Testimony of Paul Black,
Before the Senate Committee on Health Education Labor and Pensions
Achieving the Promise of Health Information Technology: Information Blocking and Potential Solutions

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Chairman Alexander, Ranking Member Murray, distinguished Members of the Committee, thank you for the opportunity to share my perspectives on the critical topic of impediments to data exchange and the best ways to address them across the health system. It is a true honor to be here.

My name is Paul Black, and I serve as the President and Chief Executive Officer of Allscripts. Allscripts is the largest developer of health information technology for this country's healthcare providers, including Electronic Health Records, revenue cycle management software, and population health and information exchange services. More than 180,000 physicians, including those delivering care in 45,000 ambulatory practices; 2,700 hospitals; and 13,000 post-acute care facilities and homecare agencies utilize Allscripts solutions to connect the clinical and business operations both within their organization and within their community. We employ 7,000 team members and have offices in 16 different states, including Illinois, North Carolina, Vermont, Georgia, and Massachusetts, as well as people working in all 50 states.

I was invited here today to speak about interoperability and concerns about information blocking, and as more independent doctors use our software to treat patients than any other commercially available product, I'm pleased to share recommendations with you on this topic. This is important for two reasons: if a stakeholder were to intentionally get in the way of information exchange, 1) it would be bad for patients, and 2) it could be anti-competitive. Period.

Congress and the American people have wisely made an investment in the advancement of health information technology, all oriented around one goal: ensuring that this country's citizens are receiving the best possible care – both from a quality and cost perspective. Robust, open information exchange across a multitude of vendor platforms and care settings is critical to ensuring that we meet that goal for America's patients. An increased level of transparency and cooperation

is needed to meet this challenge – health information technology developers, caregivers, employers, payers, pharmaceutical companies, health systems and the government must all work harder *together* to solve this problem. Tomorrow's healthcare networks won't be built by one company alone, or even by health information technology developers alone, but by all of us.

Allscripts has been working with healthcare professionals across the spectrum of care for many years during a period in which health care and health IT have evolved at a tremendously rapid rate. The changes that have been required have been challenging – they have disrupted systems that have been in place for decades. But we realize that innovation arises from disruption, and we have embraced it.

Several years ago, Allscripts made a decision to invest in an OPEN approach to connectivity – one that is grounded in our dbMotion connectivity platform and a philosophy which has led to the development of a large network of certified software developers outside of the company who build apps based on our open APIs. From North Shore LIJ – the largest private integrated delivery network in the country – to thousands of independent, single provider practices who make up the backbone of care in this country, we partner with physicians and other professionals nationwide who are taking this opportunity to innovate with us.

And while the narrative on information exchange is largely negative in conversations in Congress and in the media, it is important to note that there are many examples of providers who have worked through the process of establishing connectivity and are making it work. These providers are changing lives by preventing disease and saving money. Organizations like Holston Medical Group, which has offered to connect all providers in NE Tennessee and SW Virginia and is already working with Allscripts to facilitate data exchange between 25 different EHR systems used by two hospitals and 1,200 physicians in more than 50 groups (either already connected or in process). University of Pittsburgh Medical Center, which has set up a connected network of 22 hospitals, 4,000 physicians, imaging centers, labs and others using dozens of different health information technology systems. Citrus Valley Health Partners in California, Baylor in Texas... that's another 1.5 million patient lives, and the list goes on. In fact, while it is clear there is still effort required, our clients demonstrate every day that information exchange can lead to quantifiable and demonstrable improvements in care delivery.

It is true, however, that today not all stakeholders in the healthcare industry seem to be equally motivated to make information liquidity a reality. While the money spent through HITECH and other Congressional investments have helped the industry to realize measurable benefits from the rapid adoption of electronic health records – an important success that shouldn't be overlooked – clinical data exchange is not where it needs to be. There are many factors that need to be addressed for us to ultimately be successful:

- We need to expand the standards development process, building on the real progress underway with guidance from government and allowing the private sector to continuously develop, adopt and modify new standards
- Key constituencies, such as public health registries, labs, state health information exchange organizations and others who are not following available standards in their work, should be required to do so;
- State laws and regulations must be harmonized, particularly those related to privacy and security, patient consent and other similar topics;
- Legal and liability concerns among providers about how the data will be used outside of patient care must be addressed;
- We need to get beyond the focus on how data is transmitted and agree on what and how data is stored;
- Activation strategies are needed to increase use of health IT by patients and their caregivers, while also generating accountability for their health outcomes;
- We need a national patient matching strategy – a way to identify each individual patient. This is a real challenge to both robust data exchange and patient safety, and Congress needs to stop blocking progress on this critical issue; and
- Finally, generally, greater transparency around interoperability and health IT among virtually all stakeholders must be achieved.

Beyond all that, though, the sluggish progress we're discussing today most closely stems from one critical deficit: the lack of a strong business case or a true market driver for interoperability.

At the end of the day, healthcare in most environments is a business where margins must be considered and the bills paid, and the current payment system simply does not provide appropriate financial motivation for providers to truly be invested in creating an interoperable healthcare environment; this is especially true given that the burden of cost falls to them almost exclusively.

