

Health Information Exchange Strategy

Claudia Williams, Director State HIE Program

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From The Office Of The National Coordinator: The Strategy For Advancing The Exchange Of Health Information

ABSTRACT Electronic health information exchange addresses a critical need in the US health care system to have information follow patients to support patient care. Today little information is shared electronically, leaving doctors without the information they need to provide the best care. With payment reforms providing a strong business driver, the demand for health information exchange is poised to grow. The Office of the National Coordinator for Health Information Technology, Department of Health and Human Services, has led the process of establishing the essential building blocks that will support health information exchange. Over the coming year, this office will develop additional policies and standards that will make information exchange easier and cheaper and facilitate its use on a broader scale.

**“ I BEAT CANCER
SO I COULD
DANCE AT MY
DAUGHTER’S
WEDDING. ”**

Dave deBronkart

Cancer Survivor / Health IT Advocate

Putting the **I** in **HealthIT**
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The Office of the National Coordinator for
Health Information Technology



ePatient Dave

Cancer Survivor and Proud Father

Little exchange occurring

- Almost three quarters of the time (73 percent) PCPs do not get discharge info within two days. Almost always sent by paper or fax (2009, Commonwealth)
- Only 19 percent of hospitals report they are sharing clinical information electronically outside system (2010, AHA)

Cost of exchange high , time to develop is long

- Interfaces cost \$5K to \$20K due to lack of standardization, implementation variability, mapping costs
- Community deployment of query-based exchange often takes years to develop

Poised to grow rapidly, spurred by new payment approaches

- New payment models are the business case for exchange
- More than 70 percent of hospitals plan to invest in HIE services (2011, CapSite)
- Number of active “private” HIE entities tripled from 52 in 2009 to 161 in 2010 (KLAS)

Many approaches and models

- In addition to RHIOs, many other approaches emerging, including local models advanced by newly emerging ACOs, exchange options offered by EHR vendors, and services provided by national exchange networks
- Seeing a full portfolio of exchange options, meeting different needs

- 1 in 5 discharged Medicare enrollees is readmitted within a month
- More than 40 percent of outpatient visits involve a transition
- Referring physicians receive feedback from consultants 55 percent of time
- Physicians make purpose of referral clear 74 percent of time

Today's Situation is Unacceptable

- Patients should not have to worry about whether their health information can be securely transferred to their point of care when they need it most
- Clinicians should not have to worry about whether they are going to be able to securely access a patient's health information when care decisions need to be made
- Health systems should not have to worry about whether they will lose business if they share patient information with their competitors
- Vendors should not have to worry about whether their systems can talk to each other

Receipt of Discharge Information by PCPs

Time Frame (n=1,442)

