

Ask the HIMSS HIE Steering Committee?

Question:

The following question was posed to the *Healthcare Information Exchange Steering Committee* during the January 2008 HIMSS Chapter RHIO Liaison Roundtable meeting:

"There seems to be more consolidation of data or acceptance of standard quality indicators and performance indicators for Chronic Disease Management. Are HIEs an effective tool for Chronic Disease Management? What is the state of this and efforts nationally?"

Response:

The HIE Steering Committee believes that Chronic Disease Management (CDM) typically requires the coordination of care with one or more specialists. The average Medicare patient sees approximately 6 physician specialists annually. The recent policy efforts to coordinate chronic disease, also called Patient Medical Home (Advanced Medical Home, Patient-Centered Medical home, depending on the society that articulates the concept) recognized the need for proper IT tools and infrastructure to implement this plan. Health Information Exchanges (HIE) today provide value to physicians involved with CDM through the aggregation of data from various sources into patient registries (depending upon the disease being monitored), allowing quick and efficient retrieval and analysis of pertinent data without the effort of data re-entry and/or searching many sites.

The HIE Steering Committee views:

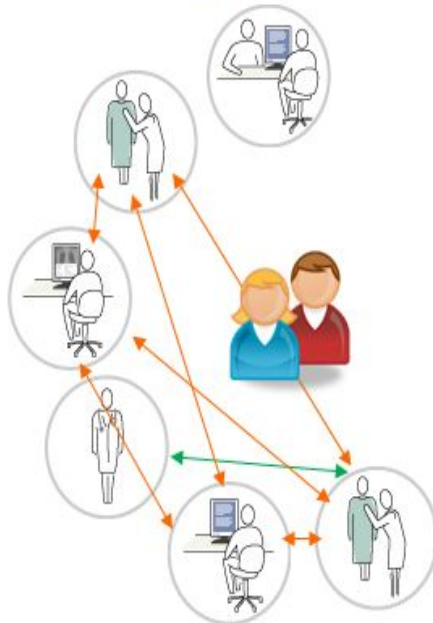
- HIEs are an enabler for effective CDM through the exchange of information across the providers. This allows the HIE to be the enabler for various caregivers to coordinate care among the specialists, the primary care physician and patient.
- HIEs would allow CDM to be implemented without providers having to implement duplicate information exchange infrastructure.
- An HIE, however, unless it is specifically designed with a CDM case management component as part of the HIE's portal solution, would not be expected to be an actual functional case management tool. There are some examples of RHIOs around the country that have blended an HIE component with a specialized hosted EHR that allows a physician to manage their patient's cases through the hosted portal. In order for this model to be fully effective, all caregivers who participate in the patient's care must either use the RHIO's hosted portal, or must be sending data to the RHIO upon completion of testing, and/or visits. The Northern Sierra Regional Health Network is an example of this kind of "specialized RHIO" that provides EHR-type functionality (www.nsrhn.org) for safety net providers in northern California.

- HIEs can also play a role in CDM as the aggregator of practice metrics (as registries do for some diseases today), where quality indicators can be derived and best practice standards can evolve.

Below is a diagram that is an example of the level of complexity of managing multiple relationships. This was presented at the IHE Showcase in 2007.

HIE enabling Care Management

The Point-to-Point Nightmare



Typical Medicare patient gets care from average of 6 specialists annually¹

“Network” costs of managing large number of potential interactions²

- 2 MD's - 1 interaction
- 4 MD's - 6 interactions
- 6 MD's – 28 interactions

1. Berenson Partnership for Solutions, 2002.
2. *Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction*, Health Affairs, Feb., 7, 2006, pg. W37

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