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CapMed, A Division of Bio-Imaging Technologies, Inc.

Written Testimony for the Consumer Empowerment Workgroup Hearing On Personal Health Records

CapMed, founded in 1996, is a leader in Personal Health Records (PHRs). We offer a PHR solution as a hybrid application – a single application available in three form factors, a web-based PHR, a desktop-based PHR and a portable PHR resident on a USB-drive. To date CapMed has distributed over ½ million PHRs.

CapMed's focus is to provide PHR solutions that are both accessible and usable. A 'one size fits all' approach to providing a PHR does not work. Our research has shown that consumers have a preference in the form factor of the PHR that they use based on the sponsoring entity of that PHR. We have found a direct correlation in a consumer's willingness to engage in online applications when they are offered or sponsored from a trusted entity, such as a physician, hospital or pharmacist.

With regard to usability, both the user interface (easy to understand and interact with) and the PHR applications/services must be addressed. Research continues to support that consumers are much more interested in engaging with a PHR application that has the capability of being populated electronically. We believe the future of the PHR is a patient-centric model where the consumer is at the center of the integrated medical information network. The testimony I am going to share with you today will address our position on incentives and interoperability to support widespread adoption of PHRs.

Incentives are frequently discussed with regard to EMR adoption; however incentives are critical to the adoption of Personal Health Records (PHRs) by consumers. Through our exposure to the PHR market, we have seen various incentives used to attempt to influence consumer adoption of PHRs. These have ranged from one-time financial rewards for the initial completion of a Health Risk Assessment (HRA) to ongoing

company "Wellness Programs" that encourage the use of PHRs to track various health programs and initiatives.

What has been demonstrated in the industry, particularly by PHRs that have been distributed by employers, is that consumers can be incentivised to take a first action, such as completing the HRA, but rarely make a return visit to the PHR application for ongoing use. The most common incentives for completing an HRA are financial, either in terms of a direct cash payment or a reduction in healthcare premiums. It has been demonstrated that one-time financial rewards have been effective for an initial exposure to a PHR but have not been effective in engaging consumers to continue to utilize the applications or services.

For a PHR to be truly effective, the consumer must have regular interaction with their PHR. We believe that incentives should be tiered so that consumers are encouraged to have ongoing interaction with their PHR, and are rewarded accordingly. For example, a consumer that completed the HRA may receive one point, another for updating the HRA 6 months later and yet another for enrolling in one of the available health management programs to qualify for the incentive. It is our belief that these incentives would need to be recurring per calendar year.

There is an opportunity for policy makers to ensure incentives are in place for consumers. Currently the onus is on private industry to both cover the costs for deploying a PHR and for any incentives for PHR usage that are extended to the consumer. As there is a direct correlation between the level of involvement a patient has in their own care management and improved outcomes, there is a policy level opportunity to mandate the reduction in health insurance premiums for the consumers that demonstrate active involvement in managing their own health. This can be equated to a reduction in healthcare premiums for consumers who use seatbelts.

With regard to clinicians, a PHR directly supports pay-for-performance initiatives. Engaging consumers in maintenance and follow up care through their PHR will assist

clinicians in being more compliant with required care management protocols. Clinicians also can find efficiencies in PHRs when they complement and simplify current processes in a clinician's office, such as simplifying patient registration.

However despite the benefits and proposed incentives for ongoing PHR usage, it is our belief that widespread consumer adoption of PHRs will follow the availability of standardized electronic clinical information. The overall adoption of PHRs is going to be driven by the availability of clinical information in an electronic form that is easily imported and exported.

In order to have clinical information in an electronic form, a physician must be using an electronic medical record or EMR system to manage his patients. Herein lies the challenge; at this point in time approximately 20% of physicians are utilizing EMRs in their practice of medicine. Based on this statistic, there are 80% of the physicians today that cannot help their patients easily populate and maintain a comprehensive PHR.

We have seen that a clinician's adoption and support for PHRs is usually dependent on whether they are using an EMR system. If a clinician is using an EMR and it is easy to import data to and export data from a PHR, they are big supporters of using PHRs. Those clinicians not utilizing an EMR cannot easily help patients maintain their PHR, and therefore they are not big PHR supporters.

We believe that any action that the government can take that would accelerate the adoption of EMRs by clinicians will subsequently accelerate the adoption of PHRs by individuals. The increased adoption of EMRs and PHRs should give us the ability to improve the quality of the healthcare services we deliver in a much more efficient manner.

Regulations that would drive finalized interoperability standards between the various clinical information systems will facilitate adoption of EMRs and subsequent adoption of PHRs. As interoperability standards are finalized, the government should require that all

EMR systems comply with and support the established standards. Likewise, the government should require that any PHR system that chooses to accept or transmit electronic data between systems also comply with and support the established standards.

A comprehensive PHR, such as CapMed, should be able to import data from EMRs that are used by a person's physicians, aggregate the information in an organized patient centric fashion and export back to an EMR electronically. Once established, this flow of information will allow individual health care providers to always have the complete picture of the person's health, including medical records from physicians' offices that are still paper-based; over-the-counter medications; home monitoring results; alternative treatments; and adherence to medication therapies and treatment plans when they are diagnosing or treating an illness.

We believe that in addition to EMR systems, there are other valid sources of medical data that could potentially be used to populate the PHR with medical information. These include electronic access to medication history through the pharmacy systems, insurance claims data, and lab and imaging systems. Some of this data, including insurance claims data is already available for PHR use and serves as a good starting point for interoperability.

There are several pharmacy e-prescribing networks that link electronic communications between pharmacies and physicians, and currently process electronic prescription data for a large majority of the nation's pharmacies and pharmacy benefits managers. It is only natural to extend this network to the patient, allowing access to their prescription history and hence, supporting the PHR user's ability to manage their sometimes complex medication regime.

A final electronic source of medical data is from home monitoring devices such as glucose meters, blood pressure monitors, cholesterol monitors and weight scales. To date, there are neither data standards nor interoperability standards that extend to these devices. Each device manufacturer maintains proprietary interfaces between their

devices and the computer, which hampers a PHR user from being able to access this data and include it in the PHR system. Either the patient must hand-enter the readings from their devices into their PHR, or the PHR vendor must develop a custom interface to each individual device. We recommend that the government extend requirements for data and interface standards to these home monitoring devices to facilitate the ability to electronically add and track this information in the PHR, where the patient and physician will be able to analyze the results in context with the patient's medical history.

As we move forward with our interoperability initiatives, the government needs to re-address policy to ensure valid sources of electronic medical data are available for PHR use, while maintaining strict adherence to privacy and security of personal health information. PHR vendors should be required to meet standards to ensure the privacy and security of their PHR system, whether it relates to the PHR application itself, or the receipt and transmission of electronic medical data to and from the PHR system. In all cases the consumer should be the owner of their medical history as it resides in their PHR, and should be given the final say in the information they share with healthcare providers. PHR vendors must provide robust, flexible applications that allow sharing of medical information without compromising the patients' rights to privacy and security, but still protect the integrity of the information as it becomes part of the patient's PHR.

Thank you for this opportunity to share our testimony to the Consumer Empowerment Workgroup Hearing On Personal Health Records. It is an honor to be here and a privilege to participate in the emerging Personal Health Record technology.