



## Standards Insight

### An Analysis of Health Information

### Standards Development Initiatives

May 2004

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### ***Is healthcare local? Implications for Interoperability***

Important healthcare information technology policy issues are currently being framed and debated in Washington. Two of these issues are 1) how to implement an electronic health record (EHR) system and 2) what is the national health information infrastructure (NHII)?<sup>1</sup> One would assume these issues are interrelated, and by more than the need for interoperability standards. However, they have become enmeshed in a singular approach to the problem that prevents a unified solution.

### ***Local Health Information Infrastructure as the model for the NHII***

As currently proposed, the NHII would consist of the sum of a series of interoperable local health information infrastructures (LHII). In a sense this is simply implementing the value proposition of health information exchange formulated by the Center for Information Technology Leadership (CITL), which we discussed last month.

An LHII would support the local pattern of healthcare in a community. Such an LHII would share “data” among the “local” users, including medical records, prescriptions, insurance claims or other data using national interoperability standards. At the edge of the

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<sup>1</sup> <http://www.aspe.hhs.gov/sp/nhii>

LHII, data could be exchanged with other LHII or other secondary users, such as the Centers for Disease Control. Fundamentally this approach reflects an assumption that most care-related data, like care itself, is local and that networking, registry and directory services should be optimized to efficiently provide “90 percent” of the data requests. This is not a bad system architecture for the distributed healthcare system in the U.S.

The Agency for Healthcare Research and Quality (AHRQ) is preparing to select and fund a series of demonstration projects, including LHII proposals, to determine what works in practice. Again this is not an unreasonable alternative to a top-down mandate, particularly when there is neither authority nor funding for what is sometimes referred to as “HIPAA II”.

However, this LHII model does not necessarily advance national objectives and priorities. By implementing local health data exchanges, we may produce multiple and diverse automations of our current fractured and dysfunctional system of healthcare. There are currently many proposals and demonstration projects underway for local or community health information exchanges.<sup>2</sup> Their commonality is also their diversity in terms of problems being addressed, participants, functions and approaches. Moreover none appear to have found a business model independent of grants.

Why is an LHII different than the failed community health information networks (CHINs) of the nineties? The Lorenzi report highlights accomplishments of two local health data exchanges without identifying a viable business model, absent grant funding. If we look at the parallel universe of telehealth, for example, we will find that telehealth networks are organized at state levels, partly to achieve critical clinical mass, partly because of licensure and malpractice laws, and need of state resources and backing. While these telehealth networks are years ahead of us in terms of organization, legal structure and management of their widely varying participants, they have not yet found sustaining business models for their infrastructure.

### ***A Failure of Imagination?***

A term of the day, emanating from the 9/11 Commission, is a “failure of imagination”. Are we as HCIT leaders along with our policymaking colleagues missing the point of leadership? Demonstration projects may stumble into both finding national purpose and a scalable and reproducible care delivery and business model. But is this how we should be developing a NHII? There are three further considerations necessary. First, the goal of the NHII should be to explicitly support a shared EHR for all; second, this requires a technical and business transition roadmap from our current organizations and systems; and third, meaningful IT investment may require real change and transformation of our healthcare system.

A shared and universal EHR system should be the central vision of the NHII. Infrastructure is a necessary but insufficient vision for information technology in 21<sup>st</sup> century healthcare. We should make the commitment to a shared EHR system for all, not

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<sup>2</sup> Strategies for Creating Successful Local Health Information Infrastructure Initiatives by Nancy Lorenzi from December 2003 is available at <http://aspe.hhs.gov/sp/nhii/>.

a series of local data exchanges. In fact it is the EHR system and not infrastructure, that is required for coordinated, prevention-focused, evidence-based care delivery. As we outlined in the April 2003 *Standards Insight*, an EHR system can be designed to support patient-centered care and secondary users.<sup>3</sup> As a matter of equity, access and effectiveness, this is a national objective, not a local choice.

Transition is the practical requirement. One could envision self-starting local initiatives creating healthcare information exchanges to meet their perceived needs. An LHII model that depends on fully interoperable EHR systems is both technically and practically unlikely, given current HCIT systems and standards. A ten-year adoption, as posited by CITL, may be inevitable or even optimistic. But what is the end result? Will the developing NHII be a series of local stovepipes, built for different health purposes, e.g., e-prescribing, lab reporting or eligibility checking, with different funding schemes, all contributing to a grand national patchwork? Why instead do we not commit to implementing a pilot EHR program starting with the new Medicare screening, as proposed by Newt Gingrich?<sup>4</sup> Or why not require a standard Continuity of Care Record to be generated at the conclusion of any care encounter? These projects will immediately force us to address care delivery, business and technical issues on the road to the universal EHR. That they are implemented locally, statewide or nationally is a secondary feature to being a national priority within the roadmap.

Meaningful IT investment requires real change and transformation of our healthcare system. Our current lack of a universal, shared EHR is not due to lack of technology or the cost of EHR systems. Our current model of care delivery is based on the reimbursement of autonomous providers for piecework. This results in a fractured, uncoordinated, error-prone healthcare system despite the best efforts of individual providers and healthcare organizations. Sharing an EHR in this “system” is not only financially unrewarding but unworkable in practice. In this respect we might consider healthcare transformation such as that described by Gingrich’s Center for Health Transformation or the “New Model” being advanced by the Future of Family Medicine Project Leadership Committee<sup>5</sup>. The latter group proposes that each American would have a “medical home”, which represents a relationship with an enlightened and empowered primary care physician and practice team. Clearly a shared EHR, augmented by evidence-based medicine decision support, is an enabler of this vision. Whether we collectively judge the “New Model” as a vision of 21<sup>st</sup> century healthcare or choose another, until we fix the health care system, HCIT and the NHII will be enabling solutions to the wrong problem, automating our broken system.

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<sup>3</sup> A draft White Paper “Interoperability Standards: A Barrier to HCIT Investment?” by the author is available at [www.erlinc.com](http://www.erlinc.com).

<sup>4</sup> See EHR white paper at [www.healthtransformation.net/](http://www.healthtransformation.net/)

<sup>5</sup> The Future of Family Medicine: A Collaborative Project of the Family Medicine Community. *Annals of Family Medicine*. Vol 2, Supplement 1, March/April 2004 available at [www.annfam.org](http://www.annfam.org).