



Standards Insight

An Analysis of Health Information Standards Development Initiatives

September 2004

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In July, Tommy Thompson, Secretary of Health and Human Services, kicked off the Decade of Health Information Technology at the Secretarial Summit NHII 04 Conference. Secretary Thompson infused the meeting with a sense of urgency by announcing a series of steps that the Federal government is taking to accelerate adoption of EHR systems, e-prescribing and other initiatives. The new National Coordinator for Health Information Technology, David Brailer, laid out the strategy, the *Framework for Strategic Action*, and collected reactor feedback for the balance of the three day meeting.

The Framework for Strategic Action

The centerpiece of the meeting was Dr. Brailer's introduction of the Framework for Strategic Action. The goals of the strategic framework follow:

❖ *Inform clinical practice*

Providing caregivers access to patient data whenever and wherever they need it, strengthens the need for EHR systems and their accelerated adoption through strategies of incentives and certification to reduce risks.

❖ ***Interconnect clinicians***

In order to move patient data between different EHR systems, an interoperable infrastructure at a regional and national level is needed. This infrastructure must be built on a common framework and standards.

❖ ***Personalize care***

This will be accomplished through the use of personal health records (PHR) and informed consumer choice. Paired with a strategy to extend the use of telehealth, this goal was identified to address the needs of rural providers and patients, always a key consideration in Washington.

❖ ***Improve the population health***

An infrastructure that supports interconnected and interoperable EHR systems can become a significant resource for improving population health from real time surveillance to deep clinical and public health research. This involves non-invasively extracting appropriately protected data, standardizing quality metrics and using this infrastructure to communicate research results to accelerate adoption in bedside care.

Financial Incentives

Significantly, both the Centers for Medicare and Medicaid Services (CMS) and private payer and purchasing representatives asserted their intent to provide incentives for use of EHR systems by physicians and to move to “pay for performance.” Misaligned incentives and lack of a clear return on investment (ROI) have consistently been identified as the primary limitation to widespread adoption of HIT. It also should be noted that these incentives are being targeted for physician practices, not hospitals and health systems. An order of magnitude for these incentives was discussed: \$3 to \$6 per patient visit or approximately \$7 billion dollars a year, one percent of ambulatory care spending. This proposal came from an excellent analysis by Connecting for Health.¹

Mark McClellan, the head of CMS, announced his intent to accelerate the Medicare Modernization Act (MMA) e-prescribing program by one year. Standards are needed by the end of this year in order to begin pilot programs in 2005 with a goal of implementing e-prescribing in 2006 along with the full prescription drug benefits. CMS will also sponsor a pilot Medicare portal in Indiana this year. Beneficiaries can go on line and get information about their Medicare billing and coverage. If successful, it is likely that other PHR-like functions will be added.

¹ Connecting for Health is a public private collaborative, primarily reflecting academics and other thought leaders, to advance HIT interoperability. It is sponsored by the Markle Foundation with support from the Robert Wood Johnson Foundation. Until his appointment as National Coordinator, David Brailer was member of the team that produced “Achieving Electronic Connectivity in Healthcare”. This “roadmap” is reflected in the strategic framework and is likely to inform much of the next planning steps. <http://www.connectingforhealth.org>.

Political Implications

In addition to the Administration and private sector leadership, Senator Bill Frist, the Majority Leader, Representative Nancy Johnson (R-CT), Representative Patrick Kennedy (D-RI) and former speaker Newt Gingrich participated in the Summit. Although Representative Kennedy did not speak, he has introduced recent HIT legislation. All were very positive that this was the “tipping point” and that HIT investment was essential to the future of healthcare in the United States. What none of the political leaders suggested was new funding. Senator Frist referenced the MMA as a catalyst for significantly changing Medicare into a patient-centric, consumer-driven and provider-friendly health system. His recommendations included litigation reform and tax code changes but he did not call for new funding. Representative Johnson, a strong proponent of HIT on the House Ways and Means Committee, proposed that HIT was changing Medicare, not the inverse, and strongly warned against proprietary and closed solutions. Gingrich continued his message of transformation into a smart 21st century healthcare system, beginning with the point that paper records are killing patients every day. A Gingrich recommendation, which is relevant in this election year, is to make the National Coordinator a permanent office. Currently it is established by Presidential order. Although there is an assumption that HIT investment has bi-partisan support, a change in administration could certainly impact the momentum and leadership now in place and might change directions and priorities.

