Site Visit Report

The Electronic Health Record in Practice: Why, How, and What Next?

THE GEORGE
WASHINGTON
UNIVERSITY

W A S H I N G T O N   D C

Contents

ACKNOWLEDGMENTS

NATIONAL HEALTH POLICY FORUM

The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at ***www.nhpf.org.***

The Electronic Health Record in Practice: Why, How, and What Next?

INTRODUCTION

An article of faith in health policy is that a necessary component of high-quality, resource-efficient health care is an electronic health record. At the federal level, both the office of the National Coordinator of Health Information Technology and the Agency for Healthcare Research and Quality have used their contract and grants authority to signal a commitment to EHR adoption on a broad scale. Certain players in the U.S. healthcare market have already moved ahead with EHR implementation.

The National Health Policy Forum developed a local site visit to observe the EHR as used in practice by two U.S. leaders in technology and quality, the Veterans Health Administration (VHA) and Kaiser Permanente (KP). The VHA has employed an EHR system since 1997; KP is in the process of implementing a standard system for all clinicians nationwide.

The site visit was designed to provide an opportunity for participants to explore both the analysis of expected benefits from EHR adoption—the value proposition—as well as the specific lessons these two large, integrated delivery systems have learned in their transition from paper to electronic records. How the experiences of the VHA and KP might apply to smaller, more fragmented medical practices also was a topic. Issues explored included privacy protection, infrastructure building, beneficiary access, and interoperability. More fundamentally, the group was asked to consider what barriers might be removed or incentives created to speed the dissemination of health information technology (HIT).

PROGRAM

The site visit took place on June 23, 2006, beginning at KP's North Capitol Street clinic site. In the morning, participants heard a presentation on the planning process that needs to precede a successful HIT implementation—not just for big systems, but in any medical practice. KP clinicians described their implementation strategies, challenges, and successes and demonstrated their EHR's capabilities.

The lunch period was devoted to a discussion of policy issues, with particular attention to what policymakers could do to remove barriers to HIT proliferation. After lunch, the group moved to the Veterans Affairs Medical Center in northeast Washington for a review of the VHA's HIT history and a demonstration of its EHR in action. Participants were also given an opportunity to talk with clinicians about their use of HIT within the hospital.

IMPRESSIONS

Why: The Case for Health Information Technology

The purpose of EHR adoption should be clearly delineated in advance.

Objectives should center on improved care delivery and quality, not technology for its own sake. "Let's see what happens" is not the recommended approach.

Workflow redesign is critical to optimizing HIT.

Enabling poor processes electronically benefits no one. Integrating HIT into daily practice and using it to enable improvement is more significant than the efficiency gains (such as lower cost of medical transcription) sometimes cited. Redesign may be particularly challenging in small, independent practices when there is no clear physician leader to encourage colleagues to do things differently.

Cost-benefit misalignment is a major deterrent to EHR adoption.

Physicians make money by scheduling visits and performing procedures and tests. Optimization of HIT is primarily a matter of improving information and quality management (activities not typically reimbursed by insurance payers and improving the value of visits (for which there is no additional reimbursement).

Integrated systems, such as Kaiser Permanente and the Veterans Health Administration, are able to capture HIT-related savings.

The efficiencies attributable to EHR use, such as eliminating duplicative tests, tend to benefit insurance plans rather than individual physicians. Physicians actually lose reimbursement when tests and procedures are eliminated. When an organization incorporates both financing and delivery of care, savings realized on the insurance side can be used to offset losses in other parts of the organization.

Having an operating EHR system is a competitive advantage at the present time, in terms of attracting both patients and clinicians.

In addition to Kaiser and the VHA, federally funded community health centers—many of which have EHRs—report that this capability is a clear advantage in recruiting physicians.

One of the major benefits an EHR can offer is enabling the patient to take a more active role in his or her care.

The EHR may be a means of preparing for the demands of aging baby boomers because it can support self management of chronic conditions and extend care beyond the physician's office.

