

Members of the Assembly Health Committee, thank you for accepting public comment on the topic of Health Information Exchange (HIE).

Clinical Informatics was founded in 2000 to optimize the use of technology in clinical practice. Toward that goal, Clinical Informatics provides consulting services and advises clients on public policy in healthcare, strategic planning for health technology, opportunities for innovation, organizational governance, provider engagement, and clinician training.

I have been involved in the HIE conversation for more than 20 years, participating in some of the early work in Santa Barbara (Care Data Exchange). Notably, and pertinent to my testimony, after \$10 million in funding from the California Health Care Foundation, SBCDE went out of business in 2006 only a few years after it started operating. I was involved in the discussion about the formation of Cal eConnect - the entity created to support the statewide initiative for HIE. I received a commendation from the State of California for support of the grant application the State submitted to the Federal government in 2010 for HIE funds from The Office of the National Coordinator for Health Information Exchange. I led the finance discussions. During the statewide conversation that led to that grant award, we estimated that statewide HIE would cost approximately \$2 billion. The state was awarded \$38 million. I could say more, but the intent of this background is simply to provide the context for my comments. I suspect you may find my testimony differs significantly from other testimony, but it is not because I am unaware or ill informed.

For more than 10 years, I have said that HIE is the wrong answer because we are asking the wrong question. The question we ask is: how do we get healthcare entities and clinicians to share data? In response, we create mechanisms for clinical entities to be at the center of doing that. By contrast, I believe that the question we should be asking is: considering the complexity of our healthcare system and its sometimes conflicting incentives, how do we design data sharing to benefit patients in a way that is financially sustainable? I believe the answer to that question is: consider who benefits from data sharing and design a solution around them. If you examine who benefits, you see that health systems pay a cost and risk increased competition when they share data with other health systems. Individual clinicians do not want to pay for and often do not want review the information from other clinicians. Why should these clinical entities support, let alone pay for data sharing? The premise of HIE has this fundamental flaw. It is why we have seen so many HIEs go bankrupt over the years; there is no willing customer for the manager of the data to remain solvent. It is the proverbial technology in search of a problem a customer wants to solve.

Patients, on the other hand, do benefit from data sharing. They are the only stakeholder who consistently benefits from the sharing of their data. If we design a solution that sends all the data directly to the patient for them to share with whomever they wish, we can design a sustainable system. With HIPAA on their side to get their digital data, they are in a good position to be the repository of their data.

I would be more than happy to answer any questions and hope that you find this perspective to be useful in your consideration of how the State can best move forward.

Sincerely,

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