TMA Tennessee Medical Association

Physicians Caring for Tennesseans

May 15, 2013

The Honorable Lamar Alexander
United States Senator
455 Dirksen Senate Office Building
Washington DC 20510

RE: Response to Letter to Stakeholders on Health IT

Dear Senator Alexander:

On behalf of its nearly 8000 physician, resident and medical student members, the Tennessee Medical Association (TMA) submits the following comments to "REBOOT: Reexamining the Strategies Needed to Successfully Adopt Health IT" as you requested in your April 16, 2013 letter. Our organization believes that federal laws seeking to promote adoption of health IT were well intentioned. It seems logical that such adoption would reduce the amount of duplicate tests ordered. However, in the planning phase the federal government failed to lay the foundation for the successful adoption of health IT and in the implementation phase it once again relied on the heavy hand of mandates and penalties to force the medical community into compliance. All this was done in the midst of the largest health system reform in our nation's history.

Health IT laws were destined to fail from the onset because two prerequisites were never met. First, there was unconvincing evidence proffered that health IT adoption would indeed improve care. There needed to be stakeholder "buy-in" from the beginning. This never took place. Most Tennessee physicians feel like health IT mandates were shoved down their throats without an understanding of what needed to be accomplished.

Second, the federal government failed to set the rules first. It needed to have enacted guidelines that all health IT players had to follow BEFORE instituting "meaningful use" and the myriad of other mandates. Yes, there would have been winners and losers but in the end all who participated would ensure that their technology "talked" to each other. Instead, the result is that there are dozens of systems that do not interact and the cost to get them to interact is prohibitive. Hospital systems are reluctant to be the one to invest millions to make their system interactive with another system because of the competitive advantage the system which does not have to change. It is like school being let out for summer. Everyone is running as hard as they can in a dozen different directions. Better leadership and planning could have avoided a lot of the problems we have today.

The key implementation deficiencies identified in "Reboot" are dead on as far as our organization sees it. Sure, there are the well-oiled machines out there which can afford the expertise but we submit even those

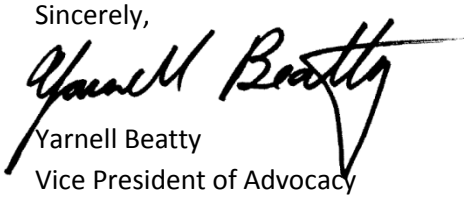
organizations had “growing pains” at some point in the adoptive process. We identified little, if any, content in the white paper with which we disagree. So, the key question becomes what now? The TMA does not envision that the federal government will all of a sudden put the brakes on all this. There is no rewind but as you put it, we can push “pause”.

There are, however, a few common sense steps that can be taken to slow this train wreck down and refocus the effort.

- What is the goal? Who should have what IT capabilities? What is it the health system needs to do with this technology? Then work backward as to how it can be affordably accomplished.
- Set the standards before inventing the requirements. Then set reasonable time tables for implementation. Example: the “code creep” and record clone problems would not have existed had the standards prohibited them from the beginning. How can you now put the genie back in the bottle?
- Keep the incentives in the law to adopt health IT but repeal the penalties like the progressive reduction in Medicare payments for failure to adopt.
- Consolidate the effort to create guidelines for the use and interoperability of health IT. End multiple cross-purpose agencies and offices and place the authority under one roof.
- Stop making up the rules as we go along. All stages of “meaningful use” need to have been derived BEFORE implementing the first stage. It is a lot more expensive to upgrade a black and white TV than it is to just to go buy an HD.
- Look at what is already working well as a model for health IT adoption. Data is carried efficiently and securely in some industries like financial institutions. What can we not learn from that experience that translates into a successful health IT effort?
- The entities that benefit from the sharing of health data should have “skin in the game”. The big money in health care can be traced back to the health insurance plans. If they are going to benefit by collecting electronic data, they should have to pay for access by helping the health providers afford and maintain health IT.
- If we are going to have a health care SYSTEM, then create one. Having different standards for government payers than the rest of health care adds cost to the system. Example: Every health plan has its own physician rating program, satisfaction survey, payment rules, etc. Reduce duplicity in the system.
- Come up with a plan for maintaining all of this health IT when the government money runs out. 2021 will hit without physicians being able to afford to upgrade their 10 year old system.

Thank you, Senator, for this enlightening white paper. The TMA hopes that it gets the attention of lawmakers and executive branch officials who can do something about this issue. We appreciate the opportunity to support “Reboot” and your efforts to have a proper blueprint created for health IT adoption in the U.S.

Sincerely,



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