How: Implementation

IMPRESSIONS

Like politics and health care delivery, all implementation is local.

There is no such thing as an off-the-shelf product or a prescribed process. Implementation requires a great deal of time, attention to detail, and consultation among clinicians and software technicians. Clinicians must work at using and customizing a software package to suit the needs of their practice. Defining fields and data elements requires multiple decisions, even for an entry as seemingly simple as gender. A practice must plan for substantial ongoing costs in training and maintenance.

Operational leadership is essential.

An implementation delegated solely to IT staff is bound to fail. Physicians need to see their peers engaged.

Getting physicians' attention and overcoming their distrust is the first hurdle in widespread EHR deployment.

HIT champions must develop strategies to make the transition, with its expected disruption and loss of productivity, seem worthwhile. Leaders must also instill a sense of ownership by physicians.

Physician receptivity to HIT is partly related to age.

Young physicians expect it, and may drive adoption if they move to new settings that lack it. Older physicians may be willing to devote time to an activity they find interesting and novel. Those at the peak of their practice tend to resist anything that takes time and even temporarily diminishes productivity.

Six months seems to be a turning point in HIT implementation.

Both the VHA and KP found that was the point in the process when physicians seemed to "get it," and began exchanging tips and techniques.

Decision support as an EHR feature may contribute to quality, not efficiency.

Easily accessible decision support information can confirm a physician's judgment, point out conflicting factors that might not have been considered, or suggest additional steps to be taken. A concomitant reduction in errors might be expected. On the other hand, decision support seems biased in favor of taking some action, and probably doing more rather than less. HIT can lead to higher spending insofar as it identifies underuse of services.

The EHR can cut both ways in terms of malpractice liability.

Its existence may make the practice more vulnerable to discovery in legal proceedings. By recording the time and the individual who ordered a test or a drug, the

system can document inappropriate action. The same features, however, can provide a solid audit trail of appropriate actions taken. Although there has been some discussion of discounts on malpractice insurance for those who have EHRs, especially EHRs that incorporate decision support, none apparently have been offered.

The capabilities of a personal health record (PHR), such as MyChart or MyHealthₑVet, are still unfolding.

They may be used by an individual for administrative tasks such as scheduling appointments, self management of care (for example, tracking blood pressure over time), linking to sources of health information, and so on. The exchange of clinical data between the PHR and the EHR is more complicated, raising issues such as who can enter data, who can authorize access, and who actually owns the information.

What Next: Policy Considerations

Adoption of HIT should not be a goal in itself.

Incentives for purchasing hardware and software can divert attention from health system redesign. HIT should be regarded as a tool for enabling change.

There seems to be agreement among those with operational EHR systems that the federal government needs to specify EHR standards and then mandate their use.

Interoperability has become a mantra, but it is meaningless in the absence of widely accepted standards for data and communications.

The supply of trained personnel to customize, maintain, and upgrade EHR systems is already a concern.

For EHR systems to work to their potential, technicians need to be cross-trained in medicine and IT.

Inconsistent state laws are a complicating factor in designing EHRs for practices that draw patients from more than one state.

Two examples are the varying scope of practice acts—who is allowed to do what—and the differences in privacy standards designed to protect certain transactions or categories of information (for example, Massachusetts does not permit records of HIV status to be shared among providers without the explicit consent of the patient; similar provisions relative to mental health status are on the books in several states).

The use of Medicare incentives as a means to drive the adoption of HIT may result in leaving out some segments of the population.

Medicare trust fund dollars may be expended only on behalf of Medicare beneficiaries. A lack of corresponding incentives for providers who serve other populations could potentially lead to more "siloing."

