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Perceptions of Competitor Advantage

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Dr. Tang and distinguished Members of the Committee. I am pleased to offer you my testimony on on questions about how to incent vendor organizations to engage in HIEs and invest in interoperability and advance interoperable healthcare nationwide. As most of you know from my work on meaningful use, I have dedicated nearly all of my professional life as a vendor to advancing the adoption and use of electronic health records to improve our healthcare delivery system and make a difference in the lives of patients. I have another chapter that is less known.

Let’s step back in time about 30 years. This was the time when vendors were building interfaces to collect data from lab systems to store in clinical repositories. I engaged in an initiative to converge the work of ASTM with a fledging HL7 organization and my company backed it by investing and continuing to invest in standards development. We joined HL7, sent developers to meetings to develop these standards, and have held various leadership roles. I say this as way of background because it shows vendors commitment to standards and interoperability and more importantly providing clinicians access to lab data.

Fast forward to the era of eprescribing. Many of you here remember the early days when getting trading partners and vendors with eprescribing solutions to the table to exchange prescription / medication data was quite challenging. Independent pharmacies did not want to play, vendors complained about the certification process, etc. However, the vendors engaged because our clients wanted to eprescribe. Today Surescripts works with more that 700 eprescribing applications across 300 vendors. A couple factors were key to making exchange successful. First, the pharma industry came together to found Surescripts for the sole purpose of establish a network focused on a basic set of use cases and standards necessary to support e-prescribing. Market demand created by the physician incentives to use eprescribing led to implementation and use. Usage even today however still focuses on the basic transactions set.

Last week, you heard from Medallies and the progress being made with implementing Direct over the past year. Last year, it took up to two weeks to connect a provider; today it takes minutes. The vendors are at the table because their clients want to exchange data in support of meaningful use incentives and emerging value based care models. When the vendors delay for various reasons, clients are upset due to lateness and are making their voices heard. Vendors are listening and scrambling in some cases because optics around data blocking are quite visible. Even with the progress, Dr. Blair recognizes that Direct is not the end game and that improvement in exchange elements must continue.

I share these examples because context is important. In all of these cases, you can see that the vendors are rational in that they are responding to their client needs and and business opportunity. HITECH was a huge signal that the government was willing to pay up to $30B for adoption and meaningful use of EHRs. Stage 1 requirements were low enough to drive a huge influx of EHRs into the market; pretty reasonable behavior and investments in sales and marketing. Stage 2 introduced more stringent requirements such that vendors invested more into research and development.

So, with this background, let’s consider the questions that were posed:

1. How should vendors be incented to engage in HIEs and interoperability?

There is a simple answer. Make providers (our clients) care about interoperability and vendors will care. However, given current regulatory demands and timelines, it is a thornier question. So here are the business facts:

* HITECH meaningful incentive money have been paid out and the market is at about 80% adoption. Vendors are analyzing where will future sales and revenue come from. They must consider how earnings be achieved. Where will the funnel future investments? It is a zero sum game. What are the tradeoffs?
* Vendors are also working on other regulatory requirements, such as ICD10 and controlled substances. Stage three is introducing more certification requirements which may or may not be adopted and / or needed by their customers.
* With the advance of value-based payment models right around the corner, the market wants EHR 2.0 and not interoperability. There is a disconnect between payment policies and interoperability. While those of you here understand where interoperability is critical to new value-based models, we are early on in broad implementation of these models. Providers are looking for population health management solutions and are less focused on solutions that manage and coordinate individual patient encounters.
* Lastly, the interoperability problems facing us are hard and costly to solve for: unlike the Surescripts scenario, variation is high due hundreds of different models, etc., This makes investing in development fairly unappealing.

The bottom line: As evidenced by over 30 years of investments in interoperability, vendors are willing to invest as a means of responding to problems that their customers are trying to solve and willing to pay for. Market demand for real function that requires interoperability would create the right incentives.

1. What strategy would you recommend for achieving interoperability across the country?  Is a single strategy sufficient, or is it more likely that a hybrid strategy will be needed?

