ELECTRONIC HEALTH RECORDS

Mr. ALEXANDER. Madam President, I ask unanimous consent that a copy of my opening statement at the Senate Health Education, Labor, and Pensions Committee be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ELECTRONIC HEALTH RECORDS

Mr. ALEXANDER. In 1991, the National Academies urged the adoption of electronic health records to improve patients' care. However, for many patients and for many doctors, electronic health records have made care more complicated.

No one knows this better than Dr. Kelly Aldrich, who is the Chief Clinical Transformation Officer at the Center for Medical Interoperability in Nashville and whose husband, Eric, experienced a life-threatening emergency that could have been prevented if his electronic health records had been interoperable.

Eric woke up one morning with a splitting headache and went to see his primary care doctor, who sent Eric to the hospital for a CT scan, the results of which prompted an MRI. Usually, the hospital's electronic medical records system sends the results of the MRI directly to Eric's primary care doctor.

But in this case the results were never sent, so 12 hours after the test, Eric's doctor called the hospital and learned that Eric had a tumor so large it was causing his brain to swell and shift, putting him at risk of seizures, permanent brain damage, and possibly death.

Eric, however, assuming no news was good news, was already 500 miles away, on his way to a fishing trip in Louisiana. Eric went to Tulane Medical Center, which had to do another MRI because they could not obtain Eric's original test results because the two hospitals used different electronic medical records systems. Eric flew back to Nashville, where he had to have yet another MRI before entering surgery. Eric later spent several weeks recovering in the ICU.

At multiple points during this traumatic experience, a lack of interoperability between electronic health records caused a life threatening delay of care, redundant tests, higher costs, and additional pain.

This is the second hearing on the proposed rules implementing the electronic health information provisions in the 21st Century Cures Act. Improving electronic health records is important to this committee.

In 2015, while working on Cures, we realized that our electronic health records system was in a ditch.

This committee held six bipartisan hearings on how to improve interoperability, and formed a working group that recommended provisions in Cures to ban information blocking—which is when some obstacle is in the way of a patient's information being sent from one doctor to another.

And this year, this committee is working on legislation to lower the cost of health care.

50 percent of what we spend on health care is unnecessary, according to Dr. Brent James of the National Academics. Electronic health records that are interoperable can prevent duplicative tests —like Eric's repeated MRIs—and reduce what doctors and hospitals spend on administrative tasks.

In March, the Office of the National Coordinator and the Centers for Medicare and Medicaid Services issued two rules to implement the electronic health records provisions in Cures:

First the rules define information blocking—so it is more precisely clear what we mean when one system, hospital, doctor, vendor, or insurer is purposefully not sharing information with another;

Second, the rules require that by January 1, 2020, for the first time, insurers must share a patient's health care data with the patient so their health information follows them as they see different doctors; and

Third, all electronic health records must adopt publicly available standards for data elements, known as Application Programming Interfaces, or APIs, two years after these rules are completed.

Last month, we heard from those who use electronic health records, and here is what they have to say about the rules. First, I asked our witnesses if these were good rules—and all four said yes, the intent and the goal of the rules were correct.

Mary Grealy, president of the Healthcare Leadership Council said: "Interoperability is not simply desirable, it is absolutely necessary . . . These rules represent an important and perhaps groundbreaking first step for true national interoperability."

I also asked our witnesses what one change they would make to improve these rules. Mary cautioned about not rushing implementation, saying, "We don't want to prevent moving ahead, or progress, but I think we also have to be very cognizant of the challenges that providers and others are facing trying to do this complex work."

In 2015, I urged the Obama Administration to slow down Stage 3 of the Meaningful Use program, which incentivized doctors and hospitals to adopt electronic health records. The Obama Administration did not slow down implementation, and looking back, the results would have been better if they had.

The best way to get to where you want to go is not by going too far, too fast.

I want to make sure we learn lessons from implementing Meaningful Use Stage 3, which was, in the words of one major hospital, "terrifying."

I am especially interested in getting where we want to go with the involvement of doctors, hospitals, vendors, and insurers, with the fewest possible mistakes and the least confusion.

We don't need to set a record time to get there with an unrealistic timeline. Because these are complex rules, I asked CMS and ONC to extend the comment period, and I am glad to see they have done so and want to thank our witnesses for allowing more time for comment.

We also heard concerns about ensuring patient privacy. lf the 21st Century Cures Act is successfully implemented, patients should be able to get their own health data more easily and send it to their health care providers.

Patients may also choose to send that data to third parties—like an exercise tracking app on their smart phone—but this raises new questions about privacy. Lucia Savage, Chief Privacy and Regulatory Officer at Omada Health said, "I think the committee . . . is rightfully concerned about privacy and security . . . None of this will matter if the consumers don't have confidence, and their doctors don't have confidence that the consumers have confidence."

Dr. Christopher Rehm, Chief Medical Informatics Officer at Lifepoint Health in Brentwood, Tennessee reminded us at the hearing that these rules are "not about the technology, it's about the patient, their care and their outcomes."

I am looking forward to hearing from the Administration today about how they plan to implement these rules.

WILD AND SCENIC RIVERS POSTAGE STAMP

Mr. WYDEN. Madam President, on May 21, 2019, the U.S. Postal Service will release a series of postage stamps commemorating America's Wild and Scenic River system. These are America's remarkable rivers and streams unique for their free-flowing beauty, along with their contribution to recreation, fish and wildlife habitat, and countless other important benefits.

As we recognize the 50th anniversary of this landmark conservation law, I want to make a point that Oregon has always been a leader in protecting rivers and just this year added more than 250 miles of Wild and Scenic Rivers designations, increasing our miles of protected rivers from 1,916 to a grand total of over 2,170 miles. That gives Oregon the State with the most miles of Wild and Scenic River designations in the contiguous United States.

Three Oregon rivers are being recognized by the U.S. Postal Service in this commemorative stamp edition: the Deschutes, the Owyhee, and the Snake Rivers. Each is remarkable and unique in its own way, and together, these rivers embody Oregon's tradition of providing habitat for endangered salmon and steelhead, clean drinking water, and recreation opportunities for countless outdoor enthusiasts from all over the United States and the world.

One of these rivers, the Owyhee, carves its way through some of the harshest and most arid and remote landscape of Oregon's high desert in the easternmost parts of our State. The Owyhee River flows through a steep, eroded canyon with cliffs towering hundreds of feet above. Added to the Wild and Scenic Rivers system in 1984, this river is revered for its remarkable cultural, geologic, recreational, and scenic values. It is of particular historical significance to Tribes across Oregon, Idaho, and Nevada. Beyond its significance as a Wild and Scenic River, the Owyhee region is a critical lifeline to the rural economy of eastern Oregon and the local ranching community.

Moving westward to central Oregon, the Deschutes River is an oasis that winds through sandy, pumice-filled soils and sloping plateaus. A Wild and Scenic River since 1988, the Deschutes is world renowned for its fly fishing, rafting, and hiking opportunities. For centuries, Native Americans have honored the cultural and fishing uses of the river and venerated its historical value.

The final Oregon river honored in this series is back to the east in Oregon but north of the Owyhee: the mighty Snake River. It flows through Hells Canyon—the deepest gorge in North America—on the border between Idaho and Oregon. First designated a Wild and Scenic River in 1975, the Snake River holds significant cultural value for the people of the Shoshone and Nez