

TESTIMONY OF MICHAEL J. MIRRO, MD, FACC, FAHA

AMERICAN COLLEGE OF CARDIOLOGY

United States Senate Health, Education, Labor, and Pensions (HELP) Committee Hearing
Achieving the Promise of Health Information Technology: Information Blocking and Potential Solutions

JULY 23, 2015



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Chairman Alexander, Ranking Member Murray, and members of the Committee, thank you for the opportunity to speak today about the important issue of information blocking, unforeseen problems that have been created, and possible solutions to help improve patient care.

My name is Michael Mirro and I am testifying today on behalf of the American College of Cardiology, a 49,000-member medical society that is the professional home for the entire cardiovascular care team. I am board certified in internal medicine, cardiovascular disease, clinical cardiac electrophysiology, and geriatrics. *[In addition to seeing patients, many who suffer from multiple chronic conditions, I also serve as Chief Academic Research Officer at Parkview Health System in Ft. Wayne, IN where I manage over 90 clinical trials.]* I have focused the majority of my clinical work on cardiac implantable electronic devices in patients with serious heart rhythm problems and clinical investigation into new and advanced technology to enhance their function. *[I have worked extensively on remote monitoring of cardiac devices and electronic messaging patients their data from their individual device.]* I have worked in the development of health informatics tools since 1995, assisting in the refinement of clinical decision support software to improve point of care quality related to congestive heart failure.

The private practice that my partners and I owned was an early adopter of electronic health records. These systems, implemented before HITECH's passage, had a user-centered clinical design, as opposed to the software centric certified EHR systems of today. Additionally, many current systems lack clinical usability and thus create substantial practice inefficiency and reduced quality patient-physician interaction during an office visit.

I first became aware of information blocking when my colleagues in other private cardiology practices adopted EHRs and were forced to spend substantial resources to interface with their health system's EHR. These practices would have been able to better plan financially if these costs had been disclosed at the outset. *[Fortunately, the practice was in a financial position to absorb these costs, but many other practices are not.]* **Transparency of additional (or hidden) fees within contracts with EHR vendors should be evaluated.** Many contracts between providers and EHR vendors include gag clauses which prevent providers from speaking publicly about problems associated with EHRs. **EHR vendors should not be allowed to include such clauses.**

The delay of information sharing is another form of information blocking. I once had a patient admitted to the emergency room in cardiac arrest. *[The patient was a*

truck driver from out of state.] Because of a delay in receiving his cardiac history, data critical to his care was not available in a timely fashion. The patient experienced a complication during the emergency heart procedure resulting in prolonged illness. *[The support of electronic messaging of standard clinical summaries is a critical issue with respect to quality and safety of patient care.]* Rapid, secure exchange of health information is critical and in some cases can mean the difference between a patient living and dying. **Data fluidity should mean not only that information reaches the provider, but that the data is transmitted quickly and securely.**

Many EHR vendors provide the functionality needed, but require the user to purchase their health IT products to make the elements of the EHR interoperable. Like other products such as consumer electronics, you are able to connect, but you must buy a specific company's products to do so with ease. The ramifications of technology in health care that are unable to communicate are serious, resulting in decreased care quality and stunting improvements in population health. **EHR vendors' products should be universal and connect to other EHRs offered by different companies.**

Another advantage of the free flow of data is to empower patients in their health care decisions. One of my recent projects was to establish a way for patients to remotely monitor their implanted devices. Each element of the four devices available in the market had a different vendor, requiring us to contract with four different vendors and pay four different set-up costs to allow patients to accomplish one task. **Health IT vendors and providers should be incentivized to establish networks for patients to monitor their devices, empowering them to actively participate in their health decisions. In addition, adoption of public data standards should be expected and supported in the best interest of patients.**

Many information blocking problems stem from the financial incentives of EHR companies to obstruct data. The HITECH Act, along with implementation of the Meaningful Use Program, has improved data sharing and data liquidity. With that stated, the unintended consequence of Meaningful Use is that systems were designed to facilitate charge capture and revenue cycle management and focus less on clinical data and usability. *[The importance of exchanging a clinical summary document has been enhanced by this program, but we need surveillance of individual vendor behavior.]* Although the Meaningful Use program has brought favorable results within the context of data transfer, many of the requirements set

forth in the program are unattainable. Recognizing that only 11 percent of physicians have attested to stage 2, I recommend, in concert with the ACC, that stage 3 of Meaningful Use be delayed in its entirety.

In addition to what I have discussed, the College has called for many of the same actions recommended in the Office of the National Coordinator's April, 2015 Report to Congress on Information Blocking, including:

- **Number 1: Strengthen in-the-field surveillance of health IT certified by ONC.** [The ACC feels strongly that a program such as this is needed and that ONC would be the appropriate entity to administer such a program. ONC could hire an outside contractor to affirm compliance – similar to what CMS has done with the Meaningful Use program.]
- **Number 2: Constrain standards and implementation specifications for certified health IT.** [This committee has debated whether the federal government or the private sector should establish common standards, and the ACC believes it should be a combination of both. Medical specialty societies are well-equipped to engage in the creation of these standards, while the federal government is needed to oversee enforcement of the standards.]

- **Number 3: Work in concert with HHS to improve stakeholder understanding of the HIPAA provisions related to information sharing.** [HIPAA is outdated and in many cases is actually an impediment to patient care. The ACC would encourage the committee to reevaluate HIPAA in its entirety – including its successes and failures – and whether all aspects of HIPAA remain appropriate given today’s technology.]
- **Number 4: Work with CMS to coordinate health care payment incentives and leverage market drivers to reward interoperability and discourage information blocking.** [As with my example given earlier about creating a mechanism to remotely monitor devices, this is proof that when coupling providers with innovative companies, we can improve the wellbeing of our patients and reduce costs.]

In closing, I commend you, Chairman Alexander and Ranking Member Murray, and your excellent staff for gathering us today and taking the initiative to accomplish specific goals related to interoperability and information blocking. Furthermore, I applaud your collaborative, bipartisan approach. Thank you again for the opportunity to be here today. I look forward to the discussion.

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Enclosure: “American College of Cardiology – EHR Interoperability Top Concerns – Senate HELP Committee – 061615.pdf”