**HEALTHCARE INFORMATION TECHNOLOGY PANEL**
**OCTOBER 16, 2008**

**RF: Good afternoon everyone, my name is Ralph Fargnoli, I'm President and CEO of Beacon Partners, a healthcare management consulting company serving clients throughout America. I'll be moderating this panel today was we discuss our very important topic. It is my pleasure to introduce our panelists today, whose organizations all play a key role in the area of healthcare IT. And who will all bring a unique perspective to this conversation and will help provide us with some helpful insight.**

**So for introductions, first Steve Lieber, he's President and CEO of the Healthcare Information Management Systems Society (HIMSS), the country's largest health-care association focused on information technology. Steve brings with him more than 27 years of experience and leadership in healthcare and healthcare association management, for which he has been nationally recognized as one of the top 100 most influential people in U.S. healthcare in 2004 through 2007.**

**Jane Horowitz is joining us this afternoon. She brings 20 years of experience in business and brand development, marketing and communications to the task of spearheading The National Alliance for Health Information Technology (NAHIT), of which she currently serves as Chief Operating Officer. Jane is critical**

**to, I'm just going to say National Alliance, NAHIT, accomplishments and has a uniquely successful approach to consensus building among all healthcare sectors.**

**Also joining us this afternoon is Dan Michelson, who is General Manager and Chief Marketing Officer of Allscripts, the leading provider of clinical software connectivity and information solutions that physicians use to improve healthcare. Dan is responsible for driving growth and operational excellence I the company's e-prescribing business as General Manager, as well as developing and driving the company's go to market strategy as Chief Marketing Officer.**

**So thank you for joining me this afternoon. I'd like to take a moment and set the foundation for the discussion and then we'll get into some of the questions and some commentary. In 2004, President Bush announced the goal of ensuring that most Americans have electronic health records within the next ten years. These electronic health records will be designed to share information privately and securely among healthcare providers when authorized by a patient. Today there is a bill moving through the U.S. House of Representatives which aims to speed development of nationwide electronic health records infrastructure, but some critics say the measure lacks the necessary funding and patient privacy protections. The House Energy and Commerce Committee plans to vote on the $575 million**

**legislation. The Subcommittee approved the measure by a voice vote in late June. The bipartisan bill sponsored by the Committee's leaders calls for $115 million in federal grants and loans each fiscal year from 2009 to 2013. Physicians and hospitals could compete for funds to purchase certified health information technology. Applicants would be required to demonstrate financial need and contribute $1 for each $3 given b the Government. Small practices and hospitals for those in underserved areas would get preference. Health and Human Services estimates that widespread use of EHR's would save about 100,000 lives annually through a decrease in medical errors and reduce healthcare spending by as much as 30 percent. Rand estimates that widespread adoption of HIT would reduce spending by $81 billion annually over the next 15 years. On September 8 of this year, over 100 associations, businesses, unions, patients and provider groups signed a joint letter to Congress urging passage of HIT legislation this year. HIT has overwhelming bipartisan support in both the House and the Senate, and yet the American people are still waiting for Congress to act. On September 15, Representative Pete Stark introduced a new bill geared towards speeding the adoption of electronic health records by physicians and hospitals. The bill would use the Medicare reimbursement system as a lynchpin to adoption. So setting the stage for our discussion today, as you**

**clearly see, we're talking a little bit about the Government's role in healthcare adoption of HIT. Looking back on the last ten years, or excuse me, President Bush's ten-year goals, we're four years into the ten years. And can we really say that – is it realistic that most of the American citizens will have access to healthcare or advanced electronic health records over the next ten years. So Steve, I'd like to start with you, do you believe the goal is realistic and what movement are you seeing in the IT adoption?**

**SL: I think it would be fair to say that based up on what we've seen in the first four years, it's probably not a realistic expectation to assume that in the next six that the other 85 percent of physicians will adopt an electronic medical record and whatever the numbers are beyond that in terms of institutions which are in a better place, but certainly not even at a majority point. The problem that I would identify is that originally it might have been fairly realistic. But a lot has happened, a lot continues to happen to distract us from achieving that goals. It's been very clear from the early stages of this discussing going back four years now, that incentives were an important part of this, and incentives have been largely lacking with some notables exceptions, especially from some payer groups who have done some very nice things in terms of providing those kinds of incentives that encourage**

**physicians and institutions to take that early hit. And we need to recognize that there is an early hit when you adopt new technology like this. You don't go from today a paper record to tomorrow an electronic record and it's without problems or without interruptions in terms of business processes. And so you've got to provide some encouragement for those things to happen and I'd say that's largely not been happening. So I think that the original concept was realistic. I'd have to say at this point in time unless there's a change from the way we do business today, it's unrealistic for us to assume that the trajectory we've seen so far is going to end up at that end point. Things change, administrations change, incentives change, other things come into play. The trajectory could change and the outcome could be different, but I'd have to say based upon where we look at things today, I don't see it happening in terms of universal adoption by that point.**

**RF: Do you think, and I'm going to open it up to the panel, do you think there's too much expectation with the adoption of healthcare IT in the sense of realization of cost containment and expanding the coverage? So in other words, are there other factors that are more important than healthcare IT?**

**DM: I'll take a shot at it. This is Dan, and I'd like to thank you for letting me join on the panel. I guess the perspective that I would give is no, there isn't anything more**