Healthcare providers are genuinely committed to providing the best care they can to patients, of course, but in many instances, the common reality of running on only a few days' cash flow often trumps loftier goals. Much as CMS policy has already had a marked impact on hospital readmission rates by associating them with payments, creating a direct relationship between payment and data exchange would have the same result. This could be the strongest step taken to create a genuine imperative for interoperability.

H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a good start in the right direction, but Congress needs to ensure that alternative payment models envisioned in this reform are rolled out appropriately. The good news is that the expansion of delivery reforms is already motivating accelerated electronic data exchange progress. We see this in ACOs, and demonstrations like the Comprehensive Primary Care Initiative, which Allscripts supports as the technology provider for a very sizable percentage of the participants. Simply put, they create a use case for health IT that focuses on clinical value and less on what level of visit they can code. We have already seen real change result within our client base from new approaches at CMS and within the commercial payer space, and I expect that will accelerate as MACRA is implemented.

For this reason, given the volume of new programs that have been and are being rolled out along with Meaningful Use Stage 3, which we expect to push the industry further in terms of interoperability, we encourage Congress to allow the impacts of these recent changes to play out further before additional legislation is passed specific to interoperability. There is an opportunity to see what adjustments providers make in response to the new payment models and what steps they start taking to maximize the new revenue opportunities.

Generally, the same recommendation applies to standards development work – it is important that there be time for maturation and the fine-tuning of elements that are already being embraced by the industry (for example, Direct and CDA), and there is no need to toss aside approaches that are working. This doesn't preclude exploring new and innovative approaches in an appropriately transparent manner, but the work done with standards development is not intended to have a lifetime of two years or five but longer than that so it's important to move thoughtfully. I do understand the eagerness of Congress, the Administration and industry stakeholders to move rapidly because everyone is keen to see the results, but looking to standards as a panacea for the challenges still ahead of us will only result in usability complaints from providers as immature technologies are

mandated by the government. Congressional attention would be best served in directing ONC to drive greater standards adoption and consistency of implementation of those standards, rather than focusing on the need for all new standards.

Further, it is important to witness what innovation comes from the private sector, generally, in response to the recent legislative and regulatory activity, as well as client requests. There are exciting technologies and services in development now and on the product roadmaps for the next several years based on what our clients have requested of us, and I think we can all agree that we want to avoid a prescriptive, heavy-handed statutory or regulatory mandate in which the government becomes the de facto product manager for our industry as a whole.

Another important consideration in this conversation about information liquidity are the physician practices (small and large) and independent hospitals who have been pressured to move off of their current Electronic Health Record system - Allscripts in some cases - to one used by the large enterprise health system in their area. Sometimes the change is compelled through conversations about referrals, for example; threats not to include people in data networks; or even just a steady drumbeat of pressure, and it's often done under the auspices of increased interoperability.

In actuality, with today's technology, changing systems just isn't necessary in order to provide physicians and other medical professionals with access to the information they need. The rip-and-replace strategy emphasized by some in the industry is many years outdated given the advanced data exchange capabilities that are out there. Allscripts' dbMotion platform provides an advanced semantic engine that aggregates and normalizes all clinical content across a connected community into a single view, accessible within *whichever* EHR the provider uses, to enable them to find relevant information quickly while with the patient. This technology is in use across numerous communities in the U.S. and overseas, including the entire country of Israel, and in each environment, it's connecting dozens of different vendors successfully and directly changing the care decisions being made because of the additional information that's available.

Many people have termed what I just described – the pressure to change systems – as data bullying; others, data blocking because one involved party isn't committed to establishing connectivity between current systems and in some instances, will even put up indirect roadblocks. This raises what I believe to be a fundamentally important issue – what, exactly, is the definition of data

blocking? The ONC report on information blocking stated that it occurs when persons or entities *knowingly* and *unreasonably* interfere with the exchange or use of electronic health information, but it also notes that the extent to which such information blocking is impeding the effective sharing of electronic health information is not clear because much of the evidence is anecdotal and difficult to interpret. This is an issue that really must be addressed before even implicit data blocking can be addressed.

An additional factor at play is the commoditization of data that is occurring everywhere within the industry. Through our partnership with our clients, one thing has become clear. Healthcare is mirroring a trend seen virtually everywhere in business – attempts to access and/or control data are driving many of the dynamics that are being discussed today. The topics that are raised in the meetings I have with clients every day are all about the power of data. "Big data", population health, personalized medicine, quality-driven reimbursement and information exchange – each a conversation about data and its enormous potential. Until there is greater clarity regarding the so-called "ownership" of the data, this will continue to be a significant factor in negotiations around interoperability.

I will note, too, that this Committee's use of its oversight authority has had important effects already in driving undesirable behavior out of the industry, and we encourage continued attention in the coming years as health information technology is used not only as envisioned within the EHR Incentive Program but also for other important purposes, such as population health and personalized medicine.

Lastly, Chairman Alexander has said previously that the best way to solve the problems around interoperability would be for the Health IT industry to do something itself. I share the view that we have a real responsibility here, along with the provider organizations that we support, and I feel strongly that this is doable. I challenge all of my colleagues to continue working together with us, with you, the provider stakeholders, the ONC and the patient community that have so much to offer in this conversation until we have achieved success.

Thank you again for the opportunity to be here today.