IMPRESSIONS

Friday, June 23, 2006

AGENDA

8:45 am Arrival at Kaiser Permanente North Capitol Medical Center
[1011 North Capitol Street, Fourth Floor, Patient Health Conference Room]

Coffee available

9:00 am Welcome and Introductions

Lisa Sprague, *Senior Research Associate,* National Health
Policy Forum

9:15 am DOING ONE'S HOMEWORK: PLANNING FOR HEALTH
INFORMATION TECHNOLOGY (HIT) IN MEDICAL PRACTICE

Peter Basch, MD, *Medical Director,* MedStar e-Health

- Defining problem-solving, care-delivery objectives prior to
  information technology (IT) decisions

- How workflows and processes change before and as a result of
  IT implementation

- Connectivity and interconnectivity considerations

- Financial incentives for electronic health record (EHR) adoption
  in a fee-for-service world

10:00 am TAKING THE PLUNGE: IMPLEMENTING HEALTH CONNECT

Andrew Wiesenthal, MD, *Associate Executive Director for Clinical
Information Support,* Permanente Federation

Mark Snyder, MD, *Assistant Medical Director,* Research
and Information Management, Mid-Atlantic Permanente
Medical Group

- Chief objectives for system-wide IT system

- Health Connect rollout

- HIT in the exam room

- Sharing information with non–Kaiser Permanente (KP)
  practitioners

- Providing information to members and purchasers

- HIT in the service of preventive medicine

- Population care management

Demonstration – HealthConnect

Friday, June 23, 2006 / continued

11:15 am	HIT IN THE EXAM ROOM: CONVERSATION WITH KP CLINICIANS

- Communications strategies
- Decision support

Noon	Lunch and Roundtable Discussion

- What are the policy goals that IT can and should serve?
- What can policymakers do to eliminate barriers and/or create incentives for EHR investment and use?
- What can IT innovators do to foster diffusion?

1:00 pm	Bus Departure – Veterans Affairs Medical Center [50 Irving Street, NE]

1:30 pm	TWENTY-FIRST CENTURY VISTAS: HIT IN OPERATION IN THE VETERANS HEALTH ADMINISTRATION

Robert Kolodner, MD, *Chief Health Informatics Officer,* Veterans Health Administration

Sanford Garfunkel, *Director,* DC Veterans Affairs Medical Center

Ross Fletcher, MD, *Chief of Staff,* DC Veterans Affairs Medical Center

Neil Evans, MD, *Co-chief, Primary Care,* DC Veterans Affairs Medical Center

Diva Shroff, MD, *Hospitalist,* DC Veterans Affairs Medical Center

- Lessons learned during EHR design/deployment/nationwide operation
- Chronic disease management
- HIT in physician training
- Beyond the "closed" system—EHRs in the mainstream
- Providing information to beneficiaries

Demonstration – Veterans Health Information Systems and Technology Architecture (VistA)

2:45 pm	VistA in the Ward: Conversation with VA Clinicians and Students

3:30 pm	Bus Departure – Union Station

Federal Participants

Cheryl Austein-Casnoff
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Federal Participants

Cheryl Austein-Casnoff is the associate administrator for health information technology at the Health Resources and Services Administration (HRSA). She provides leadership to HRSA's grantees to promote the adoption and effective use of health information technology among safety net providers and populations. Before moving to HRSA, Ms. Casnoff served as the deputy director of the Finance, Systems, and Budget Group at the Centers for Medicare and Medicaid Services (CMS). In 2004, she was selected for the Senior Executive Service Candidate Development Program and served in the Office of the Inspector General and in CMS, where she was involved with the implementation of the employer-subsidy portion of the Medicare Modernization Act of 2004. Earlier, Ms. Casnoff was director of the State Children's Health Insurance Program (SCHIP); she was also responsible for designing and implementing SCHIP in 1997. She received a master of public health degree in health services administration from Yale Medical School, Department of Epidemiology and Public Health, and a bachelor of arts degree in biological sciences from Northwestern University.

