

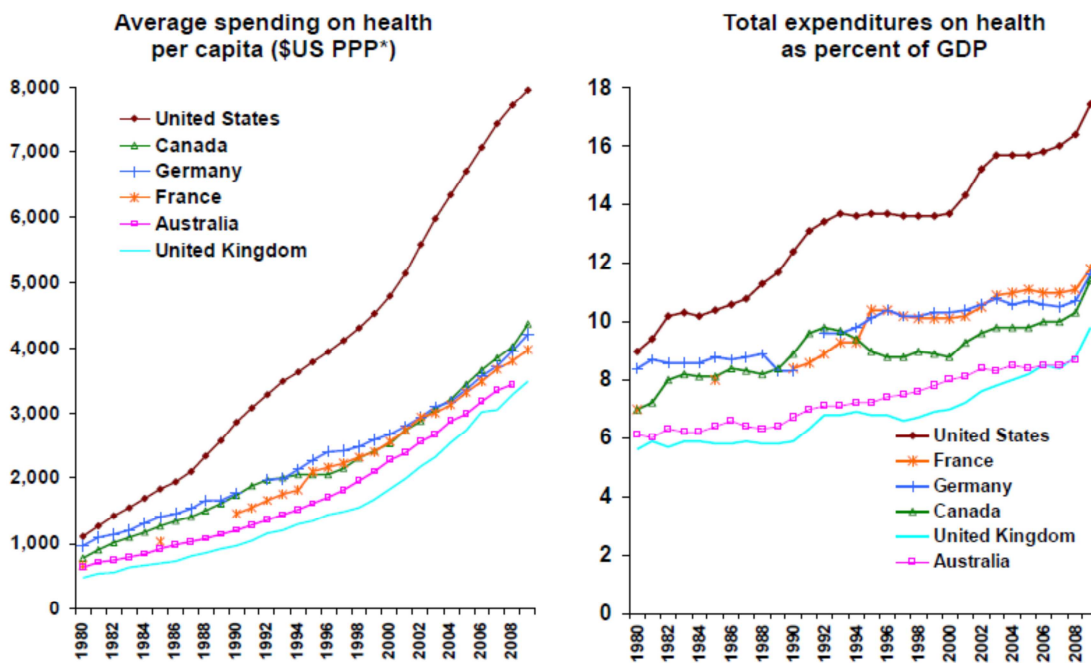
American Global Competitiveness Requires Connected Communities of Health

By Glen Tullman, Chief Executive Officer, Allscripts

When I joined Allscripts in 1997, I knew we were going to do important things. No industry is as essential as healthcare and I was convinced that Allscripts could make a difference using software and technology to improve the quality of care and reduce costs. Today, Allscripts is leading a transformation that promises to contribute more to American global competitiveness than any other industry. How? By using technology not only to automate care, but to build Connected Communities of Health that deliver higher quality care at lower cost.

