



Statement by the

IEEE-USA

To The

**Subcommittee on Federal Workforce
and Agency Organization
House Government Reform Committee
U.S. House of Representatives**

On

**The Federal Family Health Information
Technology Act of 2006 (H.R. 4859)**

15 March 2006

IEEE-USA congratulates Reps. Jon C. Porter and William L. Clay, Jr. on the introduction of HR 4859, the Federal Family Health Information Technology Act of 2006, which would establish Electronic Health Records in the federal employee health insurance program.

Electronic Health Records, or EHRs, show substantial promise in improving the efficiency of health care and reducing medical errors. EHRs can also contribute to improvements in healthcare treatments by collecting the information needed to validate the efficacy of treatments and incorporating that information into evidence-based healthcare.

In order for the bill to achieve its admirable goals, there are several factors that we believe will need to either be added to the legislation or be carefully considered by the Office of Personnel Management (OPM) during its implementation. These include interoperability, funding, privacy and EHR maintenance, scope of the initial implementation, and measurement of results.

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Interoperability

The strategy incorporated in the bill of “jump starting” EHRs by mandating them for carrier participants in the Federal Employee Health Benefits Program (FEHBP) is a logical step to move the process of providing EHRs to all Americans forward. Although there are a range of commercial EHR products available, there has been no forcing function to insure any level of interoperability among them. This bill would provide this forcing function by requiring the transfer of EHRs between carriers when an FEHBP participant chooses to move between healthcare carriers in the program. The bill also includes a number of other interoperability requirements, including the transfer of a carrier-held individual personal health record from the carrier to the individual, another carrier, or to another “entity designated by the individual ... upon the request of the individual.”

IEEE-USA has recently published a white paper on this issue of interoperability for the National Health Care Information Network, which includes consideration of the problems associated with EHR interoperability. We are providing a copy of the white paper with our testimony. The white paper points out the wide range of standards that must be incorporated into systems to meet the Bill’s requirements. Coordination of the use of these standards, and even the determination of the standards to be used, will require a working group that includes the health insurance carriers, the commercial EHR system providers, and potentially other participants. Such a working group would be a natural outgrowth of the work of the Office of the National Coordinator for Health Information Technology (ONCHIT). While OPM is required to “consult” with the ONCHIT, a stronger role for ONCHIT is indicated, including organization and leadership of an interoperability working group responsible for dealing with the many interoperability issues that will arise during implementation. It is difficult for the carriers themselves to directly form such a group for a number of reasons, including laws against collusion, so explicit Federal sponsorship of such a group is necessary.

The working group should also determine what shared infrastructure, in addition to standards, is required for the overall system. This infrastructure should include a common approach to identification and authentication of participants. We have also included with our testimony an IEEE-USA position statement on *Voluntary Healthcare Identifier* that addresses the issues associated with identification. The Defense Department work with the Common Access Card, now issued to all U.S. military personnel and defense contractors, is also relevant to determining an appropriate identification and authorization approach, and should be reviewed by the working group.

The bill requires some level of interoperability among carrier, personal, and provider EHRs. However, there are other groups that need to be considered. These include the research, the public health, and the environmental communities. In order to get many of the benefits of EHRs, the information collected must be available in some form to the healthcare research and public health communities. And in order for these communities to get the full benefit of the EHRs, they will need to be able to correlate environmental information with healthcare information. While expansion of the Bill to fully include these communities might unduly add to the complexity of implementation, these communities should be involved in the initial implementation in an

advisory role, in order to ensure that the potential for interoperability in the future is incorporated. One step to assist this would be to include representatives of these communities in the interoperability working group.

Funding

With respect to the funding mechanisms, it is not clear that the incentives and the expenses are sufficiently aligned to insure adequate funds for a successful implementation. Funds will be required to implement carrier, personal and provider EHRs. The carriers appear to be largely unfunded. To participate in the FEHBP, carriers will be required to implement carrier and personal EHRs. Depending on the value they see in implementing EHRs, carriers can take a number of actions. They can, among other options:

- implement a full EHR and actively participate in the interoperability working group,
- implement a minimal EHR that meets the minimum requirements of the bill, and
- at the extreme, decide to discontinue providing services under the FEHBP.

For a carrier to meet the spirit of the legislation, and choose the first option, the carrier would have to see financial benefit. More precisely, the carrier may need to see a positive financial benefit as compared to the other carriers. If the carriers perceive that implementing the EHRs will allow them an advantage with their other non-FEHBP customers, or if they see an increased likelihood that their implementation of EHRs will allow them to keep or increase their FEHBP customers at equal or better profit margins, then they will implement the spirit of the legislation. One way to increase the likelihood of broader utility of EHRs for the carrier is to minimize the government-unique requirements associated with the EHRs. As a minimum, the guidance to OPM and ONCHIT should include a requirement to follow commercial practices wherever possible in the EHR implementation.

