really is one of those eye-opening
7 experiences that once you see your data, once you
8 see that you've only screened eight percent of the
9 diabetics in Allentown for retinopathy, once you
10 see that your number of patients at goal for blood
11 pressure is only 35 percent, it really makes you
12 stand up and look at your data, look at your
13 processes in your office more critically in order
14 to improve the care.
15 Another easy example goes with
16 immunizations, flu shots, pneumococcal vaccinations
17 is, again, one of the recommendations for patients
18 with all chronic diseases, including diabetes.
19 When you look at your data for the first time, very
20 often you will find that you haven't immunized your
21 patients, as per the guidelines, as per the
22 protocols. Through very simple office-based
23 protocols that we have all developed and modified
24 and shared with each other throughout this
25 collaborative, practices have gotten their

1 immunization rates for flu -- influenza shots and
2 for pneumococcal vaccination up in the 80 to 90
3 percent range. That's through very simple
4 innovations that you would never have thought to do
5 unless you looked at your data critically.
6 REP. PASHINSKI: I have also
7 received incidents where the collaboration of the
8 material has also discovered new methods of
9 treatment that have been more successful in other
10 areas, and now, because of that collaboration, more
11 doctors are using that.
12 DR. GERTNER: Absolutely. What
13 we find is -- especially with your high risk
14 patients. If you have a subset of your patients
15 that score highly on a risk score, we've all
16 developed different ways of risk stratifying our
17 patients, and you look at that subset of patients
18 that just doesn't move, you can't get the
19 hemoglobin A1c down, you can't decrease the blood
20 pressure, you can't affect the cholesterol, you
21 have the opportunity to speak with other folks
22 around the State what worked for you. You can take
23 that data to your endocrinologist and sit down with
24 that endocrinologist with ten patient charts open
25 and say: Here are my ten patients that I'm having

1 trouble with, help me globally, and through one
2 short intervention with that specialist, you've
3 cared now for ten patients. So that's really the
4 power of this kind of collaboration is the ability
5 to share information in a meaningful way, not just
6 electronic information, but that face-to-face
7 contact that really sparks the innovation and
8 improved health outcomes.
9 REP. PASHINSKI: To recognize the
10 fact that this collaborative would not have taken
11 place without the Chronic Care Commission and it's
12 vital to continue on.
13 Have you had any discussion with
14 the HAP representative?
15 DR. GERTNER: I have not, but I
16 would surely welcome that.
17 REP. PASHINSKI: Thank you very
18 much, Doctor.
19 DR. GERTNER: Appreciate it.
20 REP. HENNESSY: Doctor, how did
21 you get to be involved in the south central
22 collaboration?
23 Were you invited in?
24 Did somebody sort of preselecting
25 groups and say: Let's invite them and see if we

1 can interest them, or was it sort of a broadcast
2 advertisement saying: Anybody who wants to get
3 involved and let us know? Because if you were here
4 for some of the other questions that I asked, some
5 of my doctors in Chester County, I don't know if
6 they know about this, maybe only a select few do,
7 that some are resistent and they're seeing these
8 kind of -- they're looking at potential expenses
9 down the road, or in the near future not that far
10 down the road, to try to buy the equipment, the
11 software to get into this program. They're not
12 necessarily seeing the benefits and we're trying to
13 figure out how to get that information to them.
14 DR. GERTNER: One of the things
15 that's helpful with these collaboratives is that
16 they have been forged with sponsorship, with input
17 from the insurers. So without their backing,
18 without the incentive dollars that they're
19 providing us with, it becomes difficult to
20 transform your practice. We're trying several
21 models around the State currently up in the
22 northwest, second collaborative in the southeast.
23 We're having a second collaborative in the Lehigh
24 Valley, which will not be -- the rewards may or may
25 not be as much, the incentives may or may not be as

1 much, but the infrastructure is already in place.
2 In Chester County the president
3 of the Chester County Medical Society, Dr. Ruth
4 Holland, and I had spoken about this in the past,
5 as well, of her interest and how can she get more
6 of the Chester County physicians involved. One of
7 the things -- and I will come back to my -- how I
8 became involved, it's a little bit different than
9 maybe most, but the call for practices went through
10 all of those aforementioned societies. The
11 Pennsylvania Medical Society, the PAFP, PA chapters
12 of the ACP and AAP to recruit practices.
13 I just also happened to be ready
14 for this. You can't just turn the switch one day
15 and say: I think I will become a medical home,
16 because there certainly is some preparation that
17 needs to go into it. So finding practices that
18 have already laid some of that infrastructure or
19 have thought about practice redesign becomes
20 important.
21 My involvement started before the
22 Chronic Care Commission kind of globally. There
23 was a program called the Academic Chronic Care
24 Collaborative, which was 23 academic centers around
25 the country that came together with the folks from

