Testimony of David C. Kibbe, MD MBA, President and CEO of DirectTrust, and Senior Advisor for the American Academy Of Family Physicians before the U.S. Senate Committee on Health, Education, Labor and Pensions

Hearing on "Achieving the Promise of Health Information Technology: Information Blocking and Potential Solutions" July 23, 2015

OPENING REMARKS

Chairman Alexander, Ranking Member Murray and distinguished members of the Committee, thank you for the opportunity to share my thoughts on problems that impede the sharing of health information between and among parties authorized to access such information, now often referred to as "information blocking." I will offer some near-term suggestions to help improve upon the current situation.

My name is David Kibbe and I serve as the president and CEO of the non-profit trade alliance DirectTrust, and also as senior advisor to the American Academy of Family Physicians, the physician membership organization representing over one hundred thousand of the nation's family physicians, residents, and students.

DirectTrust's 150 plus members are a vibrant community of service providers, health IT vendors, and health care organizations dedicated to the use of interoperable, secure, standards-based health information exchange via the Direct standard, as well as other vendor-agnostic technologies.

Direct exchange was designed to replace paper-based mail, fax, and efax transmissions of health information with secure electronic messaging between users of different software applications, like EHRs. Direct messaging is very similar to electronic mail, or email, in that a sender can compose a message, attach a file or files, and send the package over the Internet. Both sender and receiver need to have Direct addresses that usually have the format

firstname.lastname@Direct.MyMedicalPractice.com, supplied by Health Internet Service Providers, or HISPs. The word "direct" in the address signifies that both the message and attachments are encrypted end-to-end, and that the identities of both parties have been validated.

Because of the added privacy, security, and identity layers of Direct exchange, this method of sharing of data between providers using different EHRs, and between providers and patients, is ideally suited to the handling of personal health information which must be protected at all times.

Interoperable Direct exchange has grown rapidly since becoming a required feature of EHR technology certified by ONC in 2014. There are over 300 EHRs that are certified as Direct-enabled, and over 50 HIEs nationwide provide Direct exchange services.

DirectTrust members alone have provisioned nearly one million Direct addresses in the health care industry, enabling Direct exchange at over 40,000 health care organizations. Over 30 million Direct messages have been exchanged in 2014 and 2015 so far in support of transitions of care and care coordination. The Indian Health Services, US Postal Service, Veterans Administration, and the Centers for Medicare and Medicaid Services all have Direct implementations under way to replace mail, fax, and efax communications between these federal agencies and providers in the private sector beginning later this year.

DirectTrust members have significant experience with interoperability testing and the problems that can impede Direct exchange information flows. Indeed, DirectTrust is something of a laboratory wherein these problems are routinely identified, investigated, and usually solved. Here are some of our collective observations on information blocking from an "on the street" perspective.

Examples of information blocking

While it is true that interoperable health information exchange has made great progress in the past two years, information blocking by health care provider organizations and their EHRs, whether intentional or not, is still a problem for some providers wishing to use Direct exchange, as well as for these providers' clinical partners who want to be able to exchange Direct messages and attachments with them.

1101 Connecticut Ave. NW
Suite 1000
Washington, DC 20036

DirectTrust.org
913.205.7968
www.directtrust.org

2) Persisting information blocking problems include:

- Local EHR and provider organization policies. For example, an EHR might require that an incoming Direct message be accompanied by a particular attachment type. No attachment? The inbound message and its files are discarded, often without letting the sender know. Which is very frustrating to relying parties. Clearly this was not the original intent of Direct exchange, which supports virtually any kind of file transmission, with or without an attachment.

- EHR product design and/or implementation flaws. For example -- believe it or not -- although certified to send and receive Direct messages, some EHR vendors' products lack an "inbox" or "compose" button, or other key component needed to allow the user to compose messages, attach files, and so on.

- Lack of or inadequate product/service support. If an EHR customer can't get service assistance for their product's interoperability functions, this inhibits or delays information exchange set up and implementation for providers seeking to use interoperable health IT.

- High pricing for HIE-enabled software upgrades. While some vendors include the costs of upgrading from Stage 1 to Stage 2 features and functions, including Direct exchange capability, others make the new features a new cost that practices must bear. Clearly, this hurts the smaller practices more than it does the bigger institutions.

