Transcript of Remarks by Senator Kent Conrad (D-ND)
at Senate Budget Committee Hearing on Health Information Technology
With Health and Human Services Secretary Mike Leavitt
July 20, 2005

Opening Remarks

Thank you Mr. Chairman, and I thank the Secretary very much for being here. This is a critically important subject. Back in the '90s I co-founded the Telehealth Caucus here in the Senate. We have been very active ever since. And we have also focused on the whole question of information technology and the opportunities that presents.

I would like to just go through a couple of slides quickly, kind of setting the context for this discussion if we can, and then have a chance to hear from the Secretary. This is what is happening to health care expenditures in the United States. They continue to rise. Last year, 15.4 percent of gross domestic product, by far the biggest percentage of our national income going to health care of any of the industrialized countries.

This is what the Chairman and I are – I think it is fair to say – most concerned about. And that is the trend line for Medicare and Medicaid expenditures. As we see going forward, we're looking out to 2050 and the long-term outlook according to the head of the Congressional Budget Office, according to the head of the Government Accountability Office, we're headed for a circumstance, if current trend lines continue – I want to emphasize that – we would be spending 21 percent of GDP just on two programs. That's more now then we spend on the total of the federal government. This is the enormous challenge that we face.

This to me is one of the things that requires us to focus like a laser. Six percent of beneficiaries are using 51 percent of the money. At times it's been 5 percent using 50 percent of the money. And who are they? The are the chronically ill. They are people who have multiple conditions. And that's what presents us, I believe, with our biggest opportunity. This is where we can get the biggest bang for the buck in terms of savings for Medicare and Medicaid. It's also the place where we can most dramatically improve health care outcomes. So I think we really need to rivet our attention on this statistic and the reality of peoples' lives behind those statistics. Chronically ill people have multiple conditions. Their care is not being well coordinated now. As a result, they're subjected to multiple tests. They are also taking many too many prescription drugs, many times actually making them less healthy rather than more healthy.

The administration's framework for IT infrastructure emphasizes:

- electronic health records
- computerized treatment options and best practices easily accessed by doctors
- computerized health assessment and treatment recommendations from doctors
- electronic health information/patient data exchange.

I think the administration has been quite right to focus on those areas of opportunity. As I have talked to health care providers around the country, as I have talked to people running

major health care companies, they tell me they think there is an enormous cost multiplier here, cost savings multiplier, by using best practices. And it's simply not happening. There are huge management opportunities, places where we could save substantial sums of money and improve the efficiency of health care.

What are the benefits of information technology in health?

- Reduction in medical errors. We have just seen a national survey on medical errors -- really quite stunning. The number of errors that are occurring in some of our best facilities and we all know how it happens. Charts that can't be read. Charts that aren't available at the key location at the right time.
- Improvement in access to health care
- Improvement in coordination of care.

And I want to emphasize the last one if I can, improvement in coordination of care. I have said this to my colleagues many times, and I'll say it again. I truly believe one of the biggest opportunities we have is with that small percentage of those who are eligible for Medicare and Medicaid, roughly over time 5 percent who use 50 percent of the money, we need to better coordinate their care. We did a pilot with some 21,000 patients and we found out when we put a nurse practitioner on every one of their cases, the first thing they did was go in their homes and lay out all the prescription drugs they were taking. All too often they found they were taking 16 or 17 prescription drugs and half of them they shouldn't have been taking.

It happened with my own father-in-law. I went into his house, laid out all the prescriptions he was taking. He was taking 16. I got on the phone with the doctor, and went down the list. About the third drug I mentioned, he said, "My God, Kent, he shouldn't be taking that. He shouldn't have been taken that the last three years." I went further down the list. Two drugs he was taking, and he said he should never take those drugs together. I said, "Well, Doctor, how does this happen?" He said, "It's very easy how it happens. He's got a lung specialist. He's got a heart specialist. He's got an orthopedic doctor. He's got me as his family practice doctor. He's getting medications at the hospital pharmacy, at the corner pharmacy, at the pharmacy down at the beach, mail order several pharmacies. Nobody's coordinating." The problem is no one was coordinating. He was sick and confused. His wife was sick and confused and that's how it happens. And we have got to do a better job of making certain that this care gets coordinated because we'll get better health care outcomes and we'll save money.

Additional Comments

You know in this area you want us to focus like a laser on interoperability. I have had legislation that would create what we would call a National Emergency Telemedical Communications Act. And it would provide a $150 million for three state consortia to set up networks that could connect CDC in an interoperable way with major hospitals and major clinics and law enforcement so if we God forbid had a bioterrorism event we would have a communications network that has been tested and vetted and was interoperable. I would hope very much that the administration would support that legislation or comparable legislation. The important thing here is that we really go down this trail and go down it quickly.