Less than 48 Hours

27%

2 to 4 Days

29%

5 to 14 Days

26%

15 to 30 Days

6%

More than 30 Days

1%

Rarely/Never Receive Adequate Support

6%

Not Sure/Decline to Answer

4%

Delivery Method (n=1,290)*

Fax

62%

Mail

30%

Email

8%

Remote Access

15%

Other

11%

Not Sure/ Decline to Answer

1%

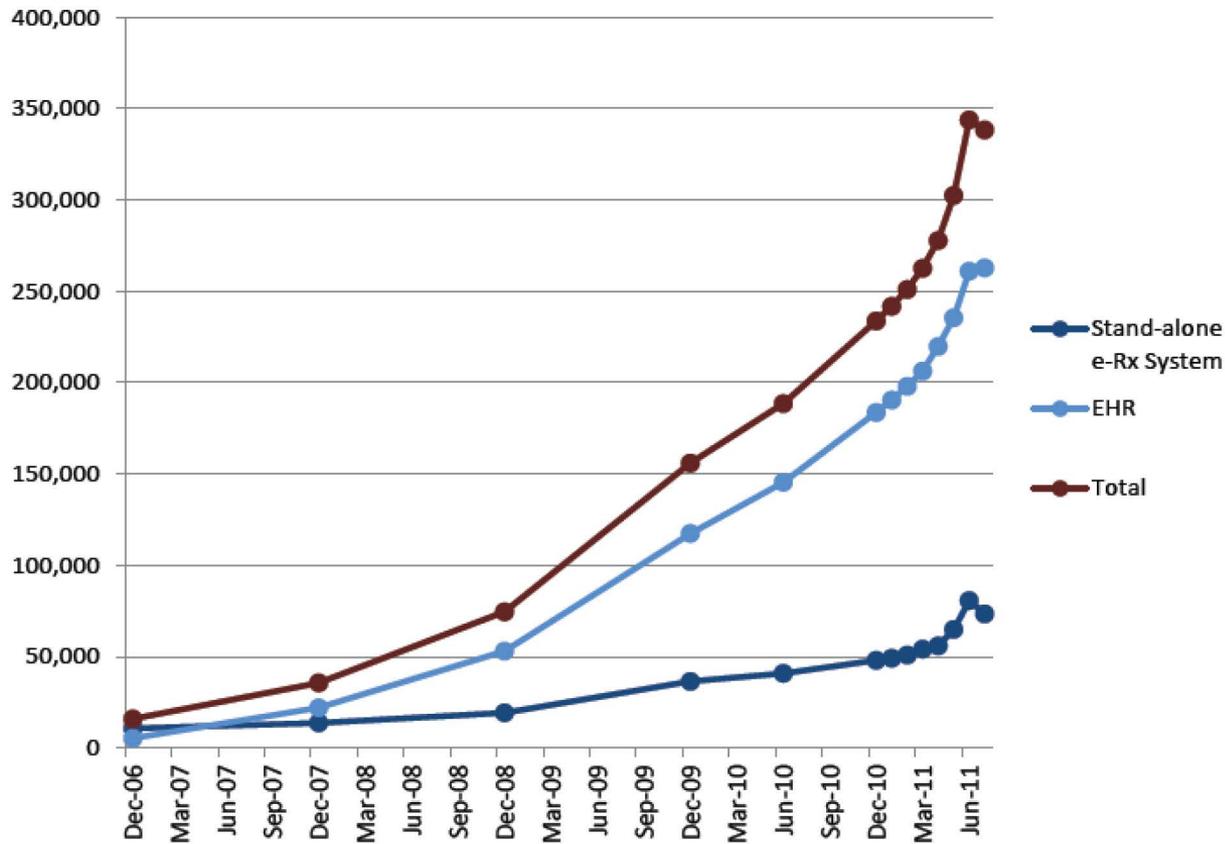