**important. The two basic essential issues in healthcare are relatively simple, but very complex. They are cost and quality. You can't get to either one in a methodical way without data. You can't get to data without having the infrastructure and the applications in place to move that data back and forth, so it's pretty fundamental, and I go back to the information that was put out a few years ago by the Leapfrog Group, which I think was very helpful and the way GM looked at their costs bars, the cost of healthcare was more on a per car basis than the cost of steel. I think that was an eye opener for a lot of people. So the question is how do you contain it? Well if you don't have the data, you don't have a shot. So I think it is the basic building block and I think you're seeing in the Presidential campaign that folks are looking at it not as a, oh by the way, this is a surprise that the candidates are mentioning this, but it is an expectation. So I think that's really critical. And I will go back to the opening question relative to IT adoption and use an analogy here, so back in the 1950's the microwave oven was invented. No one used it in the 50's, no one used it in the 60's. No one really used it until around the mid-70's and suddenly everyone had a microwave oven. So some technology that's out there has to find its time and place in space in order for it to be effective in the market. If you go back to 2004 when Bush put forward the mandate arm-in-arm with Dr. David**

**Brailer, the reality is that the basic building blocks were not in place, right? So the standards weren't in place from a functional perspective, from a security perspective, from an operability perspective they didn't exist. And then also the other building block, which is probably more important is the psychology of whether you need that microwave oven or not. So whether you want to wait for your food to cook or whether you need it really quick wasn't in place. So now when physicians go to conferences and they look around the room, and they're sitting at a table, most of the physicians, at least some of them, really in any setting are using electronic health records and it's on the tip of their tongue. So the shift from 2004 to 2008 has been incredibly dramatic, just in terms of EHR being and expectation of a cost of doing business as opposed to just a technology that's a curiosity.**

**RF: Okay, so over the last couple of debates, we saw Senator Obama and Senator McCain talk about HIT and they skimmed over it a little bit last night. Senator Obama allocated $10 billion, John McCain is supporting healthcare IT adoption. Not a lot of specifics. Can you give an opinion, Dan, should Government be playing a role in funding the IT?**

**DM: Well I think, to me it's a no-brainer, right? And only for one reason. They cover 40 percent of the bill, so they have a huge stake in it, and if you believe once again that cost**

**and quality are the issues, they need the data, so they need to be able to manage it. So I think they have a huge stake in it from that perspective, which is self-serving in nature. So they understand that they need to be there. And because of that they can provide leadership to the other payers to jump into the pool and I think the recent CMS move related to e-prescribing is a perfect example. So after CMS made that move, there were a lot of eyebrows that were raised. There's been a lot of action in the market, and subsequently a lot of other payers, and I consider the government a payer, have followed suit. So I think they can set the tone. I think going back to 2004 with the work of Dr. Brailer, clearly that was not a financial tone that he set, but more of a leadership tone, and I think a lot of people followed suit and it made people realize that there is a pathway and there needs to be a plan. He put the plan essentially in place that we've been following since, and we've all benefited, so I think there is a role from a federal government perspective, but I don't think it's contingent upon the federal government playing a leadership role. I think there's a role for them to play, but everyone needs to step up because stakeholders across the board need to be at the table in order to make it work.**

**JH: Yeah, and I think that's really the point. Is that there's no single action that if taken would really create this**

**nationwide system of healthcare information technology. It really does take some action on the federal level. Certainly Dr. Brailer's office in ONC has really set the tone for much of the activity that's happened over the past five years. And you can see that there are many state activities that are going on. New York State allocating a significant amount of funds for the creation of RHIO's or health information exchanges, depending on how you want to define that term. But also the easing up of the Stark regulations has allowed providers to help physicians obtain electronic health records. So there's lots of actions that are happening, both at the adoption level, at the interoperability level, which winds up being rather technical in terms of standards; but also in terms of just the connectivity. So the hardware and the things that actually allow us to do that.**

**SL: And I'll add to that, and this is somewhat just confirming the two previous comments. Government is capable of doing things that individual organizations and individual people can't do. It's setting that tone, again, as we often said. David Brailer was the HIT cheerleader in the early days, because there was really nothing he had, there was nothing in place, but he was out there cheering everyone on towards a particular goal. And Dan's right, the contribution, the role that government plays as a payer, is an important one. And they need to assume**

**a proportional responsibility. But because of the nature of healthcare being so much influenced by federal policy, their role I think is even greater than their share as a payer. Because we do rely upon them to convene the industry for the purpose of developing harmonized standards or convening the industry to establish certification programs for IT products. They are capable of doing that in places where associations might want to, but we don't necessarily carry the authority, whether real or perceived, or the credibility that the federal government could. So there's a very definite role in terms of government. There's one other role that I think government has in this, and it's the traditional role that government has of intervening and working in places where the market can't or won't. And I would point to small and rural hospitals, inner-city hospitals, those who carry extremely disproportionate share of Medicare and Medicaid patients. They simply don't have the resources to do things that other hospitals do that are in much more fortunate circumstances. That's another place where the government has a role in terms of intervening and assisting in HIT adoption. In those places where it's just physically not affordable for that to happen. Small physician group practices is another place. A small physician group practice, and there's nothing negative about the statement I'm going to make here, but they're mom and pop businesses. They're very small businesses**

**with no retained earnings, no great access to capital. They need some help. Any expenditure for technology is right out of EHR or his pocket. And so that's a place where government can do something that otherwise wouldn't happen, because the consequences of not taking that action creates a very unhealthy difference in terms of a digital divide between those who have and those who have not. So I see government having a very active role in the things that they've done. And certainly the building blocks were absolutely important in terms of dealing with state by state privacy standards and building certification and harmonization of standards and now working on the national network. All of those were things that very much needed government intervention. I'd go beyond that though, and there are some other places where I could see them playing as well.**

**JH: The AHA did a survey of hospitals and their adoption rates of healthcare IT, and what was interesting about this study was the difference between the urban larger and/or teaching hospitals' ability to adopt and implement healthcare IT. Versus the rural, not as financially sound, if sound at all, hospitals. And there is such a difference and if we're really talking about a national health infrastructure really having people connected, you have to also include the rural hospitals. And as Steve said, they need help. They can't afford the funding. It's really a difference of can I do this**

