



Health Information Exchange: Building the Infrastructure for Better Care

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

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THURSDAY, JANUARY 14, 2010

11:45AM–12:15PM—Lunch

12:15PM–2:00PM—Discussion

LOCATION

Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
*(Across from the Dirksen
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OVERVIEW

Effective use of health information technology requires data “liquidity,” or the capacity for automated transmission of patient information among doctors, hospitals, pharmacies, clinical labs, patients, and others. But while electronic transmission of health insurance claims data is widespread, many obstacles have prevented the routine sharing of clinical information, and many efforts to foster systematic health information exchange have struggled or stalled. The American Recovery and Reinvestment Act of 2009 authorized more than \$1 billion to build up the infrastructure for health data exchange. But time lines are tight for implementing the Recovery Act’s provisions, and infrastructure development entails many challenges. This Forum session will examine current health data exchange activities and strategies to expand them through Recovery Act programs.

SESSION

In addition to creating incentives for providers to adopt electronic medical records, the American Recovery and Reinvestment Act authorized more than \$1 billion to build up the infrastructure for the use of health information technology (IT). Those funds include \$564 million to be distributed through the states to support the development of health information exchanges (HIEs) to facilitate electronic information-sharing among health system entities. The \$35 billion to \$45 billion incentive program requires providers to demonstrate “meaningful use” of health IT, a term denoting not just the acquisition of health IT as an end in itself but its employment to improve quality, efficiency, and population health outcomes.¹ The criteria for meaningful use developed by the Office of the National Coordinator for Health IT (ONC) are the basis on which the Centers for Medicare & Medicaid Services (CMS) must formulate regulations for disbursing the incentive payments to individual providers.² Of the 94 specific objectives included in ONC’s recommended meaningful use criteria, about 40 require not only that providers collect and store patient information electronically, but that they be able to send and receive data to and from other legitimate sources and users of patient information.³ Thus without data exchange, Recovery Act incentive payments to providers might not be triggered.

Regional HIEs, also known as regional health information organizations, or RHIOs, were a centerpiece of federal health information

policy after the creation of ONC by a presidential executive order in 2004. But few of these organizations developed or thrived. Trust issues arose among stakeholders who were being asked to share data with competitors and others with whom they had adversarial business relationships, resulting in conflicted governance. For many providers, the costs of the technology investments needed for electronic data exchange exceeded any foreseeable financial benefit. In a 2008 survey, lack of a “business case” for health data exchange was the most frequently cited reason for the failure of many RHIOs and HIEs to get off the ground from 2004 to 2008.⁴

But forces conducive to exchange may yet outweigh the obstacles. Organized systems of care such as the Veterans Health Administration and some large health maintenance organizations have demonstrated that “interoperable” health IT can improve quality, reduce costs, and improve the experience of care for both patients and health care professionals. ONC recommended that providers be able to receive lab results and order prescriptions electronically to qualify for meaningful use incentives in 2011, but CMS-proposed regulations published December 30 apparently relaxed this deadline. In the near future, though, one of the strongest factors favoring the growth of HIEs is expected to be pressure from providers to create exchange arrangements so that doctors and hospitals will be able to receive incentive payments—a condition that was not present during the period when RHIOs and HIEs failed to thrive. However, many providers, especially smaller physician practices, are still concerned about the costs of acquiring and sustainability of using health IT.

ONC has assigned state governments primary responsibility for facilitating the development of HIEs, and it is channeling Recovery Act assistance funds through the states. Readiness varies widely among the states. Some have laid the groundwork for data exchange in the course of their RHIO experiments, sometimes subsidized by state funds. Others will be starting from scratch. Also widely varied is the climate for collaboration among data sources and users, including hospitals, primary and specialty care physician practices, clinical labs, pharmacies, imaging facilities, public health agencies, payers, quality monitors, and—ultimately—patients. Some forms of data exchange have begun to take root in local markets. Sixty-eight million prescriptions were ordered electronically in 2008, although this figure represents only 4 percent of total prescription volume.⁵ The nation’s large clinical laboratory chains have standardized interfaces for electronic delivery of lab results, although a majority of tests are still performed in small, independent, hospital-based labs.⁶

State grant applications were due in October 2009, and awards ranging from \$4 million to \$40 million were to be announced in December, with programs beginning in early 2010.⁷ Applications were required to include detailed strategic and operational plans. The plans must explain how states intend to align HIE activities with Medicaid and other federally funded health programs such as community health centers. The states are required to establish a collaborative governance model and a state coordinator's office. They must devise a business plan that demonstrates sustainability beyond the life of the stimulus grants. The plans must also specify how HHS-approved standards for technical interoperability will be incorporated by HIE participants, and how privacy and security safeguards will be implemented.⁸

In addition to operational challenges for the states, difficult policy questions face the federal ONC. Because functional HIEs exist in only a few locales, providers will face obstacles to earning incentive payments that are beyond their control and could thwart the purposes of the stimulus program. So in fairness, and as a practical matter, ONC's Health IT Policy Committee has discussed how it might recommend recognizing existing, ad hoc data exchange arrangements (such as e-prescribing and lab results reporting) as satisfying initial meaningful use requirements for data exchange.⁹ The potential problem with following this path is that most such arrangements are built on proprietary technology platforms that could frustrate future efforts to establish broad-based interoperability and data exchange across all systems and providers. Members of the Health IT Policy Committee report that they envision a gradual progression from 2011 to 2015 in the stringency of requirements for standardized exchange.