19 percent of hospitals are exchanging clinical care records with ambulatory providers outside system (2010)

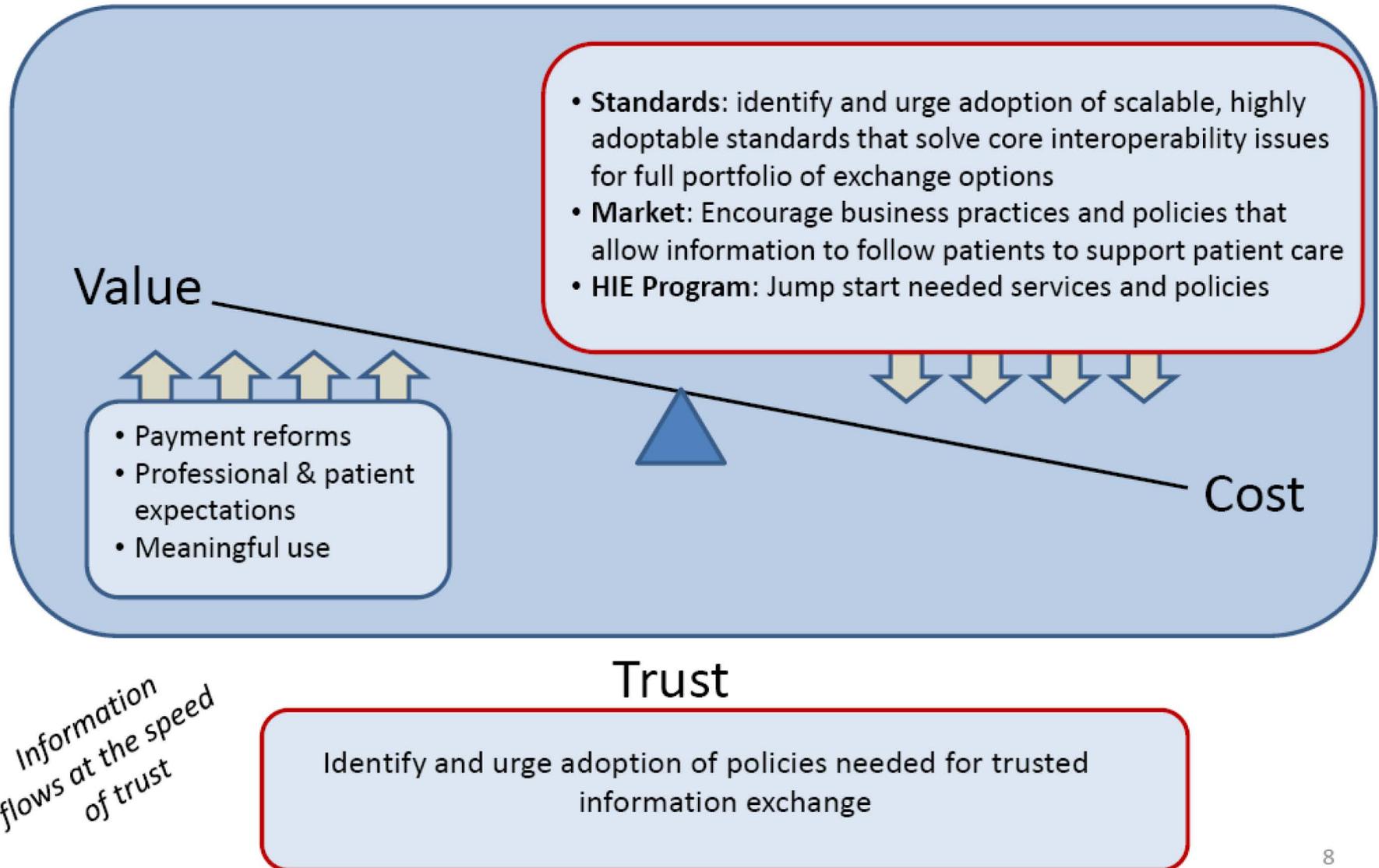
*Respondents could select multiple responses. Base excludes those who do not receive report. Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Will We Soon See this Curve?