**or can I do that. And for many of the ones that we've talked to also, it's not just financial. There really are cultural issues within that organization that are, they can't make the business case. They don't understand the value of it. And it's not just an ROI case, it really is the value of what is my standing in the marketplace? What's the impact of the transparency issues? What's the rise of consumerism in my marketplace and how does that affect me? And it's not just ROI, it's a much bigger issue than that. And a lot of it does come down to the cultural issues within that organization, both from the C team, the leadership team, but also then the clinicians' piece of that. And clearly there are adoption issues from physicians. You are asking them to redefine how they've done their job, how they've thought of themselves, and you're interrupting workflow and work processes.**

**RF: Thank you. Steve, I want to take a step back and Jane had touched upon it briefly. The Pete Stark law – your organization had some concerns about it. Could you touch briefly about what some of those points were?**

**SL: Yeah, let's separate two different things. The Stark proposal versus you were referencing the Stark antitrust law in terms of relaxation there. We do have some issues with Representative Stark's proposal. We worked with his office in the very beginning of the development of this legislation. We**

**have a very close relationship with his office and many others on the Hill for the purpose of providing education and advice in terms of what certain provisions mean, what the consequences are. And a place where we disagree with Representative Stark is the concept of government having a role in this particular place of developing an electronic medical records system. Unlike the other points I made a moment ago in terms of government has a role in terms of setting the tone, providing incentives, we don't see government as an IT development organization. We don't feel that government is necessarily qualified, necessarily has the bandwidth to be the organization that develops a health information technology application. Again one of my basic premises in terms of my opinion about government's role is government works where other forces don't. This marketplace has shown very clearly whether it's open source or proprietary, there are a multitude of applications that exist in this marketplace. Why would we want or need the government to develop another one? Also as you read this proposed legislation, it says "A" electronic health information system. Does that mean the government's going to create one that we all are supposed to use that is going to be mandated use? I don't think that's where it would end up. I don't think that's really what the intent is, but it's troublesome to us. So we really have two issues there. One is that an appropriate role**

**for government in the development, to oversee even the development of an HIT application. Nor do we believe it's appropriate for government to designate that there be a single one.**

**RF: Okay, thank you for that input. I'll just open this one up to the panel, any opinions on which party would be best for HIT adoption?**

**[No response]**

**RF: Okay, so we're going to move right along.**

**[Laughter]**

**SL: I'll take that one!**

**RF: Well I threw it out there and I didn't know if I'd get a shot back at me or what.**

**JH: I can't take that one.**

**RF: That's okay.**

**SL: I'll make a comment on it, and I think that the first comment is that we've been fortunate that this is a bipartisan issue. It's a matter of differences on how to achieve the goal versus is it the right goal or not? I think that as is evident by the two campaigns so far, we do see a different level of specificity at this point in time, one versus another. So I think in terms of do we know what we can expect from one versus the other, I think there is a clear direction from the Obama campaign in terms of what we would likely see. Would one be**

**better than the other, no I'm not going to tackle that question. But I think from our standpoint we have a better understanding of direction.**

**JH: And there is momentum for it as well and whoever winds up, whatever administration it is, there is already – the building blocks are starting to be in place. The healthcare IT bill does call for the codification of ONC. That would probably be a very good move to keep what we've been building over the past four or five years to keep going forward.**

**RF: Right, and I would agree with that. The momentum's definitely driving our clients to do more with technology.**

**JH: Yeah, there's no question.**

**SL: And I think if we could before we go off of Representative Stark's bill, because as Jane just said, it does include the codification of ONC. There are some other positives in that bill. And depending upon the outcome of the elections, this may well be a significant starting point. And so therefore there are things including assistance to providers that's built into this bill and so that's certainly a positive. It calls for the development of a strategic plan for health IT. There are some very good elements in this legislation, and so I think it's important for us to recognize that this is, as I say, a likely significant starting place for the debate come January. And there is as much in this bill that we do support than we don't.**

**RF: Thank you. We're going to move onto the vendor responsibilities and talk a little about interoperability. Dan, I'm going to throw this one at you. There are many vendors in our market-space and we know that they're all trying and working hard towards something called interoperability. And there's a market expectation, there's a government expectation, but is it a realistic expectation that true competition can exist in interoperability. And I know your CEO the other day wrote an article that was posted on the internet. What's your perspective on interoperability and having to be competitive and having shareholders and so forth?**

**DM: Yeah, well I think it's core, right? So at the end of the day you have to do what's best for your clients and at the end of the day they need to deliver for their patients. And the only way to do that is with information and it has to be connected. It can't sit in what we call a software silo. And I think that's a huge risk for the business, is perpetuating standalone systems that automate a process but they don't bring the information together, so their utility is somewhat limiting from a future look perspective. So Allscripts got very involved in partnership with HIMSS and others initially in forming an EHR vendor association which has been a great experience for us. So we sat as competitive companies. Eight of us got together and decided this was a good thing, and now virtually every vendor in**

**the industry is part of it. And so what does that mean? Well, if CCHIT is developing a standard or a standard is proposed in whatever fashion, now we can reply to that as a universal organization, and that being an organization of organizations. So that's an incredibly helpful thing to have in place in order to accelerate standards. I'll give you an example. Allscripts now has one out of every three physicians in the country using our applications. So if we decide that we don't like a standard and we want to act alone, that wouldn't be in the good of the market. So if we're combined in our effort with other vendors, we can reply universally and do what's right for our collective client base, which is what is going to ultimately allow us to have our systems talk. So I think that, coupled with the formation of CCHIT, which was a step clearly in the right direction. There's been fits and starts along the way, but we were one of the original organizations that were involved with CCHIT. Now that standards have been put in place for interoperability, for security, for functionality, you can begin to see grains of sand coming together into one sandbox. And so there's been a number of – HIMSS and NAHIT and others have been involved in bringing folks together for the purpose of providing demonstrations of that interoperability and in many cases it's live and in the field today. So if the question is will it happen? The answer is yes. If the question is, is there**

