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Thank you to the Policy and Standards committees for today's important hearing and especially for the invitation to participate. I feel fortunate to have experience in both the public and private realms of the advancement of healthcare information technology and specifically that of health information exchange through my work at Greenway as a technical lead focused on interoperability, as co-chair of the IHE Patient Care Coordination Planning Committee, and as co-chair of the Technical Workgroup within the Beacon EHR Affinity Group. I am very encouraged at the progress within both realms having been in some aspect of the standards development and implementation trenches overall since 2007.

When it comes to furthering the advancement of scalable information sharing across EHRs, within HIEs and health systems, I believe the key is to continue to foster that collaborative spirit of public/private policy agreement that I have experienced. There is evidence this type of approach works on a technical level that has begun fostering a sense of trust in the provider community, which in turn will lead to successful business models for all stakeholders.

For example, Greenway commissioned a survey of CIOs that not surprisingly found that interoperability was the number one CIO concern about utilizing health IT. It went on to find that when it comes to who should be responsible for interoperability, 82 percent said it should be a shared process between the health system and the EHR supplier, and half of that number even expressed the desire for the EHR provider to lead the interoperability implementation process. So the need for a mutually beneficial, collaborative approach is clear. My company has also completed a development agreement with RelayHealth, for example, which is finding not only interoperable success in the market, but has furthered some satisfaction in the provider community that EHR leaders are in it for the right clinical reasons.

I also believe that it is necessary to avoid the creation of any new initiatives around the exchange of health care data, and instead to embrace existing ones offering better avenues of coordination between these groups. We must also support coordination over consolidation unless consolidation improves the situation for both the EHR suppliers and health systems. This approach is very much in line with the public/private direction that is proving to be so effective in advancing healthcare IT.

As an EHR supplier, my company always strives to provide our customers, the industry and ultimately the patient with technology solutions that improve care. To do so we must also have a deep understanding of what policies and standards are in place. In

order to achieve this understanding we elect to participate in a number of ongoing standards initiatives. Moving forward we must balance the time taken to explore and consolidate standards with the time needed to continually advance internal innovations and the release of new functionality.

Overall the standards are in place, and initiatives like the EHR/HIE Interoperability Workgroup and the Beacon EHR Affinity Group are prime examples of collaboration on technology and use case. Meaningful Use Stage 2 is a manageable advance toward large-scale exchange that sends the right message that it is time to get serious about exchange across boundaries, which should foster the same types of collaboration required for emerging care delivery models such as value-based medicine and accountable care.

There is of course room for considering the type of payment incentives that have shown success in other areas of adoption, and perhaps penalties for not sharing data that supports optimal patient care as well as patient safety. I think closely watching the progress of the eHealth Exchange and ONC's grant program for the establishment of state and regional HIEs – as continued examples of public/private exchange programs – will help determine whether further incentives or penalties should be considered. Also in terms of existing programs affecting EHR adoption and ultimately exchange, the continued relaxation of the Stark Law beyond 2013 should be addressed, to allow it to coincide with the remaining or future years of the Meaningful Use program.

The committees also make a great point in that Meaningful Use does not cover or incentivize all of the needed areas of data exchange. I would agree specifically that statewide or regional HIEs and labs are two priority targets in which to broaden incentives as an approach to success, possibly driven by Meaningful Use measures that already speak to the exchange and flow of lab results, which currently place the emphasis on providers and their EHRs.

On the technical side we need to continue the support of as few as possible standardized clinical content templates. In Meaningful Use Stage 2 there are only a handful: Consolidated Clinical Document Architecture (C-CDA) for Transitions of Care, Quality Research Document Architecture (QRDA) for population health and HL7 version 2 for labs and immunizations. Expanding this to incorporate new content standards will significantly increase the workload needed to achieve semantic interoperability between systems. If new content needs to be standardized for exchange then we must consider how we can use existing standards first. In my experience at IHE I have found this to be second nature as we do not create new standards but profile existing ones. Transport protocols implemented across healthcare communities may vary, and this is largely without significant consequence as long as such transport standards support a minimum set of requirements for security and privacy. Meaningful Use Stage 2 addresses many such requirements.

Greenway's collaborations to date with Cerner and Epic on data exchange and physician alignment have not encountered any hindrances due to implied or existing policy, and has shown real progress as a functional and business framework. Instead collaborative success has only been a matter of mining normal levels of bureaucracy or corporate structures to simply put the right heads together. Overall I do not foresee any regulatory pressures around these efforts at this time.

Time in the literal sense is a factor to watch as new payment and care delivery models such as accountable care and patient centered medical home (PCMH) take hold and whether they will translate into a proven business case for data exchange. I think within the next 12 to 24 months we will see the outcomes and results of these care coordination initiatives to determine what to build upon and fine-tune in terms of interoperability best practices. Really to see what sticks with providers although clearly the programs have increased the understanding that data exchange is necessary.

Payers, and more specifically payer data, is one area of ONC oversight to explore within the exchange market. It is well understood that payers generate and store great amounts of clinical and financial data that can be made transparent, analyzed and shared as decision support and advanced into data visualization. This would only enhance patient care.

In closing, on the national level, that sense of fostering collaboration and grassroots ideas can lead to a sense of market competition that would lead to new business cases. The emergence of Integrating the Healthcare Enterprise (IHE) is an example of this through a recognized need to add the structure of use cases to accompany content, transport, security and privacy standards. This was good for the overall industry and has arguably led us to the successful interoperability portions of the Meaningful Use program being experienced today. IHE USA, now offering a certification in collaboration with ICSA Labs is another example of initiatives allowed to percolate into reality. There is no lack of innovation and entrepreneurship in healthcare information technology that the right amount of public/private collaboration cannot advance as sound policy and business opportunities that the provider community – and patient, who are becoming savvy consumers of healthcare and self-help technology tools – cannot embrace.