Shawn Bishop joined the Democratic Staff of the Senate Finance Committee in 2005. Her primary areas of responsibility include Medicare Parts C and D, which encompass the new Medicare Advantage and prescription drug programs. Previously, she was a principal analyst at the Congressional Budget Office (CBO) where she developed models to estimate the cost of legislative proposals related to Medicare+Choice and competition among Medicare health plans. Ms. Bishop has worked in health care payment policy for over 15 years. She helped develop the prospective payment system for outpatient hospital care at the Centers for Medicare & Medicaid Services, and she analyzed the veterans and defense health programs at CBO and Medicare payment policy at the Prospective Payment Assessment Commission (now part of the Medicare Payment Advisory Commission). In addition, Ms. Bishop worked in the private sector as a consultant in the health economics practice of Price Waterhouse, LLC, and at a regional hospital trade association in California. She has a bachelor's degree in English literature from the University of California, Irvine, and a master's degree in public policy from the University of California, Berkeley.

Jody Blatt is a senior research analyst and project officer in the Division of Payment Policy Demonstrations within the Medicare Demonstration Programs Group/ Office of Research Development and Information at the Centers for Medicare & Medicaid Services (CMS). She is responsible for implementing the Medicare Care Management Performance Demonstration as well as the Medicare Replacement Drug Demonstration, both of which were mandated under the Medicare Modernization Act of 2003. Before joining CMS, she served in various capacities with managed health care plans and health insurers. Ms. Blatt has an undergraduate

degree from Brown University and a master's degree in health policy and management from the Harvard University School of Public Health.

Denise Buenning is a senior advisor to the Office of E-Health Standards and Services (OESS), Centers for Medicare & Medicaid Services (CMS), for e-prescribing, consolidated health informatics, and integrated data strategy. She previously was technical advisor and served as deputy to the Division of Community-Based Education and Assistance; in addition, as national co-lead for CMS's Long-Term Care Prescription Drug education campaign, she spent the last year working to implement the Part D benefit in long-term care facilities throughout the country. She joined CMS's Kansas City Regional Office in 1998. A published author and former *Kansas City Times* newspaper columnist, Ms. Buenning has held management positions at Sprint, two Kansas City medical centers, and a Washington, DC–based agricultural trade association. She earned her undergraduate degree in broadcast journalism from the American University and a master's degree in management from Baker University. She has been honored by CMS's Federal Women's Program as one of the agency's 16 Significant Women, and she is a six-time recipient of CMS's national Administrator's Achievement Award/Certificate.

Aaron Burstein has been a trial attorney in the Antitrust Divison of the Department of Justice since September 2004. He has handled both merger and nonmerger matters in a wide variety of industries, with a particular emphasis on the health care and insurance industries. Mr. Burstein is a 2004 graduate of the University of California, Berkeley, Law School (Boalt Hall). Prior to attending law school, he worked as a researcher for a medical imaging research group affiliated with the VA Medical Center in San Francisco and the University of California, San Francisco. Mr. Burstein holds an master of science degree in chemistry from the University of California, Berkeley, and a bachelor of science degree from Brown University.

Nancy DeLew is a senior advisor to the director of the Office of Research, Development and Information in the Centers for Medicare & Medicaid Services (CMS). She assists the director in carrying out special projects, currently implementation activities surrounding the Medicare Modernization Act of 2003. Formerly, Ms. DeLew was the deputy director of CMS's Office of Legislation. In this position, she worked with the Congress to develop the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997. The office develops legislative proposals for the President's annual budget, prepares testimony and other materials for congressional hearings, facilitates CMS's work with state governments, and maintains liaison with other executive- and legislative-branch agencies. Earlier, Ms. DeLew held several other positions in the Department of Health and Human Services. She joined the department in 1985 after receiving master's degrees in political science and in public administration from the University of Illinois at Urbana.