**evidence? There absolutely is. We can point to lots of examples where it's already happening today. And if the question is can it happen full-force throughout our entire industry? I would say to look no further than banking. So if people care about anything more than their health, it's their money. And right now we tend to move money pretty seamlessly through the ATM system. Even though there are security issues or concerns, even though there are functional concerns, even though there's interoperability concerns, all of those have been addressed. It took some time but the good news is that in the last four years have really addressed it in a very dramatic fashion whereas now it's just a matter of turning the switch on in many cases. So if you're an end-user, if you're a provider, what's the best thing you can do? Contractually obligate your vendor to talk to other systems within your environment. So the customer pressure is ultimately what puts it forth and makes it happen. The vendors can only do so much, but I think ultimately it's going to be provider-driven in order to make it seamless across their entity and across their community.**

**JH: Last year we were asked to define some healthcare information technology terms and the feedback that we got after going out for public comment several times was, the thread through everything was the concept of interoperability with the recognition that there probably weren't enough at this point**

**nationally recognized standards. And nationally recognized standards is the process that the AHIC has set up for recognizing standards. And that's what it is referring to. So there obviously is that demand for it, there's the need for it, and there's a process in place for developing standards around that. But I will also say that in talking with many of our members, the hospital CEO's, there is a real misunderstanding about what is a standard and what is interoperability, interestingly enough. And there is this feeling, and it could be, you know how price is always an objection, it's always the low end, it's what you throw out there first. And it could be that standard is that too, that it's the objection that people are throwing out because they want to see all the standards in place before they go out and they buy that EHR system, and that's sort of what we're hearing, but not the recognition that this is incremental. It's like everything else that you buy at a hospital, it evolves, it's incremental, you don't buy it once and think it's perfect and that's going to be the end of it. So that whether there are a plethora of standards or not, that you have to jump into the marketplace and you have to start doing it now. And the standards will be developed with organizations like HBSEN(?) and CCHIT and the good work that all of them are doing. But there is this misunderstanding about what are standards and what is interoperability.**

**SL: I think also, Ralph, this concept of for-profit companies won't agree to collaborate because of competitive pressures and that sort of thing has been debunked in a number of places, as Dan pointed out in banking. But it has in healthcare as well. Ten years ago, HIMSS and RSNA started the IHE Integrating the Health Care Enterprise project, and today, and this has been the case for some number of years, radiology is very, it works off of a very common technical framework, vendor to vendor. It just simply became, as Dan pointed out, an expectation of the customer that you will. And there's no competitive pressure that will overcome the customers' demand that you must provide me with this or I'm not going to consider your product. Jump forward a few years, and IHE operates in a number of domains now. And as Dan pointed out within the EHR space active participation in terms of companies who truly are recognizing that they must compete on a different level, not the uniqueness of their product. So I think we really have gotten well beyond that point now. And the consumer, meaning the buyer of the IT applications, can move this along even faster, as soon as they truly do put into their RFP's you must have, and then you just go down the list from that in terms of the expectations. But again, the movement of information is critical, getting back to one of Dan's very early points in terms of dealing with the issues of cost and quality. And if**

**you can't move the data, you're not going to be dealing with those issues. And so there's just an absolute fundamental expectation that I've got to be able to move that data around. And if your application won't do it, I know somebody's whose will.**

**RF: So let's take a look at the interoperability, the competitive nature, and the market as we know it with the number of vendors. So what we're saying is if you're not moving towards interoperability in your platforms and you don't have access to capital, do we see shrinkage in the number of vendors out there? Or is it just such open systems that every electronic medical record has a booth at HIMSS and about five or ten years ago, there were many, many vendors. Each of them had a web-based solution that solved some healthcare problem. And most of them are gone. So interoperability, does it drive the market to shrink in the number of vendors?**

**DM: I'll take a shot at that. I think there's other things that drive the market to shrink. I don't know that interoperability is one of them, right? So the more that you have standards in place, the more readily accessible fringe applications are that tie into that network. So I don't know if I would draw that conclusion on interoperability being potentially a barrier to entry or a wall against playing in a given market. But there clearly is consolidation going on in**

**the market, Allscripts is part of that in having brought a number of companies together. Yeah, there is leverage that you can gain from a corporate perspective. There is leverage that you can gain for your clients from having your applications talk more seamlessly and have enhancements, but at the end of the day, you're not going to be able to provide every product for every client, so I think you need to recognize that in the value equation, just like with computers. If you gave a – I have an eight-year-old and a six-year-old now, and so if I gave my daughter Emma a computer, she would probably be pretty excited, but if I told EHR it wasn't connected to the internet, she would say it's essentially useless. And so the connectivity is where the value equation is unlocked, and I think anybody who is in the IT space who doesn't recognize that has a very limited, very short-term view.**

**SL: I'd add to that. I think there is a likely expectation with most any business or product cycle that there is maturation in the marketplace. And maturation comes, or a consequence or result of maturation is consolidation as companies find the right combinations that make them more efficient, more profitable, more valuable. I think it's a natural consequence of the process we're going through. Is the space we're in a mature market? I wouldn't say we are yet, there are still an awful lot of early stage innovation**

**occurring. We see it every year at HIMSS. But I think I see some signs where we are moving to the place, and I think the Allscripts/Misys merger is an example of that. And there are many others, companies that have a very strong vision in terms of the direction they're going, they're putting the pieces together and putting forth a very solid value proposition to their customers and perspective customers.**

**RF: We briefly touched upon data exchange through interoperability. So let's talk a little bit about the HIPAA and security and some of those requirements and some of the expectations of our consumers. We all know that technology can be breached. The public is still wary about having their medical information as available as their financial information. Do you believe a mandate for HIT will enforce new regulations, HIPAA regulations, or enforcement of those regulations? I'll start with Steve.**