What are the Next Steps?

The National Committee for Vital and Health Statistics’ (NCVHS) National Health Information Infrastructure (NHII) Workgroup held an open hearing on the last day of the conference to elicit input and feedback from attendees. In general, the feedback at the meeting was very supportive of the strategic framework and, in fact, pushed for more details and actions.

Transforming the strategic framework to actions

It was apparent at the NCVHS hearings, if not before, that Dr. Brailer’s office as well as CMS have been working on much more detailed programs than were presented in the strategic framework. We expect that much of the Connecting for Health roadmap will be adopted. The roadmap outlines a NHII based on a common framework for standards, privacy and security, but with regional governance and control. Patient data would be distributed, i.e., held by providers, but within a federated system, which shares pointers and access controls to permit authorized users to retrieve the data as needed. The roadmap also recommends that the NHII does not require a national person identifier, but rather a system for reliably identifying individuals. Reactor feedback generally supported these directions. But each, as with all of the forks in the road discussed by Connecting for Health, represents decisions that must be made. In particular, we must know if individual patient data will be aggregated into a single physical record stored in regional repositories or left distributed among networked providers. This decision greatly alters the necessary infrastructure, standards, EHR applications and business processes.

RFI for the NHII

While nine grants for local health information infrastructure (LHII) projects were announced at the conference, these “pilots and demonstration” projects had been in the works for over a year and went through without any particular alignment with the new strategic framework. More importantly, HHS plans to release an RFI this summer for a “private sector consortia that would form to plan, develop and operate a health information network” as a model for the NHII. This may be where the action is. Major IT and infrastructure vendors are forming these consortia and recruiting the major HIT application vendors. This is very much like the British National Health Services project approach.

Changes by Big Purchasers

Additionally CMS and the Office of Personnel Management, which manages the Federal employee benefits programs, have joined an alliance of private purchasers and payers to determine how best to align benefits, create incentives and pay for performance. Secretary Thompson is seeking a panel of non-health industry executives to advise him on the economics of healthcare and impact on the economy and their employees. This is likely to put pressure on both health plans and providers to accelerate their efforts to demonstrate quality and adopt HIT. But specific reimbursement changes are necessary before one can expect a significant investment in interoperable EHR systems.

Product Certification and Market Place Confusion

HIMSS, the American Health Information Management Association and the National Alliance for Health Information Technology announced their plan to create an independent consortium to certify EHR systems. One of the working assumptions is that physician practices, particularly smaller practices, want assurances that any EHR system investment will work and remain current. The flipside of all these Washington initiatives is to freeze EHR markets until it is clear what the system requirements will be to comply with changing reimbursement and quality programs. A pending product certification program will reinforce decisions to delay EHR system investments.

Bottom line

Both the strategic framework and the Connecting for Health roadmap are too high level to develop either system requirements or determine what interoperability standards are needed. The HL7 EHR System Functional model is only a draft standard for trial use. No one has used it to create a widely accepted use profile, e.g., minimum EHR system functions for a small physician practice. Meanwhile, e-prescribing, a key component of an EHR system, is being accelerated without a plan to converge the two initiatives. More detailed plans and consensus on what EHR systems must do and how they interoperate are needed. Presumably much of this will be defined as part of the RFI proposal. We must move forward with a strategic long term vision but with practical and incremental actions. It appears that these are the gating factors determining the architecture and

common framework, which probably depends on the RFI, putting provider incentives in place and defining the role of certification. That said, we believe that the strategic framework substantially addresses the checkpoints that we defined last month, and we now have a path forward.

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