John Goetcheus, JD, has been an assistant counsel with the U.S. Senate's Office of the Legislative Counsel since 1995. He prepares and provides advice on health care and unemployment legislation. Mr. Goetcheus has worked on a wide range of legislation, including the Medicare provisions of the Deficit Reduction Act of 2005; the Medicare Prescription Drug, Improvement, and Modernization Act of

BIOGRAPHICAL SKETCHES
Participants

2003; the Medicare, Medicaid, and State Health Children's Insurance Plan (SCHIP) Benefits Improvement and Protection Act of 2000; the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999; the Balanced Budget Act of 1997; and the Health Insurance Portability and Accountability Act of 1996. Before joining the Senate Legislative Counsel's Office, Mr. Goetcheus served as the law clerk to the Hon. Ann O'Regan Keary of the Superior Court of the District of Columbia from 1993 to 1995. Mr. Goetcheus received his JD degree and a bachelor of arts degree from the Catholic University of America.

Edward Grossman is a senior counsel in the Office of the Legislative Counsel, U.S. House of Representatives. He has been a principal health care drafter for the Congress in the fields of Medicare, Medicaid, national health insurance, health insurance reform, and related areas for over 30 years. He also was a principal drafter in the field of immigration law before 1996. He has worked closely with House members and leaders from both parties on proposals as diverse as the Carter hospital cost containment legislation (not enacted), Medicare's PPS and RBRVS (prospective payment system and resource-based relative value scale, respectively) provisions, all health care budget reconciliation legislation since 1979, the Clinton health care plan and its many alternatives (none enacted), the creation of the State Health Children's Insurance Plan, patient bill of rights legislation (not enacted), recent Republican-led efforts to reform the Medicaid program, and the Immigration Reform and Control Act of 1986. He has been involved closely with the National Health Policy Forum for over 25 years and a member of its Steering Committee for over a decade.

Jim Hahn, PhD, is a health economist in the Domestic Social Policy Division at the Congressional Research Service (CRS). He works on issues related to prescription drug pricing, hospital and physician payment, and geographic variations in health care expenditures. Before joining CRS, Mr. Hahn worked at the Government Accountability Office and with Lewin and Associates, Inc. He has published articles in the *New England Journal of Medicine* on the effect of for-profit ownership and system affiliation on the economic performance of hospitals and on the comparison of physician payment and expenditures between the United States and Canada. Mr. Hahn has served on the faculties of the School of Public Health at the University of North Carolina at Chapel Hill and of Trinity University in San Antonio, Texas. He is a graduate of Stanford University.

Jennifer Jenson is a specialist in health economics at the Congressional Research Service (CRS), where her work focuses on heath care costs and spending, including federal spending on entitlement programs, tax subsidies for health insurance and expenses, and private spending. Ms. Jenson has worked on health policy issues for several nonpartisan, congressional support agencies, including the Congressional Budget Office (CBO), the Medicare Payment Advisory Commission (MedPAC), and CRS. At CBO, she worked as a budget analyst, focusing mostly on Medicare budget projections and cost estimates. At MedPAC, she was special assistant to the executive director. In that role she oversaw staff analysis and the writing and production of commission reports to the Congress. Ms. Jenson also has worked as a program examiner for the White House Office of Management

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and Budget, focusing on Medicaid. She holds master's degrees in public health and public policy from the University of Michigan.

Roger Johns, MD, MHS, is professor of anesthesiology and critical care medicine at the Johns Hopkins University and is currently a Robert Wood Johnson/Institute of Medicine Congressional Health Policy Fellow with the Senate Committee on the Judiciary. Dr. Johns studied health economics and developed interests in health policy and international health systems as an undergraduate at Stanford University. After medical school, he did an internship and residency in internal medicine and anesthesiology at the University of Virginia, followed by a clinical fellowship in cardiac anesthesia and a two-year research fellowship in pharmacology. In 1987 he joined the faculty at the University of Virginia, where he later became vice chair of the Department of Anesthesiology and in 1998 assumed an acting chair position. In 1999 Dr. Johns accepted a position as the Mark C. Rogers Professor and chairman of the Department of Anesthesiology and Critical Care Medicine at the Johns Hopkins University. While chair at Hopkins, Dr. Johns initiated an expansion of institutional information technology systems. Dr. Johns serves on the Executive Committee of the Innovations in Health Care Program at Hopkins. Recently, he completed the master of health science program in health policy and management at Hopkins' Bloomberg School of Public Health and is a candidate for the PhD degree in health policy and management, specializing in health services research.