**SL: Whether there is a mandate for information technology or electronic patient records or whatever, or not, there's an obligation to deal with the issue of privacy and security. And so let me kind of approach it from that standpoint. First of all, I think we need to be a little less emotional on this issue and a little more factual on this issue. The issue of privacy around an electronic record is really no different than the privacy around a paper record. The difference, or one of the**

**differences, is a lot more people can get to an electronic record faster than they can to a paper record, but the issue of security is the same. It's private information that shouldn't be shared without need and there should be policies associated with it. So I don't think it's the issue of mandating, it's that there needs to be in some places a change of culture. A recognition that this is private, it's not for gratuitous viewing. It serves a very important purpose, and a single purpose of dealing with that person's health condition. We've got to change the way in which employers might be able to use health information if it were inappropriately shared with them. That's part of the problem with employer-based health insurance. So it's not a standalone issue, I don't think it's an issue related to mandated HIT, and in order for us to address it, we've got to be willing to sit down as I say in a non-contentious, non-emotional way. Deal with the realities of privacy and security and find ways to ensure that those objectives are achieved. And we have to find ways to make it such that the use of that data inappropriately doesn't have the consequences it does today. And I'm referring again right back to employer use. That is clearly one of the concerns privacy advocates have, is that we have to be worried about this, because people will lose their jobs if that information is shared inappropriately. We have to work on the culture of**

**health information and data and how it is used appropriately and how it can't be used in an inappropriate way. And take away those consequences if we possibly can.**

**JH: I think your phrase of taking out the emotional is so accurate, Steve. When we were doing some work down in Louisiana post-Katrina and working on the concept of a medical home and what that might look like for New Orleans, and so much of that is based on the technology infrastructure and how you share data. And we talked to, over the course of a week, probably about 1,600 consumers, I think, in qualitative sessions, so you could really dig deep into their understanding. And we talked to people who were insured, uninsured, underinsured. People with very stigmatizing diseases like HIV, AIDS, drug abuse, alcohol abuse, and those kinds of things, as well as people with chronic illnesses that could truly benefit from having medical home and having electronic health records. And when you take out the emotional piece and you talk to them in a more factual way, privacy almost doesn't even become the issue any longer. It really gets down to access and the authorization of who has that access. And that's the non-emotional way of talking about privacy and confidentiality. So we would talk about who is authorized to see my information, who can have that access? Who authorizes that information? And when you talk about that coupled with the quality of care and patient safety issues,**

**there's a clear benefit for consumers about having people see information or have access to the information. But in every case, when we talked to them, it was the fear of the employer. And what that could possibly do to me if they know I have HIV, if they know I have been in drug rehab, if I have diabetes, and certainly diabetes is a very costly chronic illness, will I lose my job. But also the fear – and it's a little too late for this particular fear, but what will my insurance company do when they find out that I have this. Of course your insurance company pretty much knows that you have that because of the claims data, but they are so afraid of that combination of employer and payer getting together and what that could possibly mean to them. Less of a fear when it came to physicians, because physicians will give me the quality of care that I am seeking. And if they have information to treat me, I will get that quality care.**

**DM: So there's other examples there, right? So think of other emotional issues that you've dealt with in the past. The first time you went to the gas station and you put your credit card in that little slot to pay at the pump. And you were like, wow that's really cool! But then you got really concerned, what's going to happen to my credit card information. I don't know. And so it took a little while for people to get used to that. Then along comes banking, the same thing with the ATM, I think people were very scared, very worried, right? And then**

**that fear gave way to convenience. And then you look at healthcare and I think it's natural that this is going to be an issue initially. And so how do you get past that? Well you have to look under the hood. And so I think a lot of people who have commented on this issue frankly have never taken the time to look under the hood. So they don't know what's there with the system. They don't know that there's audit logs. They don't know that there's user-specific security levels that you've put in place. They don't know that there's a break-glass function that exists within the systems. They don't know that the security standards through CCHIT have been put in place, they are documented. All the systems that have gone through CCHIT have been certified as having that level of security within the system. If you have a suggestion on more security that should be put there, there's an open process through CCHIT where you can actually make those suggestions – anybody in any domain can participate in that process. So clearly it's an important issue. Clearly it's an emotional issue. But it can be addressed. We addressed through rational discussion which requires people going under the hood and looking at actually what's there. And it will require a little bit of time for people to get used to the notion that they can put a credit card in and pay for base and it will be safe. That they can put a credit card into an ATM and they'll get their money, even if**

**they're in Australia in local currency. And that if they put their information in from a healthcare perspective, they will be handled appropriately, and in Steve's example which is the perfect one, in a way which is much safer than the current system today, which doesn't provide any of that security. So the systems that are in place right now as is are more secure than the current state. And I think that's the essential point.**

**RF: If we say that we want health care IT adoption, which means that it could be web access to patient information, data on laptops, and so forth, with the adoption of IT, do we see an increase in incremental, increase in the cost of this privacy, security and changing the culture? Is there a relationship of that?**

**DM: Well I'll comment. I don't see from a vendor perspective where the cost issue lies, right? I think this is a cost avoidance issue for the most part. So people can get comfortable the security standards that need to be put in place or the ones that are already there, however you want to look at it. This is just the standard course of what you can do within the system. I think it's important that people understand that security is an emotional issue, and it is a technology issue, but very much it's a process issue. So you can make systems as secure as you want. You can have fourteen passwords to get to go, but it becomes a bit of a process issue in terms of how you**

**want to have people have access to information. You could do Venus scan, you can go as far as you want to and I think that process issue is an important element of the discussion because I think that is more of a provider burden to bear versus a vendor burden. So I don't think the cost issue is on the applications side.**