As evidenced above, there are many lessons that we can take away that will guide responses to the strategy question.

* Achieving interoperability and use of standards in practice is hard work, takes time, and incrementally improves over time.
* Getting the network and its governance, aka, the plumbing, in place to connect the stakeholders is a critical prerequisite to secure data exchange.
* Limiting use case scope and standards, having a single source of ownership and / or governance, process transparency, automating highly desired business processes and if necessary linking deployment and use to incentives are all elements of a successful formula to bring data exchange to scale.
* Vendors are rational players and will respond to market demand.

Recommendations:

* Make providers care about interoperability. This will create market demand for interoperability and the vendors will invest. Use the advancement to value-based payment models and align them with interoperability advances. Recognize the provider learning curve in implementing data exchange. It is not simply plugging the computer in the wall. Address these gaps in provider activation by integrating use of interoperability within the context of transformed business processes. Where, when, and how to share care summaries, etc.
* Measure it. You cannot manage what you cannot measure. Create a reliable framework to count the extent to which various use cases are deployed and used. HR. 2 directs the Secretary to establish such metrics for information exchange.
* Create a single source of truth. This will be hard, but make the information about vendor’s certification, compliance, deployment, usage, etc. transparent. Define the required data elements that must be monitored. Use current surveillance reporting as a starting point. Again, HR 2 directs the Secretary to examine the feasibility of establishing one or more mechanisms to assist providers in comparing and selecting certified EHR technology products. The status of interoperability needs to be included.
* Establish governance that is stakeholder driven, including providers, payers, and patients. Vendors can participate as advisors.
  + To date, conversations have been among vendors. The ownership of the problem must be an industry problem to effectively define direction and remove barriers.
  + Awareness will elevate solutions and create focus.
* Legislatively, consider consumer protections such as the Lemon Law to protect against bad actors.

1. What would you recommend to facilitate vendor business models or remove barriers?

Obstacles to investment include the degree of variation in the market. Different organizations have different approaches to different types of problems. Governance, patient matching, provider directories, discharge summaries, e-referrals, patient consent, etc. creating an incredibly complex set of issues to solve for. Public health agencies across 50 states likewise implement differently all making healthcare a cottage industry; consequently, developing, testing, and scaling solutions take time.

Recommendations:

* Recognize that the timeline is years; leverage the extent that the federal government can use it powers as a procurer to bring solutions to scale; let good not be the enemy of great.
* Focus IT resources. This includes providers and vendors. We have heard testimony from providers and vendors where more time will help. Resources are limited. Therefore, focus on what is available, what is real, getting it to work will limit distractions. Work on CCD improvement, require client certification against a test server (more than vendor certification), and keep working to clean up semantics.
* Tackle low hanging fruit. Ask for private sector leadership because it will happen sooner. For instance, KLAS is hosting key vendors in October for such as discussion. This is a good place for agreements and direction setting.
  + Agree and adopt a legal framework for providers to interoperate. This takes a lot of effort for providers to establish. Use defacto standards where possible For example, EPIC does a good job of providing a legal framework for their clients to exchange data. Clients use it. Encourage industry adoption of such a framework.
* In lieu of and / or in addition to private sector leadership, pay for value will be the most important policy lever because it will make clients care and that is where the heavy lifting has to happen.  They need to want it and ask their vendors for help as needed.  As the clients have to start figuring out where to cut costs in care delivery, interoperability will become an important strategy.

In closing, let me assure that you that those of us who work for vendors have loved ones and are patients too. Because what happens in healthcare affects each of us personally, we deeply care about interoperable health care so that the right data about a person is available where and when it it needed. We support the public law H.R.2 - Medicare Access and CHIP Reauthorization Act of 2015 which establishes a national objective to achieve widespread exchange of health information through interoperable certified electronic health records (EHR) technology nationwide by December 31, 2018. We want to be part of the solution, not the problem. Thank you again for the opportunity to testify.