

Testimony to the Interoperability Task Force of the Health IT Policy Committee, ONC

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Thank you for the opportunity to share research findings related to provider competition and health information exchange (HIE). Between 2008 and 2015, at the Center for Studying Health System Change and Mathematica Policy Research, we've done a series of studies examining the use of health information technology (HIT) in physician practices to foster coordination of care and teamwork across clinicians and inter-professional staff. Most of these studies have been funded by the Commonwealth Fund and the Robert Wood Johnson Foundation. As part of this work, we conducted in-depth interviews with 221 primary care physicians, nurses and specialist physicians in 115 practices across the country.¹⁻⁵ Through this work, we have heard from on-the-ground clinicians and other stakeholders, including electronic health record (EHR) vendors, medical executives and national thought leaders, about facilitators and barriers to using HIT to improve coordination of care, with lack of interoperability being a chief barrier.

I was asked to speak today specifically about our findings on competition as a barrier to interoperability, whether or not this is a pervasive vs. market-specific phenomenon and what might help drive provider interest in interoperability.

Challenges to health information exchange are pervasive; they are not just a market-specific phenomenon. There are some exceptions in a few markets with robust health information exchange; in some cases these are geographically isolated areas or markets served by a single integrated health system. However, most patients and providers live and practice in areas where this level of integration is absent and thus they face major barriers to health information exchange. **Competition is part of this story and it poses challenges to interoperability in both indirect and direct ways:**

Indirect challenges to health information exchange include:

1. Misaligned payment incentives: In our interviews over the years, we have heard that many primary care clinicians and specialists, as well as community support and social services, would like to exchange information to improve patient care. They also told us, however, that the current fee-for-service payment system does not promote this activity. Instead, fee-for-service payment encourages clinicians and hospitals to continually increase the volume of more lucrative procedures and diagnostic testing and other resource-intensive services to maximize revenues. Thus, exchanging clinical information to better coordinate patient care is a low priority because coordination and data exchange activities have not historically been reimbursed, at least not in a manner that can overcome the volume-based incentives. There are exceptions—for example, in staff model HMOs and some closed systems where providers' incomes are not strictly determined by Relative Value Units (RVU) or productivity incentives. Similarly in new models

of care such as accountable care organizations (ACOs) there is an effort to get both primary and specialty care providers and hospitals on the same page to better coordinate care for patients and shift the focus toward shared accountability for patients and away from the volume-based incentives in traditional fee-for-service payment.

2. A culture that does not emphasize information sharing and accountability for the whole patient. In part because of the misaligned fee-for-service incentives and the increasing fragmentation of care across an ever-growing number of subspecialists, clinical culture has shifted away from a sense of shared accountability for caring for the whole person. As a result, providers who are not part of integrated systems that share an EHR, or that are not part of pilot projects that encourage coordination, may not always understand the benefit or importance of communicating with one another to ensure that a patient receives well-coordinated care.

3. Lack of systematic communication processes across different types of providers, including primary care clinicians, specialists, community-based services and social services agencies. A common example of this is the unreliable communication between primary and specialty care clinicians about patient referrals and consultations.⁶ When providers are using the same EHR they can access the patient's record, but providers on different EHRs typically cannot exchange information electronically and still resort to faxing long referral and consultation notes from their EHRs.^{4,7} Clinicians continue to complain that referral and consultation notes generated by EHRs are long and repetitive, making it challenging to pull out the important clinical kernels from large amounts of copied and pasted text and extraneous information. The C-CDA (Consolidated-Clinical Document Architecture) is a step toward trying to systemize this type of clinical information exchange, and the nuanced free-text critical assessment of the patient is something providers value.

4. Absence of a viable business plan or standard organizational structure for data exchange also likely contributes to suboptimal rates of health information exchange. A recent review by Kruse and colleagues,⁸ noted that in the absence of a national infrastructure for data exchange, even providers that want to share information to coordinate care for patients will continue to face numerous barriers.

There are several sources of direct competition that pose challenges to health information exchange. I highlight the two that we've heard about most in our research:

1. EHR vendor competition is overt and per providers we've interviewed for several different studies, including primary care redesign projects from 2008 to 2015, this is a leading barrier to HIE. EHR vendors are selling a tool or service, so they understandably have few if any incentives to support interoperability. Reinforcing what many providers have reported, an EHR vendor told us, "Even if you want to interface, there's someone selling a similar product in the same market. Everyone talks about interoperability...but we need the cooperation of other vendors to interface with their systems." Dr. Sheikh and colleagues' recent work⁹ suggests federal stimulation of competition by mandating vendors to open up their application program interfaces.

2. Competition between hospital systems. At the Center for Studying Health System Change, researchers conducted numerous site visits to 12 U.S. health care markets over the years as part of the *Community Tracking Study*. During our 2010 site visits sponsored by the Robert Wood Johnson Foundation and the National Institute for Health Care Reform, we heard about growing employment of physicians by hospital systems.¹⁰ Hospitals have become more consolidated over the last decade; this consolidation as well as other challenges facing physicians led to the increased employment of specialists and more recently of primary care physicians by large hospital systems. Hospitals' primary motivator for employing physicians, is to increase hospital market share and garner referrals from primary care providers to the hospitals' specialists and lucrative diagnostic testing, procedures, and inpatient admissions.

Health information exchange within a hospital system can be enhanced if all clinicians within the hospital use the same EHR, but there is no guarantee that they will work together to coordinate care. Furthermore, hospital consolidation and increased hospital employment of physicians does not encourage communication with providers outside of that system. Competition between hospital systems coupled with the misaligned fee-for-service payment system which rewards volume, create little incentive for hospitals to try to exchange data with physicians or other hospitals outside of their own business entity—they want to keep the lucrative services performed within their own system.⁸⁻¹⁰

Driving Provider Interest in HIE

Maximizing clinicians' interest in health information exchange to improve the quality and coordination of care for patients requires EHR vendors to more openly share their program interfaces. It also requires a cultural shift among clinicians and hospitals to improve communication and information sharing about patients for whom they provide care. Key to this shift is removing disincentives under current fee-for-service payment that discourage providers from taking the time to exchange information more routinely.

Until reimbursement changes, providers will be less willing to alter their clinical workflows to improve communication and engage in HIE to sufficiently prioritize shared, coordinated care for patients. Modifying reimbursement to encourage coordination of care will likely drive clinicians to demand better EHR functionalities and infrastructure so that they can exchange the information needed to properly care for patients. Additional policy levers to encourage health information exchange among clinicians include emphasizing the value of such communication to clinicians-in-training; this could be reinforced by maintenance of certification requirements for clinicians. ONC has worked hard to standardize data elements for the meaningful use of EHRs. In addition to meeting the meaningful use requirements, providers' need to modify clinical workflows and to do this they need the support of a robust data exchange infrastructure and a reimbursement system that encourages clinician buy-in to coordinate care. Until there is progress along these multiple tracks, it is doubtful that any single standard or endorsement of a particular care process will motivate them to participate fully in health information exchange.

Again, thank you for the opportunity to share our research findings as you work to develop HIT and infrastructure to improve the population's health.

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