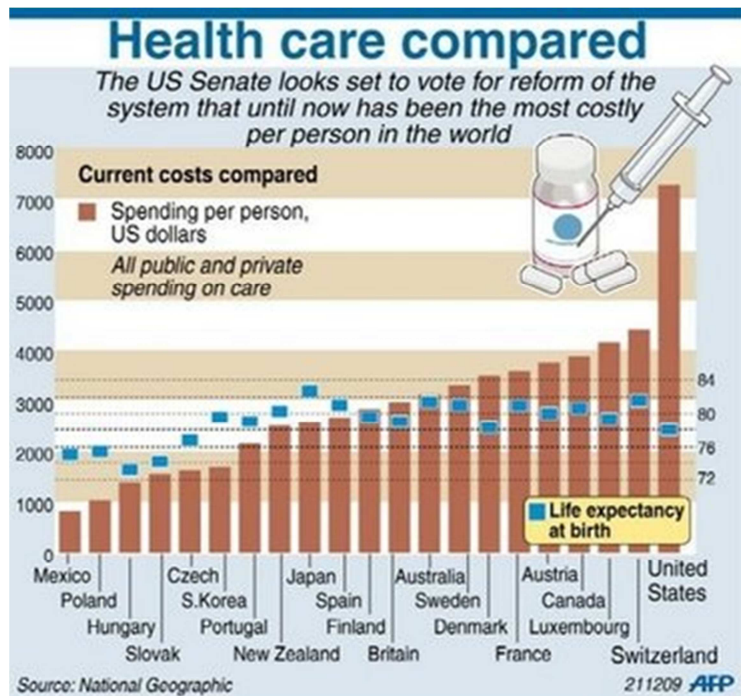
Why is America's competitiveness dependent on connecting healthcare? The answer begins with some pretty simple math. As the cost of healthcare rises, U.S. businesses have less money to invest in the future of their products, their services and their company as a whole. Companies can't aggressively hire or develop new markets when their operating margins are continually eroded by rising and uncontrollable healthcare costs. Today, the cost of healthcare is rising about five times faster than wages, profits or inflation. In 1987, healthcare spending accounted for 11 percent of GDP; today it represents 17 percent, and by 2017 it's projected to reach 20 percent.

International Comparison of Spending on Health, 1980–2009



American businesses, which provide the majority of health insurance for non-elderly adults, are paying a heavy price for our nation's outsized healthcare budget. The total cost of providing health coverage doubled between 1999 and 2008. GM, Ford, and Chrysler all spend more on employee health expenses than on the steel they use to make cars. Not surprisingly, researchers at RAND who analyzed the performance of 38 industries from 1987 to 2005 found that rising healthcare costs in the United States have directly curtailed growth and employment.

Ever-increasing healthcare costs also have a direct impact on our ability to compete internationally. In a 2011 study ("The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations") the Commonwealth Fund found that U.S. healthcare spending reached \$7,538 per capita in 2008, "far more than in any other country studied and more than double the Organization for Economic Cooperation and Development (OECD) median of



\$2,995." Moreover, the study found that the rate of increase in healthcare spending in the U.S. since 1980 "has dwarfed that of the other countries both in terms of per capita spending and as a percentage of GDP."

Findings like that might be easier to swallow if the quality of U.S. healthcare were improving in parallel with the costs. It's not. Despite having the most expensive healthcare system in the world, the United States ranks last or next-to-last among industrialized nations in virtually every measure of population health, according to the Commonwealth Fund. As a result, American businesses pay increasingly more for health coverage while losing more than \$1 trillion a year to absenteeism and lower productivity related to employee health problems, according to the Milken Institute.

Imagine how much more competitive American business could be if companies were free to invest just half that amount in new innovations and jobs.

The Answer: Care Coordination

After years of wrestling with the twin challenges of rising cost and less-than-impressive outcomes for patients, the key stakeholders – payers, employers providers and the government– have reached near-consensus on the solution. New approaches being implemented today encourage providers in every setting to work together as a team to better coordinate care while aligning provider reimbursement with patient health outcomes. These new strategies have different names – Accountable Care Organizations (ACO), Patient Centered Medical Homes, bundled payments and, more generally, payment reform – but they all focus on compensating providers for keeping patients healthy rather than for the number of services they provide. Each of these models began with two shared observations: first, that care transitions, or the movement of patients from a provider in one care setting to another provider in a different setting, are the weakest link in the U.S. healthcare chain; and second, that meeting this challenge requires health information technology, and specifically the Electronic Health Record (EHR) – software that automates clinical tasks, delivers point-of-care safety alerts and access to clinical trials, and provides insights into better care.