KEY QUESTIONS

- How has electronic data exchange been incorporated into the definition of meaningful use in the American Recovery and Reinvestment Act? What goals and outcomes are policymakers seeking to achieve by offering incentive payments to providers for participating in data exchange?
- How extensive is electronic data exchange currently in health care, both in formal health information exchange organizations (HIEs) and in limited-purpose activity such as electronic prescribing and lab results viewing? What types of data are most frequently exchanged?

- Why have HIEs been slow to form and grow? What are the obstacles to electronic data exchange generally, including privacy and security concerns, cost, and stakeholder relationships? What impact are Recovery Act incentives and infrastructure investments likely to have on participation in data exchange? Is the business case for HIEs changing?
- How can the Office of the National Coordinator (ONC) and the Centers for Medicare & Medicaid Services (CMS) balance the need to recognize existing exchange arrangements while moving toward uniform exchange standards in the future?
- What role can states play in promoting data exchange through their Medicaid programs and safety net supports? How will the costs of state HIEs be met, and what are some of the differences among state HIE plans and in states' readiness and capacity to establish HIEs?

SPEAKERS

Micky Tripathi, PhD, is president and chief executive officer of the Massachusetts eHealth Collaborative and is a consultant to a variety of health information technology organizations. He serves as co-chair of the health information exchange workgroup of the Health IT Policy Committee, which advises the U.S. Office of the National Coordinator for Health IT. **Gina Perez** is president of Advances in Management, Inc., a consulting firm that advises Delaware's Health Information Exchange Project and the Delaware Health Information Network, the nation's first statewide health information exchange (HIE). **Lammott du Pont** is senior manager at Manatt Health Solutions. He provides business and technology strategy, planning and management services, and policy and communications advice to clients in the health care industry, with an emphasis on health information technology.

ENDNOTES

1. David Blumenthal, "Stimulating the Adoption of Health Information Technology," *New England Journal of Medicine*, 360, no. 15 (April 9, 2009): pp. 1477–1479; available with subscription at <http://content.nejm.org/cgi/content/full/NEJMp0901592>.
2. See presentation of the health information exchange workgroup (slides) at the August 14, 2009, meeting of the Health IT Policy Committee (advisory committee to the U.S. Office of the National Coordinator for Health IT), especially slide number 8. Available at http://healthit.hhs.gov/portal/server.pt?open=18&objID=878091&parentname=CommunityPage&parentid=53&mode=2&in_hi_userid=11113&cached=true.

3. See transcript of report of health information exchange workgroup to the ONC Health IT Policy Committee (remarks of Deven McGraw, Micky Tripathi and committee discussion), meeting of August 14, 2009. Available at http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_11113_890820_0_0_18/HITpolicy_transcript_081409.pdf.
4. Julia Adler-Milstein, David W. Bates, and Ashish Jha, "U.S. Regional Health Information Organizations: Progress And Challenges," *Health Affairs*, 28, no. 2 (March/April 2009): pp. 483–492; available with subscription at <http://content.healthaffairs.org/cgi/content/abstract/28/2/483>.
5. SureScripts, "National Progress Report on E-Prescribing, 2008"; available at www.surescripts.com/downloads/NPR/national-progress-report.pdf.
6. See proceedings of ONC Health IT Policy Committee meeting, October 20, 2009, available at http://healthit.hhs.gov/portal/server.pt?open=512&objID=1269&&PageID=16497&mode=2&in_hi_userid=11113&cached=true.
7. William Bernstein, Helen Pfister, and Susan Ingargiola, "HITECH's State Health Information Exchange and Health IT Extension Programs: Providing Infrastructure and Support for Meaningful Use of EHRs," BNA, Inc., *Health IT Law & Industry*, November 9, 2009; available at www.manatthealthsolutions.com/publications/articles/hitech-health-information-exchange-extension-programs.html.
8. ONC, "State Health Information Exchange Cooperative Agreement Program Funding Opportunity Announcement, 2009: Appendix B," available at www.fhin.net/FHIN/workgroups/MeetingMaterials/Oct0909/StrategicAndOperationalPlanGuidance.pdf.
9. See the ONC Health IT Policy Committee transcript, August 14, 2009.