Kara Kasper is the Medicare program examiner for the Health Finance Branch of the Office of Management and Budget.

Linda Kohn is assistant director of the Health Care Team at the Government Accountability Office.

James Kretz is a project officer and senior survey statistician, Center for Mental Health Services, in the Substance Abuse and Mental Health Services Administration. For more than 20 years he has been involved in all manner of informational technology development projects, data center management, and incorporating automated support to various areas of health care delivery. He created the first medical billing service to be accredited to submit electronic claims to the District of Columbia's Medicaid program, managed data management and analysis for clinical trials of new medical devices, created the only comprehensive electronic medical record system for reproductive endocrinology and infertility practices, reengineered a major case management/utilization review system, redesigned an institutional provider's health insurance claims clearing house, and served as the management information systems planning director for Boston City Hospital. He holds an MA degree in mathematical sociology from Indiana University.

Julie Lee, PhD, joined the Health and Human Resources division of the Congressional Budget Office (CBO) in 2003. Currently, she is working on projects analyzing high-cost Medicare beneficiaries, including issues related to disease management. Before joining CBO, Ms. Lee was a research analyst in health care policy at the National Bureau of Economic Research, where she analyzed a variety of topics in health economics, ranging from the effects of medical malpractice reforms to the distributional effects of Medicare. She holds a PhD degree in economics from Yale University.

Michael Millman, PhD, is the director of the Research and Data Policy Group at the Office of Planning and Evaluation for the Health Resources and Services Administration. He was previously a study director at the Institute of Medicine.

Jocelyn Moore is a health legislative analyst with Sen. John D. Rockefeller IV (D-WV), staffing him on the Senate Committee on Finance, where he is ranking member of the Subcommittee on Health Care. She advises on Medicare, Medicaid, children's health, long-term care, and general insurance reform. Previously, Ms. Moore worked as a legislative assistant for Sen. Bob Graham (D-FL). She holds a bachelor's degree in English and a master's degree in counselor education, both from the University of Florida.

Sidath V. Panangala is an analyst in the Domestic Social Policy Division of the Congressional Research Service (CRS). He is the principal analyst responsible for veterans' health care issues and also coordinates veterans' issues at CRS. Mr. Panangala is a graduate of Auburn University and Emory University.

Al Pheley, PhD, is currently a Robert Wood Johnson Health Policy Fellow with Sen. John D. Rockefeller IV (D-WV). In July 2002, Dr. Pheley was named professor and chair, Department of Community and Rural Medicine, at the Virginia College of Osteopathic Medicine in Blacksburg, Virginia. In this role, he continues his research, policy, and service interests in rural and Appalachian populations. He is also working to develop medical student and resident experiences in rural southwest Virginia, North Carolina, and West Virginia. As the college's assistant dean for clinical research, Dr. Pheley continues to foster the research interests of junior faculty and advocate for a stronger collaborative research environment across the osteopathic profession. He is the course director of the epidemiology, public health, and evidence-based practice curriculum. From 1998 to 2002, Dr. Pheley was an associate professor at the Ohio University College of Osteopathic Medicine and the director for clinical research development. While there, he established the college's Center for Appalachian and Rural Health Research. During the 1990s he directed the Clinical Epidemiology Program at the Hennepin County Medical Center and Minneapolis Medical Research Foundation. Dr. Pheley earned his doctorate in epidemiology from the University of Minnesota, School of Public Health. He also holds a master's degree in clinical psychology from North Dakota State University.