**RF: Do we see, from a cultural standpoint, do we think that the HIPAA security, the regulations, privacy as taken a narrower, I should say a lower priority in organizations? They all know that HIPAA is required, the standards and there's usually about six points that should be covered, from access to disaster recover, but beyond that, there needs to be ongoing training and follow-up and audits and locking down. Do we see that as happening on a regular basis in organizations? Or do we just see it as they know it exists and we have to try to keep up with it, but they're not really making the change management things happen?**

**SL: I can't give you hard and fast data on this, but as measured by educational programming that we do, it's a high interest area. So I would say no, I don't see it as becoming routine or a secondary focus at all. It very much is fairly top of mind in terms of the educational programming we do, the level of response that we see to that. And in the conversations that I have with CIO's it very much is on their mind, because nobody**

**wants to be in that institution and that situation where there's the breach that becomes a public issue. You just simply don't want to be in the position of having to explain that one. So I think it very much is top of mind.**

**RF: Anyone else? No? Let's talk a little bit about the challenges facing organizations regarding competition for funding and some technology implementations. With the current economic climate and access to credit and increase in unemployment, do we see adoption to HIT slowing over the next few years? How will these organizations look to fund these investments?**

**SL: One of the things, and this is not a function of the current climate, but it's a function of the reimbursement system. Recognizing that you can gain additional revenues th rough diagnostic and treatment types of systems, but you don't gain reimbursement for the handling of data. Right there, there's a challenge in terms of what you want to access your capital for. It's a harder decision because the benefits are not as tangible, not as evident. So we've got a basic inherent problem with our reimbursement system when it comes to the handling of data that provides less of an incentive than a piece of diagnostic equipment. But certainly the current environment, in conversations that I have with CIO's the issue of access to capital is very much on their minds, and there are a number of**

**things that are going on. They're seeing a slowdown in payments, so cash flow is affected, and we're not even just talking Medicaid programs here, which are chronic slow payers, but even on the commercial payer side. Slow down in terms of some payments as other companies are affected by the credit crunch and therefore are slowing down the rate in which they are paying their bills in order to deal with cash flow issues. So there's a ripple effect throughout the economy that I think is having an impact today. And so I think added to that the general economic climate of, you know what, it just doesn't look like maybe we're going to hit the number on the bottom line like we thought we were. Commodities are costing more this year than they did last year, and so the utility costs for our institutions are higher and that sort of thing. And so there are all kinds of things that are competing for the expense dollar, whether it's a capital dollar or an operational dollar, and so I would not be at all surprised to see some impact. I think it would be foolish in terms of looking at where this economy seems to be headed today and say, oh no, it's not going to affect us. I think that would be an ostrich type of response.**

**RF: Dan, do you have any perspective on that?**

**DM: Yeah, well I don't want to be the ostrich, but I will give a little different perspective. So what I would say is**

**that as an industry we have to do a much better job of explaining and really internalizing the value of these applications and what they bring to an organization. So if the philosophy is only when capital is flowing and things are good that you can invest in IT, yeah, then I think by that measure I think it's going to be – there is certainly a challenge in the general market right now. There's no denying that. Hard to say where in particular it's going to go. I don't think any of us can do that, but in the current state, sure there's a challenge. But in terms of if you just look at as an example in the EHR application you have less transcription, right? So that's a cost, that's money that you're spending right now that you want to eliminate. This is a tool to do it. Most practices can get better documentation therefore better coding therefore better revenue for their practice. CMS now has a $3,000 to $4,000 incentive out in place for e-prescribing per physician per year, eliminating chart rooms and therefore some of the overhead that goes with it. All of those are costs that an operation has to pay out that they can get rid of or revenue that they can bring in that's additional. So the cases there in terms of from a ROI perspective, and I think now is as good a time probably as maybe a year ago, to really take a serious look at the engine which can be provided through an IT infrastructure that can really have an impact on the business. So I think that's our charge as**

**a group and as an industry is to make that message clear, that maybe now is the better time to look at it because you have to manage your operation that much more efficiently and get that much more out of it from a bottom-line perspective.**

**JH: And that's sort of always been the promise of electronic health records is that greater efficiency and cost savings that would be associated with it.**

**DM: And so, let me just make a comment on that, because I'm sensitive to that word promise. If you look across the board at time after time, example after example, that ROI is there today. So we can point to literally hundreds of groups immediately that are getting that type of return and breaking even within the first seven to eight months of using an application. So I think once again this is an under the hood issue. You've got to get under the hood and look at what's there. Because I think the cynical view is that it's out there, it can happen at some point down the road. There's a good percentage of practices in this country that are now using electronic health records. So go talk to them. The evidence is there. Ask them if they would go back if they could, and they won't. So I think we need to get a little bit stronger in terms of our statements in terms of explaining and providing examples and moving those examples forward. It's interesting to have folks in the industry like us talking about it, but the people**

**who are at the front lines, the physicians and the practice administrators who are really experiencing it, those are the real stories. And that's happening today.**

**RF: So let's…**

**DM: So I'll move on. Jane, talk, because I interrupted her.**

**JH: No, no, I'm perfectly fine.**

**RF: I won't use the word promise.**

**[Laughter]**

**SL: And I won't use the word ostrich.**

**[Laughter]**

**RF: With the tight credit markets and the large organizations reimbursements challenges and so forth, the longer that lasts, how are the small practices going to move and adopt IT technology. And Dan, you've got a large spectrum of clients, from the very small to the very large. How does Allscripts look at that market and say how do we get the smaller practices on our systems?**

**DM: Yeah, that's a great question. We break the market into parts and pieces. So all buyers are not the same, just as all of us didn't buy computers on the same day or in the same year or cell phones or any other technology from that perspective. Physicians are similar, right? So you approach them in different ways. Some of our small practices are not**