In general, it would appear preferable to align the carriers incentives with the spirit of the law than to attempt to use “the unused portion of the contributions set aside in the Employee Health Benefits Fund” to fund carrier implementations. Implementations created via an outside funding source are likely to fit the minimal implementation option above, and will be less likely to be incorporated into the carrier’s commercial practice. Such an implementation would be unlikely to meet the goal of later expansion to a national system of EHRs.

While the carriers are required to create a personal EHR, it is unclear how such a record would be used by individual FEHBP participants. It appears that participants may be able to request either an electronic copy of the personal EHR or, possibly, a paper copy. There are a number of commercial providers of personal EHRs, and, from the bill, it is not clear whether these providers would play a role. If they do play a role, will individual FEHBP participants be required to purchase personal EHR client software, or would such software be provided by the carrier, with the cost covered by FEHBP premiums? Will there be a charge for paper copies of an individual EHR? There are a substantial number of FEHBP participants, particularly retirees that may not have access to or want an electronic copy of their record. While we don’t propose any changes to the bill to deal with these questions, we do believe the alternatives should be carefully

evaluated during the course of the implementation of the legislation, and some late adjustment may be required based on that evaluation.

Funding for healthcare providers appears to be the most problematic funding area. It is unclear how the “Federal Family Health Information Technology Trust Fund” would be funded. Specifically, it is unclear who would want to contribute to it or why they would want to contribute. Provider EHRs are beginning to achieve some market penetration. A clear interface standard to the carrier systems, for both EHRs and, perhaps more important, for billing transactions, may motivate vendors of provider EHRs to participate with the carriers at their own cost. Carriers could offer an incentive for an electronic interface, assuming it would reduce their costs. This approach would appear to be more likely to achieve success than the proposed Fund, and reliance on the Fund may reduce the incentives for carriers and vendors of EHR and other IT technology to providers to begin discussions on interoperation.

Privacy and EHR Maintenance

The legislation proposes that carriers be the holder of Electronic Health Record information. We do not believe that “carriers” should be the vehicle for controlling patient electronic health records and recognize that many vendors and stakeholders have a long tradition of providing these services to the healthcare industry. We believe that in the distributed environment of healthcare delivery, that health records may be held by many healthcare stakeholders other than “carriers” and that any implemented system needs to recognize that occurrence. Further, mechanisms need to be implemented consistent with HIPAA legislation that acknowledges the patients right to control who has access to their health information and preserve the patient’s right to maintain privacy of their health information. Rather than prescribing the holder of the electronic health record, we believe the legislation should address criteria and standards necessary to which any holder of electronic health records must comply in order to participate.

Scope of the Initial Implementation

Moving the entire FEHBP to EHRs in the time frame specified by the Bill may be very difficult, especially since no direct funding is provided. An alternative is the implementation of an initial assessment with more limited scope. The scope limitation could be in terms of carriers, FEHBP participants, or providers, or some combination of all three. IEEE-USA offers to work further with the committee in determining an appropriate scope. We would point out that we have a significant membership in the Washington area, with both Washington and Northern Virginia chapters, and that a significant percentage of that membership is enrolled in the FEHBP. Our members are technically engaged, and could potentially provide, as volunteers, some excellent feed-back on an assessment.

Measurement of Results

IEEE-USA agrees with the sponsors of the bill that EHRs have substantial potential to achieve beneficial results. However, we believe it is important to have in place ways to measure those results. EHRs can be implemented well or badly, and in either case will have both intended and unintended consequences. A well planned evaluation program is necessary to determine if the

actual EHR system implemented has the anticipated results. It is these measured results, in cost, safety and quality, which are most likely to create the snowball effect on the spread of EHRs that the bill envisions. Explicit provision for the measurement of results should therefore be added to the bill. It is not enough to assume that OPM will add successful implementation to its measured goals under the Government Performance and Results Act of 1993 or other existing legislation. Specific measurement of not just the “successful” implementation of the bill, but the actual impact on healthcare costs, quality and safety is needed.

Conclusion

IEEE-USA believes that EHRs have great potential to achieve benefits in healthcare. The approach proposed by this legislation of a large initial implementation of EHRs to begin the process of moving to EHRs nationally, seems sound and the FEHBP seems like a reasonable program to capture the essential ingredients of a successful EHR national implementation. There are many areas of uncertainty associated with implementing EHRs, and much of that uncertainty cannot be resolved without a large scale assessment of EHR technology, so we believe that moving forward without trying to over-specify the EHR system in advance is the right course of action. With the relatively minor changes we have suggested, we believe that the legislation should move forward and we look forward to the successful implementation of its provisions.

About IEEE-USA

This statement was developed by the Medical Technology Policy Committee of The Institute of Electrical and Electronics Engineers-United States of America (IEEE-USA), and represents the considered judgment of a group of U.S. IEEE members with expertise in the subject field. IEEE-USA advances the public good and promotes the careers and public policy interests of more than 220,000 engineers, scientists and allied professionals who are U.S. members of the IEEE. IEEE-USA is part of the IEEE, the world's largest technical professional society with 360,000 members in 150 countries. For more information, go to <http://www.ieeeusa.org>.

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