One of the strongest indications of the problem with care transitions is this: 20 percent of patients discharged from U.S. hospitals are readmitted for the same or a related problem within 30 days. Too often, patients moving from the hospital to their primary care physician’s office or another outside setting leave without their lab results, medication lists or other vital clinical data. The same is true of patients who are seen in the emergency room or admitted to the hospital following care by their regular physician. The fault here lies not with patients but with the processes and procedures used to document care. The majority of provider organizations today still use paper, one of the few processes in our society that hasn’t changed in over 100 years. With paper charts, a patient’s information is susceptible not only to errors based on insufficient information or poor handwriting but also transfer delays or chart loss. According to the nonprofit Institute of Medicine, medical charts are lost or missing in 30 percent of patient visits.

The bottom line is this: our healthcare system is suffering from systemic information gaps that cause providers in virtually every setting to work in isolation rather than collaborating as a team. Treatment decisions too often are based on snippets of information rather than a comprehensive view of the patient, even though a more complete picture of the patient's health could help prevent medical errors and redundant tests that contribute to an estimated 100,000 preventable deaths and \$700 billion in waste each year.

Fortunately, there's an alternative that we call the Connected Community of Health.

In a connected community, providers across any region can be equipped with a single electronic chart that tells them everything they need to know to deliver appropriate, effective and economical care. Each time the patient is seen in a connected community, their shared record is updated with the latest information from a wide variety of IT systems, regardless of who makes them. Such an open collaborative system can draw data from multiple healthcare organizations in a variety of formats and "harmonize" the data into a uniform, usable structure so it can be displayed or shared as information and insights with any EHR, Personal Health Record (PHR), or other health IT system across the community. This information then becomes available for the patient's next encounter – regardless of whether it takes place in the hospital, his physician's office, a skilled nursing facility or his own home.

The result: better coordination of care, higher quality, increased patient safety, and lower cost.

It will take time to build Connected Communities of Health across America but recent events are moving us closer to that goal. President Obama's 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act provides nearly \$40 billion in incentives for providers to adopt and use EHRs to improve the quality of care delivered and positively bend the quality and cost curves. As a result, physicians and hospitals are currently implementing EHRs at record pace.

Government's Role: Promote Interoperability

With the financial hurdle to EHR adoption at least partly resolved, the federal government is focused on one final barrier to the creation of Connected Communities of Health. As the

Institutes of Medicine (IOM), the Office of the National Coordinator of Health Information Technology (ONC), and the President's Council of Advisors on Science and Technology (PCAST) have all argued, progress toward a more cost-effective and higher quality healthcare system depends on improvements in one critical area: interoperability.

David Brailer, MD, the first Director of ONC and someone I believe was a key player in the healthcare IT revolution, said "interoperability is a fundamental requirement of ensuring that widespread Electronic Health Record adoption gives us the social and economic benefits that we want. Without interoperability, EHR adoption will further strengthen the information silos that exist in today's paper-based medical files."

I couldn't agree more. Walls between systems create chaos for patients, providers and employers. With open, interoperable EHRs and other health IT systems, healthcare providers are empowered to deliver better, more coordinated care, and patients receive the quality care they deserve.

To that end, we believe that government should require health IT companies to work together to provide open, interoperable systems that can integrate with any third-party application or device and facilitate the meaningful sharing of information. Providers should be incented through payment reform to focus on the patient's health, not just when he or she is sitting in the exam room but before they arrive and after they go home. We must collectively begin gathering benchmark data on the kind of care that is being delivered and what's most effective – a process that is already underway thanks to the "comparative effectiveness" requirement of HITECH (made possible by EHRs). Finally, the payers in our system – CMS, Medicaid agencies and private health plans – must begin implementing programs across the continuum to reward optimal care, so that those physicians truly providing the best care are appropriately rewarded.

If we are able to implement a collaborative, open system as the foundation for Connected Communities of Health, not only in isolated communities but across the country, the result will be a healthier America. Rather than spending more and more each year on healthcare, we may actually be able to reverse the cost curve we've seen over the last decade. A more balanced

healthcare value equation for all Americans also would help level the playing field between U.S. businesses and their international competitors. And that in turn would free our businesses to focus on what they do best – innovating and competing to win.

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