1 McCall Institute, Dr. Wagner, to look at
2 implementing a chronic care model in residency
3 programs throughout the country. Our program was
4 the only one in Pennsylvania that was involved, and
5 yet, as a community academic center, we became one
6 of the leaders of that group. I had my aha moment,
7 so to speak, when you see the power of a registry,
8 and that got all of us actively involved.
9 In the work of the south central
10 collaborative, being on the Chronic Care
11 Commission, I certainly knew that this was coming
12 and we were already preparing for it. So we had
13 160 some odd practices throughout our network that
14 were looking at how prepared they were. We
15 surveyed all of our practices in pediatrics, family
16 medicine, internal medicine to get a sense of their
17 readiness to move forward, and then currently have
18 seven practices that are part of the south central
19 collaborative through our health network. In fact,
20 we're having another 20 practices that are going
21 forward.
22 So to answer your question about
23 in the other areas of the State, I think what we
24 have learned thus far has laid infrastructure that
25 practices anywhere throughout Pennsylvania, whether

1 it's in the southeast, whether it's in the
2 Pittsburgh area, whether it's in the northeast,
3 whether it's in the central part of the State, in
4 the rural and the urban areas, any practice in the
5 State at this point can become involved through one
6 of the collaboratives that's ongoing.
7 In addition, there's another
8 collaborative starting that's family medicine and
9 residency program. That should be starting next
10 week or next month. So this has really begun to
11 snowball within the State with more and more
12 practices coming online, more and more
13 opportunities becoming available. And I think
14 through coordination with this Authority, through
15 the Chronic Care Commission, any practice will have
16 an opportunity to become involved.
17 REP. HENNESSY: I don't know
18 whether or not you can tell me the stat, but I
19 assume there's still some sole practitioners out
20 there. Most doctors seem to have formed groups for
21 purposes of coverage, or for getting a little bit
22 of time off, or whatever. But there are still some
23 sole practitioners there. And you mentioned the
24 concept of a case manager.
25 Can Dr. McCormac here assign one

1 of her nurses to be a case manager as part of her
2 other duties?
3 Is it possible for a sole
4 practice, say, contact another office and say: Do
5 you have a case manager that we can work on a
6 contract basis; I can engage that person to be my
7 case manager, as well? Because I'm trying to
8 figure out the small practices, how they survive in
9 this program if we're going to be putting a lot of
10 expense on them to get into it. And then, when you
11 talk to a sole practitioner about hiring a case
12 manager, immediately they see dollar signs and you
13 just priced it out of my practice.
14 How do we help them?
15 DR. GERTNER: The answer is yes.
16 The answer is that for every possibility that you
17 mentioned, yes, it can work. One of the beauties
18 of the collaboration that we have with 170 some odd
19 practices involved is in some sense we have 173
20 different ways where you can involve a care manager
21 in your practice. In my practice we have a nurse
22 practitioner spending the equivalent of a full day
23 overseeing activities as a care manager and we're
24 going to be hiring a medical assistant to help with
25 other functions throughout the week. Other

1 practices have other ways of doing it, and that's
2 individual to that practice, to the staff and their
3 practice, the needs of those patients.
4 You talked about solo
5 practitioners, one of our most successful practices
6 in not only the south central region, but one of
7 the affiliated practices, and it's a practice
8 that's not part of the owned network of Lehigh
9 Valley network, is a group of -- it's a single
10 practitioner, family physician in Fogelsville who
11 has a nurse and a front desk person. They all ride
12 to work together on their motorcycles. And they
13 have -- they know every one of their patients, and
14 they are able to get in touch with every one of
15 those patients. And through this collaborative,
16 through the development of an active registry,
17 which, by the way, came to them free as part of
18 their involvement in this collaborative, not a
19 medical record but a registry product, they had
20 improved their care for their patients. So
21 absolutely a single practitioner with an activated
22 office can flourish in this kind of environment.
23 REP. HENNESSY: One other
24 question. You had mentioned the eight percent --
25 somehow somebody discovered that only eight percent