For care summary exchange? For lab exchange?

Number of e-Prescribers in US by Method of Prescribing





What Guides Our Approach?

- **Set Clear Goals** – Success is measured by whether exchange is occurring among unaffiliated providers and with patients to support meaningful use and improved patient care
- **Orchestrate not Build** – ONC's role is not to build exchange networks but to lead the community in the development of standards, services and policies that solve core problems
- **Keep the Patient at the Center** – Providers and patients must be confident that laws, policies and processes are in place and enforced to protect the privacy and security of their electronic health information

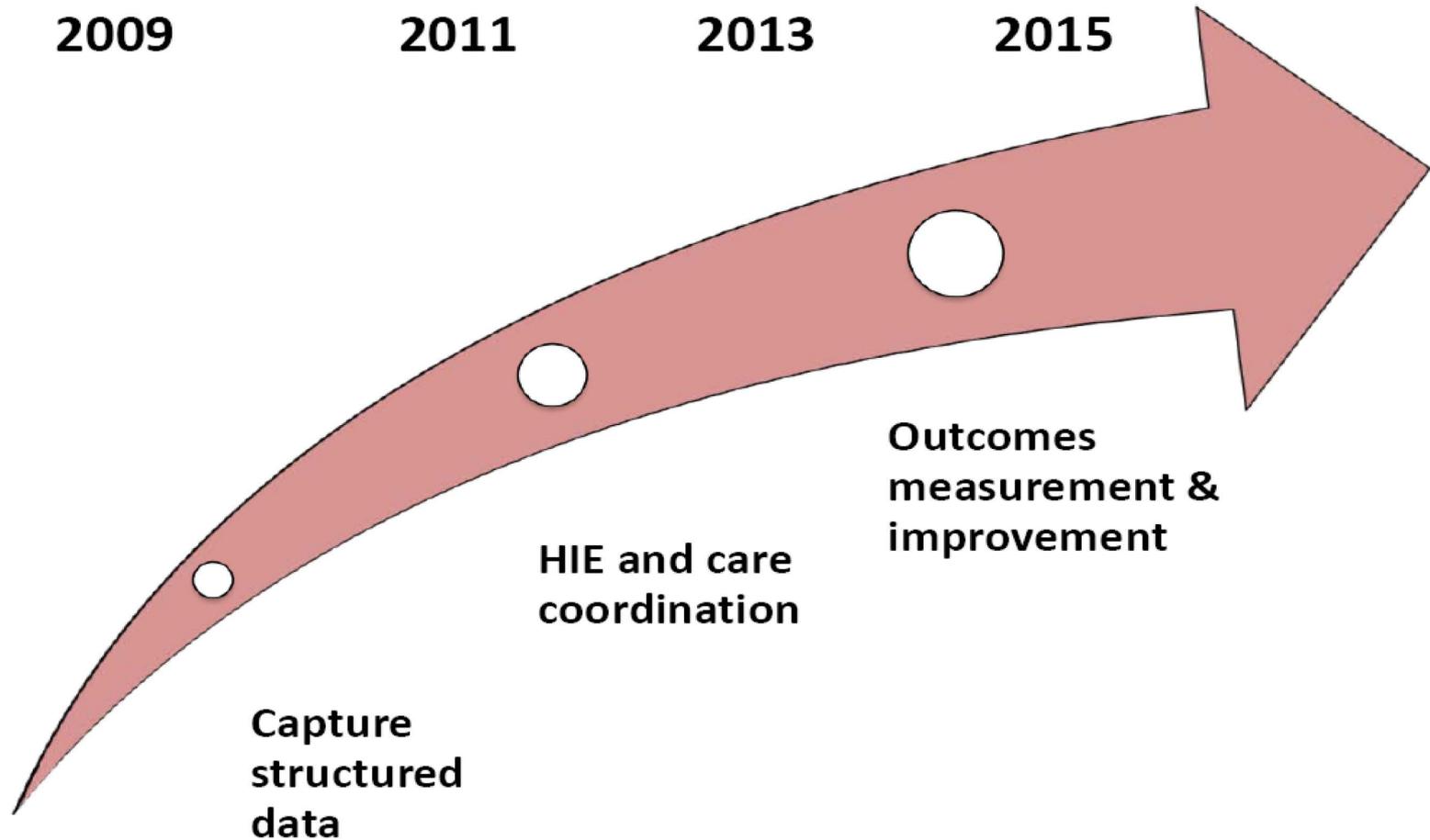
What Does it Mean to Orchestrate?

- Give everyone a pathway to participate in exchange, no matter what their level of sophistication and resources
- Acknowledge that there will be multiple networks, approaches and business models
- Take a building block approach
 - Break the problem into manageable chunks
 - Re-use building blocks across many exchange approaches
 - Middle-out approach to standards

Advancing Exchange in 2012 – Attacking on Multiple Fronts

- More rigorous exchange requirements in Stage 2 to support care coordination
- Initial standards building blocks are in place, with clear priorities to address missing pieces in 2012
- NwHIN Governance increases trust and reduces the need for one-to-one negotiations among exchange organizations
- State HIE Program jumps starts needed services and policies

More Rigorous HIE Requirements In Stage 2 Meaningful Use



Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider

Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was electronically transmitted using Certified EHR Technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender

Threshold: The percentage must be more than 10 percent in order for an EP, eligible hospital or CAH to meet this measure

The first challenge was to make sure that information produced by every EHR was understandable by another clinician and could be incorporated into his EHR

With the vocabularies, code sets and content structure standards in Stage 1 meaningful use every certified EHR can produce the standardized content needed:

- Produce and consume a standardized care summary
- Maintain standardized medication lists
- Consistently report quality measures and public health results
- Consume structured lab results

Next we needed a common approach to *transport*, allowing information to move from one point to another

- We now have two easily adopted standards for *transporting* information – NwHIN Direct and the transport protocol used in NwHIN Exchange

And it was clear that we needed more highly specified standards to support care transitions and lab results delivery