- Registration and "whitelisting" requirements for message exchange.   Making exchange partners register with the practice's or hospital's EHR in effect discourages EHR users from engaging in standards-based interoperable HIE. It's a little bit like having a phone that requires each caller to fill out a complicated form and "apply" to be able to reach you before you'll accept their call.

- "HIPAA doesn't allow." Perhaps the most significant problem of all is faced by patients and consumers trying to use Direct exchange to access their medical records, only to be told that HIPAA won't allow them to do so. Patients and consumers ought to be able to be full

participants in Direct exchange and partners with their providers in health information exchanges.

The role of government to encourage health information exchange

In my opinion, the responsibility for assuring secure interoperable exchange resides primarily with the health care provider organizations, not the EHR vendors, and not the government. Health care provider organizations must come to realize that acting in the best interest of patients is to assure that health information follows the patient and consumer to whatever setting will provide treatment, even if that means in a competitor's hospital or medical practice. And they must demand collaborative and interoperable health IT tools from their EHR vendors to make this routine and ubiquitous as a practice in every community in the United States.

However, there is a role for government to encourage and incentivize collaborative and interoperable health information exchange. Among the actions that government can take to help overcome the kinds of continuing problems I have mentioned above should be:

- To continue to shed light on these problems, and work with trade groups, standards and policies organizations, and others to set expectations for interoperability of EHRs and other applications certified as interoperable, especially those that have been federally subsidized within the Meaningful Use programs. Let's "Finish what we started before moving to more complex solutions that may or may not work."

- To bring better and improved EHR certification processes forward beyond the testing laboratory, so that the utility and usability of interoperability features of ONC certified EHR products in the field becomes part of the public record, and can be used in purchasing decisions. Collaboration and partnership with non-profit trade groups to achieve this goal would be advisable.

- To accelerate federal agency use of and demand for open, standards-based interoperable HIE with private sector providers and provider organizations, thereby removing reliance on paper-based mail, fax, efax, and courier for these federal programs.

1101 Connecticut Ave. NW
Suite 1000
Washington, DC 20036

DirectTrust.org
913.205.7968
www.directtrust.org

Examples include Veterans Health Administration referrals to and from private sector medical practices and hospitals; Veterans Benefits Administration health information exchanges with private sector medical practices and hospitals; the use by Medicare, Medicaid, and state agencies of interoperable HIE for communications with private sector providers and provider organizations for limitation of fraud, payment adjudication, claims attachments requests, and other administrative transactions now done via fax and mail.

- To continue to tie more robust ONC EHR certification and use of certified EHR technology to participation in Value Based Purchasing programs, wherein interoperability and collaboration across multiple organizations in multiple-vendor environments is financially rewarding to providers and their health IT vendors. Demand for collaboration and interoperability is best driven by underlying business models and business cases supported by regulation and oversight.

Summary

Information blocking is a persistent and real problem faced by providers, provider organizations, and patients who wish to share and exchange health information between and among parties authorized to access such information, and to use that information to improve quality and care coordination.

Progress is being made, and, at its root the causes of information blocking are not technological or due to a lack of standards for interoperability or EHR capabilities for interoperable exchange. As noted in the ONC Report to Congress on Information Blocking of April, 2015[1], "While some types of information blocking may implicate these technical standards and capabilities, most allegations of information blocking ***involve business practices and other conduct that interferes with the exchange of electronic health information despite the availability of standards and certified health IT capabilities that enable this information to be shared***." (Emphasis added.)

---

[1] http://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf

1101 Connecticut Ave. NW   DirectTrust.org
Suite 1000   913.205.7968
Washington, DC 20036   www.directtrust.org

Therefore, attempts to redress the root causes of information blocking must address the unwillingness of some providers and their EHR partners to share and exchange data, and not just the specific problems that may be encountered in making exchanges run smoothly and reliably. In my opinion, that unwillingness originates in the current business models of some health care provider organizations, and the health care industry in general, wherein fee-for-service payment creates disincentives for sharing of health information and rewards information hoarding, or at least the delay of timely information exchanges. Changes to these payment incentives could do much to reward business models where collaboration and interoperability are highly valued, and where the technological capabilities, standards, and infrastructure for interoperable health information exchange now in place would be put to much better use.

1101 Connecticut Ave. NW
Suite 1000
Washington, DC 20036

DirectTrust.org
913.205.7968
www.directtrust.org