**interested in making that switch now, so maybe they're looking at a more economical way to get started using IT. One of the partnerships that we had in the market with Dell, Fujitsu, Google, Microsoft and a number of other companies who partnered with us to provide e-prescribing to every physician in the country for free. So you can open up, got to nationalrx.com, open up a browser and within five minutes you can be writing an electronic prescription for no charge, of which using that technology will yield, like I said, $3,000 to $4,000 for the average physician next year from an ROI perspective. So you don't have to buy hardware, and I'm not trying to do a commercial here, but I am trying to promote the fact that we can talk about barriers but the reality is here's a technology that you can use at no cost that has a pretty significant yield that you can hit Internet Explorer and get to in five minutes. So the opportunity is there for a small practice to get started for nothing. Some practices are looking at an EHR system that is easier, more simplistic to use, and I think the keys to the kingdom there is you need to have good connectivity with the practice management system in order to do that. That was part of our strategy in merging with Misys is to be able to get to the largest base of small practice management users in the country. Other practices are looking at more of a community plate, so under the Stark Safe Harbor, they're looking to work**

**with the hospital and leverage that subsidy to make that investment relatively neutral when you look at an ROI, with the hospital being able to cover 85 percent. That's a pretty significant opportunity. And some other groups are looking to get started with a document management application where they can just get rid of all the paper in their practice and use document imaging to get there. So I think you have to take a number of different shots at it. It's kind of like, I guess you'd call it like building a statue. You take shots on the left, shots on the right, and eventually it begins to look like something and begins to take form. And that small office market I think the good news is it is starting to take form. There are a lot of practices that are being very successful in deploying technology in the small environment. There's an Oklahoma arthritis practice that just won the HIMSS Davies Award. It's a great example of a two-physician practice in Oklahoma. So there's lots of good examples of practices that are thriving and once again, I'll go back to my other comment, it's important to share those stories and show other practices the way.**

**RF: Thank you. Jane, is your membership with regards to the small practices in data exchange and so forth, are they seeing any challenges working with the smaller community physicians?**

**JH: I think it really goes back to what I talked about earlier in that it's the urban larger hospitals where we're seeing most of the adoption. But there are some interesting things happening at the rural and community level. Forced to happen because of distance in terms of telemedicine and telehealth and the things that they are doing. And so there's definitely investment in those areas. That's sort of what we've also seen. To get back to your point, CCHIT just came out with a report, and it was something like $700 million has been in funding that has gone out in the past two years to help some of these physician practices in the adoption of healthcare IT. And it's not just coming – some of it's from employers and some of it's from payers – but there's funding going out there to help some of these practices and their adoption. So it is happening.**

**RF: Okay, I'd like to open it up for questions. If anybody has any questions for the panel?**

**Q: Thank you very much, I enjoyed the discussion. I'm Gary Baldwin, Health Data Management Magazine. I've interviewed numbers of physicians in group practices and in hospital settings about IT and the government role. Just to summarize the big picture, for many of them it is yes, the government has some incentives that they are dangling, percentage incentives under Medicare and so forth. On the other hand, the government continues to cut back on the reimbursement they're giving us.**

**So it's kind of a mixed message which creates a bit of a – I guess an air of skepticism among the physicians. So I guess the question is what would you say to a doctor like that? And second of all, will the federal government really have the resources to fund this as needed going forward, given the fact that Medicare itself is facing this looming deficit?**

**RF: Do you want to try that one?**

**[Laughter]**

**JH: Thank you Gary.**

**RF: It's a great question.**

**SL: It is, it's a great question. And nobody can dispute the points that you make in terms of there is a mixed message there. We look at all the things that government has tackled just in the past two weeks and you have to ask the question do they have the capability to do anything about health care. You look at the forecast on Medicare, and you know where it's going, there's really no legitimate dispute about where the Medicare Trust Fund's going. One has to assume, though, that the environment, and I'm talking about the healthcare system really. The system that we're in, it doesn't have a long-term future in its current state. There has to be change. We were talking earlier in terms of, Dan mentioned I think the issue in terms of the cost of healthcare inherent in manufactured products and that sort of thing. It has to change, and so a number of things**

**have to change here, and tinkering with just the issue of incentives for information technology is not going to solve the problem. We've got to deal with all of these issues, and the more comprehensive that we can be, the more likely the right sorts of things will be done. But again, I think we've come to see after some 44 years or so that the incremental approach to change in the American healthcare system leads us to this particular point. It is probably about time for another 1960's era Medicare=-type of change to the American healthcare system that allows us to address all of these issues. Because addressing them one at a time is not going to get us out of the mess that we're in where we have the very conflicting types of reimbursement issues that you've described. The very different kinds and conflicting kinds of incentives that I mentioned earlier in terms of the reimbursement system. It's simply not something that can be addressed by just simply focusing on one part of this issue.**

**DM: So I guess what I would say is it's a really interesting dilemma, right? So at one point the federal government is trying to control spending and at the second time they're looking for opportunities that can maybe turn things around. I would say that the fact that they put the incentive in place is pretty stunning. That it got done. That's simply not an easy thing to get done, as many of us have experienced**

**and tried to promote that type of thing occurring. But it's an incredible signal from the government in terms of their support for healthcare information technology and the direction in which they want to go. And it was a terrific starting point. And you couple that with the grants that Jane mentioned, the Stark law and everything else that's being put in place. And you can see there's a clear pathology in terms of what's occurring here that the government wants to go in this direction. I think the one fell swoop, the big change, the sea change that could occur is still down the road and certainly needs to happen, but absent that I think a number of these things being put in place are starting to create a story for physician practices. Ultimately if you're a physician practice, though, that's not that exciting of a message to hear. I think the thing that most practices are looking at is what's the business model on a go forward basis, fundamentally. And then when you look at it from that perspective you have to explore different options and opportunities that may exist. So there's retail health clinics opening up left and right that are now in competition. There's certainly pressure in terms of the payment that they're receiving from the federal government. There's no question they can't stand pat and do the same things and expect the same type of lifestyle and income that they've experienced in the past. I think the spin on that is that technology is providing some of**