1 of diabetic patients were being screened for
2 retinopathy.
3 Who crunched that data?
4 Is that something that -- let me
5 ask you a preliminary question.
6 Do you have to fill out a chart,
7 or does that patient have to fill out some sort of
8 questionnaire, which then gets scanned into a
9 computer? Somebody at some point must have said
10 the eight that were being screened for retinopathy,
11 somebody checked the box saying that had been
12 prescribed.
13 Who, then, analyzes all that data
14 to say only eight percent of the diabetics here are
15 being screened, we ought to try to think about
16 whether or not we ought to be screening more.
17 Because one of the prohibitions in the Bill says
18 the collection analysis of clinical data is one of
19 the things that we shouldn't be doing, and it
20 sounds like that's what you were doing, or somebody
21 was doing, and you thought it was a good idea, and
22 it makes as sense to me.
23 DR. GERTNER: So the difference,
24 I think, from some of the things we were talking
25 about earlier in terms of the information and what

1 I described with our reviewing the data of our
2 diabetic patients is that was all done by us. The
3 review of that patient data was done internally in
4 our practice. That was looking at patient charts
5 and having that data entered into a registry and
6 where we had a box to check if the patient had a
7 screening for retinopathy, if a patient did go to
8 see an opthalmologist or an optometrist, of course,
9 screening for retinopathy.
10 Clearly, something that we
11 recommend to all of our patients, or we think we
12 recommend to all of our patients who are diabetics
13 to get that done on an annual basis. But when that
14 data went into our local registry, which is part of
15 our practice, and we crunched the numbers, in that
16 case, it was a group of us, kind of as a core
17 committee, but that can be done by a care manager.
18 That can be done by a physician champion. That can
19 be done by a lead nurse, someone within the
20 practice. When we crunched those numbers on that
21 practice, we found it was only eight percent, much
22 to our dismay.
23 The same thing, we look at our
24 data at least on a weekly to monthly basis, and
25 again, that's data that we collect on our patients

1 that we generate reports through our electronic
2 medical record using a registry that we review and
3 see where we are. Dr. Gabbay mentioned the reports
4 that we send in monthly to the State. It's
5 deidentified data. It's practice level roll
6 update. So on a monthly basis I report in to the
7 State collaborative what my percentage of patients
8 have had pneumovacs, what percentage of my patients
9 have had their yearly influenza exam, what
10 percentage of patients had counsel for smoking
11 cessation, among those patients who smoke. So I
12 follow those trends, and at this point, as part of
13 this collaborative, our practice data is about 15
14 or 16 months old and I can see the trends and I can
15 definitely point to interventions that change the
16 data. I can point to the date when we put our
17 pneumococcal protocol into place because from that
18 month on you see the steady climb in our
19 immunization rates. But that's all done internal
20 to our practice so that we can look at our patient
21 population as a whole and practice population
22 health.
23 REP. HENNESSY: I don't want to
24 belabor the point, but I was understanding the
25 purpose of the PHIX initiative that you, as a

1 doctor, can contact -- get all my records from any
2 other doctor. But somehow, at least at some entry
3 level, perhaps, you're able to contract or to get
4 numbers relating to the entire population within
5 that database.
6 DR. GERTNER: Well, part of it
7 gets back to the first speaker, the issue of
8 accessibility of that data. I can find a lot of
9 data. It might take me lot of time to find that
10 data. A very easy example for me is lab data.
11 Most of my patients have their labs performed in
12 one of two labs, either our health network lab at
13 the hospital or through Quest.
14 But there's a real percentage of
15 patients, somewhere between ten or 15 percent of
16 the patients in our practice, who get their labs
17 performed elsewhere, either at different hospital
18 network, an outside agency, someplace else. I can
19 try to get that information from the lab, have it
20 FAXed over, then manually enter it into my registry
21 so that I can have it there, or through a
22 Pennsylvania Health Information Exchange, that data
23 can electronically flow right into my registry. I
24 would have more time then to spend with my patients
25 and not trying to track their lab data. That's

1 just one example.
2 REP. HENNESSY: Thank you.
3 MR. TAYLOR: Well, thank you,
4 Doctor. Thank you for your time, and again, very
5 thoughtful testimony. I really do appreciate the
6 time you took to come down here to testify.
7 This concludes our Committee
8 meeting. We'll be reaching out to the testifiers.
9 We want to get your input based on what you heard,
10 some ideas. So we'll be reaching out to you in the
11 very near future. Thank you very much for coming.
12 I really appreciate it. And thank you to the
13 Committee members who came down to listen to, I
14 think, very thoughtful testimonies today.
15 This meeting is adjourned.
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19 (Whereupon, the meeting was
20 adjourned at 2:15 p.m.)
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1 C E R T I F I C A T E
2
3 STATE OF PENNSYLVANIA
4 COUNTY OF BUCKS
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