Rachel Post is a legislative assistant in the office of Rep. Vern Ehlers (R-MI). Before joining Rep. Ellers's staff in 2003, she held internships in the office of Sen. Mike Enzi (R-WY), the Social Security Administration's Office of Disability and Income Assistance Policy, and the National Rehabilitation Hospital Center on Health and Disability Research. Ms. Post holds a master's degree in public policy from Georgetown University and a BA degree from Calvin College in Michigan.

Jessica Shapiro is assistant counsel in the Office of the Legislative Counsel, U.S. House of Representatives. She is a graduate of the Johns Hopkins University and the University of Virginia School of Law.

Todd Spangler is a staff assistant for the Committee on Health, Education, Labor, and Pensions, U.S. Senate.

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Alice M. Weiss is health counsel, Democratic staff, for the Senate Committee on Finance. Her portfolio for the committee includes issues related to Medicaid, the State Children's Health Insurance Program, and private health insurance. Before joining the Finance Committee, Ms. Weiss was the director of health policy for the National Partnership for Women and Families. She also served as congressional liaison and health policy analyst for the U.S. Department of Labor. There, Ms. Weiss drafted patients' rights legislation and worked on the private health plan ERISA claims procedure rules and the department's ERISA litigation strategy. Ms. Weiss has testified before Congress on private health insurance issues. She received her bachelor of arts in history from Haverford College and her juris doctorate degree from Northeastern University Law School.

Mollie Zito is a legislative assistant for Sen. John Thune (R-SD), providing policy and political advice on a variety of health care issues as well as education and labor issues. Before joining Senator Thune's staff in February 2005 she served on the majority staff of the Senate Committee on Finance. In that capacity, Ms. Zito was a member of the chief Senate negotiating team which formulated, passed, and began overseeing the implementation of the Medicare Modernization Act of 2003. An attorney, she received her law degree from the University of Iowa College of Law and a BA degree in American studies from the University of Notre Dame.

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Peter Basch, MD, practices internal medicine in Washington, DC, and is the medical director for eHealth at MedStar Health. He is a frequent speaker, author, and expert panelist on topics such as electronic health records (EHR), interconnectivity, the transformation of health care through health information technology (HIT), and the necessity of creating a sustainable business case for information management and quality. Chairman of the Maryland Task Force on EHRs and co-chair of the Physicians' EHR Coalition, Dr. Basch is also a board member of the eHealth Initiative, the Delmarva Foundation, and the Maryland-DC Collaborative for HIT. He is a member of the American College of Physicians' Medical Informatics and Performance Measures Subcommittees and of its Medical Services Committee. Dr. Basch also serves on the Advisory Committees to the Doctor's Office Quality Information Technology (DOQ-IT) initiatives for both DC and Maryland and on the Health Information Technology Advisory Panel to the Joint Commission on Accreditation of Healthcare Organizations.

Ross Fletcher, MD, was appointed chief of staff of the Veterans Affairs Medical Center, Washington, DC, in January 2000. He had previously served as the center's chief of cardiology since 1972. Dr. Fletcher is also a professor of medicine at Georgetown University, where he has held a faculty appointment since 1969. He earlier served as chief of cardiology at D.C. General Hospital. Dr. Fletcher is a past president of the Nation's Capital affiliate of the American Heart Association. He received the 2003 Mark Wolcott Award for Excellence in Clinical Care from the Veterans Health Administration. Dr. Fletcher completed his MD degree (AOA), medical house staff training, and first-year fellowship at the University of Michigan at Ann Arbor. He then served two years with the U.S. Army in Washington, DC, and received his cardiology fellowship training at Georgetown University.