**those opportunities, right? For pay for performance, for participating in clinical trials more seamlessly and actively for a small practice to provide dispensive services potentially in their practices to doing employer-based contracts directly versus having to work through others, which they haven't been able to do in the past. So there are opportunities that exist out there, but it does require a shift in the mental model. It's kind of analogous to the music industry ten years ago when this funny little thing started surfacing called MP3's. And record companies were forced to view what was occurring in the market in a very different way and ten years later the record industry looks completely different. So you would expect that with, as Steve outlined, the issues that are central in healthcare that the healthcare system itself may look very different ten years from now, and I don't think any of us know what that looks like today. But as a physician you want to be in control of your future. You don't want to have it dictated to you, and I think control is dictated by information. So the more information they have, the more power they have and the more control they have of their practice. And the more they'll be able to leverage that on a go forward basis for all the things we outlined.**

**SL: One other thing that, prior to getting to that sea change, to that change in the industry that's so dramatic.**

**There's one other tactical step that I think we have to put on the table. We talk a lot about incentives, and I have as well. And pointing out the importance of that. But I think it's also important to think about the sticks as well as the carrots. Most of the proposals don't have the sticks piece, and so incentives have – go back to your Psychology 101, they have diminishing return over time, because they lost their value, they lose their influence. Not that negative reinforcement is necessarily a good way of going either, but you have to do both, and so I think one of the things that we also have to take into consideration is that failure to adopt, if we really do subscribe to the belief, not the promise, the belief that technology will, in fact, achieve those kinds of results, there ought to be some discussion around the penalty for failure to adopt. Then there becomes again, another incentive to avoid that negative situation that again, will also – getting back Ralph to one of your earlier questions in terms of what are the drivers to IT adoption. Incentive is certainly a part of it, but I think we also have to take into consideration the sticks too.**

**DM: Yes, and in the CMS rule, right, there is a stick that comes forward in year four or five so that will become more evident, but you're right, that's down the road.**

**RF: We see from incentives and reimbursements, depending upon if it's a community hospital or urban hospital, what I'm seeing in clients are the haves and the have nots. And you always know who the haves are. And where they're located and the have nots are the people that Gary, you're talking about. They don't have access to capital, they don't have the right service lines that generate the reimbursements. So I see a divide coming that the government's got to solve and address. And that is how do we get the money to the have nots so they can get the technology?**

**SL: Agreed.**

**JH: Totally agree.**

**RF: Is there another question?**

**Q: I'm Joe Conn from Modern Health Care. I just came back from the AHIMA Conference and they had a couple of the keynote speakers who were Kerrie Weems and Jonathan Perlin and Lori Evans from New York. And Lori's take is, it was kind of funny, they've got $200 million to spend in New York. And she was all smiles and thought that was pretty good idea. Having left Dr. Brailer's office where she was under the constraints to not spend any money at all for the programs that she was planning. They're working on models there, and where do you think the states are going to fit in, in terms of promoting and also funding healthcare IT expansion.**

**SL: You've certainly given an example there. You see it in Massachusetts as well, Minnesota – there are number of places that are very much engaged in this. Just in terms of pieces of legislation, there are roughly 100 some-odd pieces of legislation in the U.S. Congress. There are over 1,000 pieces of legislation across the states this year addressing the issue of information technology in healthcare. Very much is a state issue. There is important value in that approach, especially, and I'm going to point back to the building blocks that we talked about earlier. There is some, and I'll use the word security in terms of the states undertaking these steps now that might now have been there a few years ago. Because the fear that anyone should have is that we have 50 different sets of rules and regulations on how we might do things. And to the extent that states set off on their own paths doing that, that would not be in the best interest of the system overall. But having standards harmonization, having common certification standards around HIT products, I think we have that security that states will be moving in a common direction. We still have the issue, I think on privacy and security rules that very much vary from state to state which is going to put the vendor community in positions of having to meet very different standards, depending on where the application's installed and things like that. So there's some real challenges there. But**

**again, the expectation that there's one place where this is all going to happen, I think is an unrealistic expectation. We cannot expect the federal government to be the sole source of assistance in this area. States are going to be another, commercial insurers are still in there, there are a variety of places. So I think the movement is good in terms of what we see. I think innovation is going to come out of that. There are going to be practices that others will learn from and either adopt or learn from and make sure they don't do. Both will happen. We're not in a situation where everything that's done is done right. So there's still learning going on. So I think the trend is a good one.**

**RF: In Massachusetts they just allocated $25 million for an e-health instituted and mandated an EHR by 2015. They also just have a $1.5 billion shortfall in tax revenue. So I think the states, any state is only going to be able to take it so far. It's going to require the support of the federal government and I would agree with Steve. We just can't have 50 different ways of doing it. It's going to cause some interest, but even on a state the size of Massachusetts, $25 million is not going to get a lot. It's not going to take you a long way. You're going to be able to talk about, maybe do a couple of pilot programs. Blue Cross Blue Shield also had about $50 million allocated, I think it was through Rhode Island and**

**Massachusetts, for some pilot programs using an EHR. And that's moving along pretty well. But again the payer is providing the incentive to utilize that. So I think we're going to see a combination of federal payer and state allocation of money.**

**JH: I would also think that along with what you were talking about, Steve, in terms of the state levels that it maybe also part of that marketplace incentive for physicians to participate. As there is that statewide effort for exchanging health information as RHIO's are developed or whatever that next iteration of REO is, it does sort of force that marketplace and ph6ysicians to participate. So it may be that other incentive, maybe stick and carrot at the same time.**

**RF: Are there any other questions? I want to thank everyone for coming today. And I want to thank our panel, Steve, Jane, Dan. I appreciate all the input and discussion. And that concludes our discussion for today. Thank you very much.**

**[Applause]**

**END OF PANEL DISCUSSION +++**