MICHIGAN STATE MEDICAL SOCIETY

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Testimony Before the House Health Policy Committee on House Bill 4217
Brad Uren, MD
June 6, 2019

Thank you Mr. Chairman and members of the Committee for the opportunity to speak to you today on behalf of the Michigan State Medical Society to express our reservations regarding House Bill 4217. My name is Brad Uren and I am an emergency physician and the Chair of the Michigan State Medical Society's Committee on Legislation and Regulation.

I want to start off by saying that while we oppose the underlying legislation, as written, we appreciate the efforts of stakeholders, Representative Bellino, and his staff to work with us to make modifications that will help ease the transition for prescribers as we work to increase e-prescribing adoption rates around the state.

Michigan physicians are committed to addressing the deeply rooted issues that have precipitated the opioid crisis. The Michigan State Medical Society is one of several health care organizations across the state that meet regularly to discuss the myriad of emerging opioid-related issues that health professionals and patients are experiencing first-hand. We do our best to vet policy approaches with our members who are caring for patients every day through the lens of the most recent data and statistics coming out of the state.

With respect to this issue, we work closely outside of the legislative arena with insurance companies and other partners to find ways to increase adoption rates and encourage the use of e-prescribing and electronic prescribing of controlled substances (EPCS). It is true that e-prescribing has many advantages over paper prescription systems, including improved efficiency and a reduction in medication errors; however, the barriers to the safe and efficient use of e-prescribing systems are significant and before we require use we need to make improvements to maximize efficiency and safety.

Pending a potential compromise on the underlying legislation, we would first ask that we begin by identifying the barriers to e-prescribing, particularly with respect to controlled substances. What we have heard consistently from our members is that the EPCS software is often prohibitively expensive for small practices to purchase. Moreover, while not all physicians have an electronic health record (EHR), some of these systems have not even established the capability to integrate with EPCS and we are still working diligently on integrating electronic health records with our state's prescription drug monitoring system, the Michigan Automated Prescription System (MAPS).

What I want to emphasize today is that it is not the will of the physicians and other providers but the vendors keeping adoption rates below what they should be. This is not just MSMS highlighting these problems; HIT experts in the field point them out too. Rather than a mandate to use and purchase a product that does not fit with physician workflow, we would prefer that the vendors work collaboratively to create a product that can be easily integrated into a physician practice and is reliable, safe, efficient and affordable.[1]

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3995494/

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In fact, vendor behavior has come under scrutiny in the context of information blocking – a problem the federal government is working to alleviate. In a 2015 investigative report on information blocking, the Office of the National Coordinator for Health Information Technology (ONC) found that most of the complaints around information blocking involved electronic health record (EHR) developers, many of whom charge fees that make it "cost-prohibitive for most customers to send, receive, or export electronic health information stored in electronic health records, or to establish interfaces that enable such information to be exchanged with other providers, persons, or entities." We should explore this at the state level as well, and we would be open to further discussions around how the legislature can call on the vendors to step up.

Part of the stated reasoning for this legislation is that Medicare will be requiring electronic prescribing of controlled substances in 2021 under The SUPPORT for Patients and Communities Act that Congress enacted last fall. That legislation included a requirement for the Drug Enforcement Agency (DEA) to modernize its EPCS regulations to make it more feasible for physicians to adopt EPCS prior to the SUPPORT Act's mandate taking effect. According to our colleagues at the American Medical Association, thus far, DEA has not acted. If Michigan pursues a mandate, we request, at the very least, that we tie the implementation date to when the federal government actually implements the Medicare e-prescribing requirement so that Michigan physicians can prepare for one process change and one target date.

We did submit additional amendments to the sponsor and the chair that reflect the way the Centers for Medicare and Medicaid Services (CMS) have traditionally accounted for hardship exemptions under existing EHR and e-prescribing incentive and quality programs, and we appreciate their careful consideration.

In a recent investigative piece conducted by Kaiser Health News and Fortune Magazine entitled "Death by 1,000 Clicks: Where Electronic Health Records Went Wrong," John Halamka, chief information officer at Beth Israel Deaconess Medical Center, who served on the EHR standards committees under both George W. Bush and Barack Obama said, and I believe this is apt to our conversation today:

"'Every single idea was well-meaning and potentially of societal benefit, but the combined burden of all of them hitting clinicians simultaneously made office practice basically impossible."

There is no doubt that breakthroughs in research and advancements in technology, therapies, pharmaceuticals, etc. have transformed medicine for the better. However, as we've seen over the years – in the context of electronic medical records and problems arising from interoperability, costly upgrades, DEA required security features, privacy protection and the erosion of the doctor patient relationship by putting a computer in the way of the face-to-face patient contact – technology can create a plethora of other issues.

As we debate this and similar issues we must keep in mind that mandating the use of technology is not always the most effective approach but if we are to do so, we should first assess the real barriers to accomplishing our underlying objectives.

Thank you for the opportunity to testify today. I am happy to take any questions.