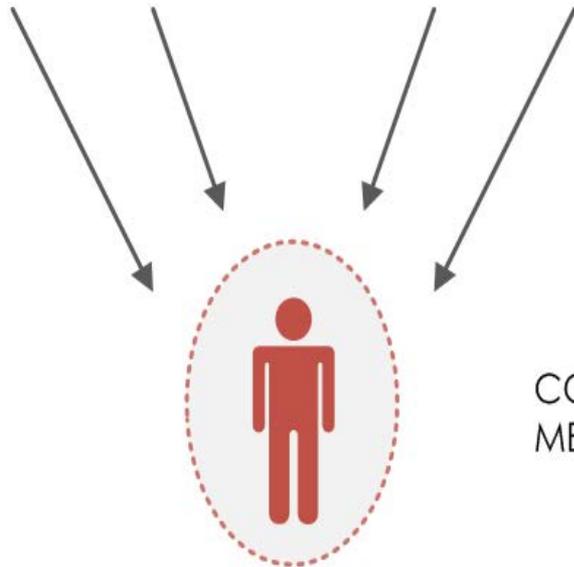
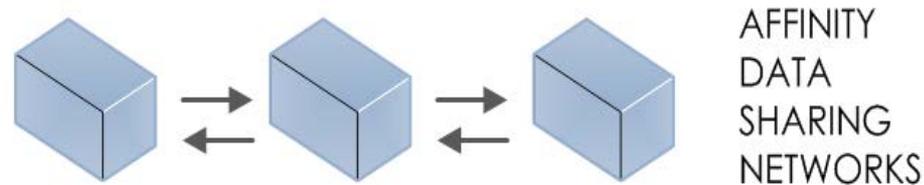
- For the first time in our country's history there is a single, broadly-supported electronic data standard for patient care transitions

This Year We Will Address the Missing Components to Support Scalable Exchange

- **Directories** – standards and policies to make them consistent, reliable, findable and open to be queried
- **Certificate management and discovery** - common guidelines for establishing and managing digital certificates and making the public keys “findable”
- **Governance** - baseline set of standards and policies that will accelerate exchange by assuring trust and reducing the cost and burden of negotiations among exchange participants

- Providers need a way to *send and receive* patient health information easily and securely, such as lab results, patient referrals and discharge summaries (i.e. **Directed Exchange**)
- Providers need a way to *find* a patient's health information for unplanned care (i.e. **Query-based Exchange**)
- Consumers need to be able to *aggregate, use and share* their own information (i.e. **Consumer-mediated Exchange**).

We Need to Reduce the Cost and Ease Adoption for All Three Forms of Exchange



Support the development and spread of exchange capabilities that help providers find information

Achieve widespread directed exchange so that every provider has way to securely send and receive electronic health Information to support better care coordination

Enable consumers to aggregate, use and share their own information

- Tremendous time and legal resources needed to craft business agreements for exchange
- Governance will provide rules of the road to guide health information exchange
- Baseline set of standard and policies to establish the foundation for trust and interoperability
- It is hoped that they will accelerate exchange and reduce the cost and burden of negotiations

- **Focus** - Give providers viable options to meet MU exchange requirements
 - E-prescribing
 - Care summary exchange
 - Lab results exchange
 - Public health reporting
 - Patient engagement
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- **Approach**
 - Make rapid progress
 - Build on existing assets and private sector investments
 - Every state different, cannot take a cookie cutter approach
 - Leverage full portfolio of national standards

Prior Assumption

Always one state-run HIE network serving majority of exchange needs of providers in the state

Focused on developing query-based exchange

Current Concept

There may be multiple exchange networks and models in a state

Key role of the state HIE program is to catalyze exchange, fill gaps and assure common trust baseline, building on the market and focusing on meaningful use

Guidance Provided in February, 2012

- When the conditions are right, we see HIT adoption progressing in a steep curve
- In 2012 we expect to see a similar progression for care summary and lab results exchange
- These are foundations requirements for meaningful use
- Every Grantee has identified and is executing the most effective strategies to make rapid progress
- Every certified EHR can produce a care summary and incorporate a structured lab result
- Payment reforms are providing new incentives, business cases and market conditions for care coordination and health information exchange

Opportunity	Strategies to Address	Number
White Space	Directed Exchange - Jumpstart low-cost directed exchange services to support meaningful use requirements	51
Duplication	Shared Services - Offer open, shared services like provider directories and identity services that can be reused	54
Information Silos	Connect the nodes - Infrastructure, standards, policies and services to connect existing exchange networks	25
Disparities	REC for HIE - Grants and technical support for CAHs, independent labs, rural pharmacies to participate in exchange	20
Emerging Networks	Support local networks – Connectivity grants and trust/standards requirements for emerging exchange entities	5
Public Health Capacity	Serve reporting needs of state - Support public health and quality reporting to state agencies	28
No Shared Trust/Interop Requirements	Accreditation and validation of exchange entities against consensus technical and policy requirements	17

- Secondary uses
- Patient matching
- Connecting exchange nodes
- Tracking sources of information
- Filtering and searching
- Automating care coordination tasks
- Provider workflow
- Liability