One of the things we learned on September 11, if we go back and look at the analysis of what happened at the Pentagon, number one problem was the lack of interoperability of communications. So the first responders, and the Chairman had it just right, couldn't talk to each other. You had police, you had medical, you had those who deal with hazardous, toxic situations all responding, fire as well. They couldn't talk to each other. It created a massive confusion.

And it seems to me the way to address this is to begin with manageable size groups and put the money into running tests. The reason we came up with the idea of having three different consortia was to test different methods. Put them in competition. I think that's what we ought to do with all these things – test and compete. That was the idea here. Let three groups go out there and test systems and compete against each other and see which one works best before we try to lay it out nationally. I think every time we've gone and tried to lay something out nationally without testing it, we've wasted a lot of money. So I hope very much we will pursue that.

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Conrad Question:

Let me just quickly turn to another subject because we're about to face the rollout of Medicare prescription drug plans. And I tell you it is very much on the minds of people in my state. People have already approached me very concerned that there is going to be confusion. And if there is confusion, that that will reduce sign up and that will reduce participation. Can you give us some insight on what you are doing to roll this plan out in a way that people understand it and aren't confused by it, and that we don't have so many plans circulating out there that people can't reach a decision?

Leavitt Answer:

Senator, yes. I'm spending at least two days a week. I'll be leaving again tonight to go out to visit local communities throughout the country. We're in the first phase of our rollout. The first phase of our rollout is to meet with local community groups. I must tell you I am quite heartened by what I am feeling and seeing. We will see rollout over the course of the next ten months a national conversation, a national conversation that will include literally tens of millions of different venues. It will be as simple as a daughter sitting down with her aging parents to say to them, "Mom, Dad, I need to help you assure that you have made a decision on a prescription drug plan." It may be a pastor who organizes a committee at his or her church to help the members. It will be a pharmacist at a store counter dealing with a customer who is a trusted relationship. It may be a doctor dealing with a patient, or a nurse at a community health center or a senior center. And we're seeing groups, senior organizations, community groups, mayors, county commissioners, state departments of health, all who are rallying to help a common constituency of seniors to make this decision. Now I feel a real optimism that while it will not be perfect in its execution, and while it will not be without complexity, at the end of the period of time, we will see between 28 and 30 million people who will have enrolled in this remarkable

new health benefit. It is in fact among the most significant events in health care in a half a century.

Conrad Question:

Can I invite you to North Dakota?

Leavitt Answer:

I would love to come to North Dakota.

Conrad Question:

We're asking the churches across our state to get involved in a very meaningful way, and we'd love to have you come.

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Conrad Question:

Let me ask if I could that you help us get a report on CDC's ability to communicate in real time with major health care providers around the country. Let me tell you what my concern is. The group that I mentioned before, the Telehealth Caucus, we've previously done a lot of analysis on bioterrorism, what would happen if God forbid there were an event somewhere in the country, what is our ability to respond in real time, what is the ability to analyze what it is and communicate with those who would be the first to confront victims, and confront providing care to victims. Our assessment is we are not in good shape there. And what I would request directly is that, and we can talk about what's a reasonable amount of time, I would hope in 30 days, that we could get a report on what is the ability of CDC to communicate in real time with major health facilities across the country, in the case of a bioterrorism event, in the case of a pandemic. Those two I think are the great potential threats that are out there and we should know with great certainty how well prepared we are to have our major institutions that can deal with analysis and diagnosis communicate in real time with the major health care institutions across the country. That may be an absolutely critical matter. We know certainly in the case of pandemic, being able to respond quickly and in the right way can make a massive difference in the outcome. So that's the request I would make. Would 30 days be reasonable?

Leavitt Answer:

Senator, we will be responsive. Perhaps, we could talk off-line the time frame. Thirty days does not seem unreasonable to me as I speak, but I should confer with my colleagues. I will tell you we are exercising constantly on this exact point. Our capacity does not meet our aspirations. We have to improve here. We have a project that I referred to earlier that I call BioSense. It's an active, aggressive effort on our part to take information technology and to use this project to move our capacity forward rapidly. We've identified 36 cities that contain 400

plus emergency rooms. Our intent is to have them interoperable and able to deliver the information you talked about in a relatively short time frame. We're not there now.

Conrad Closing Remarks:

I think it is just very important that we know here exactly where we are today, where we are headed. Are there steps that we need to take that would help? I think this is a major vulnerability for the country and we need to make very certain that we are focused on this as well.

One other point I would like to make, and this is my concluding point, Mr. Chairman. I have become absolutely convinced that after 19 years here that anytime we are doing these major efforts that we test and compete. And what I mean by that is that we don't just go down one road, that we go out there and we try variations and we get different groups to try different approaches and that we put them in competition. I am very worried in homeland security, for example, that we are going to roll out a big program on border security without having tested it and without having competed it. And we've had this conversation with the Homeland Security director. The same thing applies here. Let's not do something that we haven't tested and competed because that's what helps prevent major, major malfunctions, and major waste of money.