Sanford M. Garfunkel became the director of the Veterans Affairs (VA) Medical Center in Washington, DC, in April 1995. He oversees the management, operation, and administration of the medical center—a 171-bed tertiary care facility with specialized services in medicine, surgery, neurology, and psychiatry; a 120-bed comprehensive nursing and rehabilitation center; and a research facility—which has a full-time employee equivalent of 1,708 and an operating budget of $240 million for fiscal year 2006. Garfunkel joined the VA in 1971 at the Bronx VA Medical Center and held positions in VA medical centers in Manhattan, East Orange, New Jersey, and Brooklyn. He served as the director of the VA Medical Center in New York from 1986 until 1991. Subsequently, he was the associate chief medical director for operations, managing the day-to-day operation of the VA's 172 medical centers, 126 nursing homes, 356 outpatient and community-based clinics, and 36 domiciliaries, through the Veterans Health Administration's four regional offices.

Mr. Garfunkel received his undergraduate degree from Baruch College, City College of New York, and his master's degree in health care administration from the Baruch College and the Mt. Sinai School of Medicine, City University of New York. In 1990, he became a fellow of the American College of Healthcare Executives.

Dr. Robert Kolodner was appointed chief health informatics officer for the Veterans Health Administration (VHA) in September 2005. Besides serving as chief advisor to the Department of Veterans Affairs (VA) under secretary for health on information technology issues, he oversees development of the VHA's VistA applications, software, and systems; maintenance of over 140 national databases; and customer support for information technology to VA facilities and offices nationwide. Dr. Kolodner has been involved in developing VA information technology since 1983. He held positions as director of the Medical Information Resources Management Office and as associate chief information officer for enterprise strategy. He fostered the creation of My Health*e*Vet, a health portal for veterans and their families to access health information, tools, and services via the Internet. He was also instrumental in establishing the Federal Health Information Exchange program, an interagency health technology initiative that supports improving care to veterans and strengthening the working relationship between the VA and the Department of Defense. Dr. Kolodner received his undergraduate degree from Harvard College and his medical degree from Yale University School of Medicine. He completed a clinical fellowship in medicine at Harvard University School of Medicine and his psychiatric residency at Washington University School of Medicine.

Mark Snyder, MD, is associate medical director for information technology at Kaiser Permanente (KP) of the Mid-Atlantic States. He also directs the organization's Research Department and is leading its implementation of an electronic medical record system. Earlier in his career, as a researcher at the National Institutes of Health, he studied the genetic basis of attenuation of live influenza virus vaccines, after which he completed an infectious diseases fellowship at Johns Hopkins University Hospital. Dr. Snyder then joined KP in the Washington, DC, area as an infectious diseases specialist. He served for nine years on the board of directors of his KP medical group. He also was chief of medicine at Holy Cross Hospital in Silver Spring, Maryland, and he has served for five years on the Holy Cross Hospital Medical Executive Committee. Dr. Snyder has published 30 scientific papers on topics such as influenza virus vaccines, bioterrorism surveillance, and health care quality issues. He received his bachelor's degree from the Pennsylvania State University and his MD degree with honors from Jefferson Medical College in Philadelphia, later completing an internal medicine residency at George Washington University in Washington, DC.

Andrew M. Wiesenthal, MD, SM, is associate executive director of the Permanente Federation for Clinical Information Support. From 1983 until April 2000, Dr. Wiesenthal served as a pediatrician and pediatric infectious disease consultant with the Colorado Permanente Medical Group (CPMG). He also led CPMG's quality management program and served as associate medical director for medical management, with responsibility for quality management, utilization management,

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regulatory compliance, risk management, credentialing and physician perfor-mance, and informatics. His current work is in the arenas of development and deployment of automated medical records, decision support, and other clinical systems for all of Kaiser Permanente. Dr. Wiesenthal graduated from Yale Uni-versity with a BA degree with honors in Latin American studies and received his MD degree from the State University of New York, Downstate Medical Center, in Brooklyn. He completed his pediatric residency at the University of Colorado in 1978 and then served as an epidemic intelligence service officer with the Cen-ters for Disease Control from 1978 through 1980 before returning to the Univer-sity of Colorado for a pediatric infectious disease fellowship. In 2004, Dr. Wiesenthal earned a master's degree in health care management from the Harvard School of Public Health.

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