



Standards Insight Summary—March 2005

Moving forward with Interoperability Standards; funding questions remain

By Ed Larsen

We have witnessed a flurry of activities surrounding the interoperable EHR and investment in healthcare information technology over the last several months. The President visited the Cleveland Clinic to reiterate his support for HCIT investment. The Centers for Medicare and Medicaid Services (CMS) issued proposed rules for not only the Medicare Part D prescription drug benefit plans but also for the “foundation” electronic prescribing standards to go into effect January 1, 2006 along with the Part D benefits.

The Office of the National Coordinator for Health Information Technology (ONCHIT) reported it received over 500 responses to its RFI for the National Health Information Network (NHIN). Connecting for Health prepared a Collaborative Response from many of the key lobbying, standards and industry associations including HIMSS. The Interoperability Consortium, composed of eight large IT companies, also submitted a response. Both recommended a decentralized approach in which electronic health record (EHR) data remained with providers, but this data would be indexed in record locator services so that other providers and authorized users could access it. Both also recommended a central standards setting body. Based on the alignment and support of the Collaborative and Consortium responses, one suspects this is the likely path forward.

Interoperability standards must be put in place if information is to be shared. We believe that Integrating the Healthcare Enterprise (IHE) is clearly demonstrating that we can move forward with existing standards to create useful clinical document and data exchange between enterprise systems. HL7 appears to be shaking off its Version 3 paralysis and again tackling big problems. Although Version 3 remains its future, HL7 is focused on three major projects: completing the EHR system functional model, fulfilling the NLM EHR transfer contract and reconciling terminology and information models. Each is a necessary component of the shared EHR and NHIN.

We have observed less progress in resolving funding issues both for a healthcare organization’s EHR system and for the infrastructure. Most health systems have already made the business case for EHR systems and two-thirds will have them operational within three years. The point of concern is physician

practices, particularly small practices, which do not have the funds, IT resources or potential cost savings to invest in EHR systems. Here we need the payers, led by CMS, to determine that it is in their own and their stakeholders' interest to require and pay for EHR systems.

The infrastructure is a different economic proposition. Ultimately, the costs of the infrastructure will be borne by the users through "use/subscription tax" in the same way as the Internet is funded. But the Federal government must make the initial investment and assume the start-up project risks. Otherwise, there will be uneven, inequitable and incompatible local health information networks arising. Moreover, given the many community "pilots" already in progress, prompt pre-emptive action by the Federal government is imperative.

We look to the Commission on Systemic Interoperability (CSI) for help in addressing the funding gap. CSI can use its independent position and its report to the President and Congress to step up and make the argument for Federal funds to create the infrastructure and for CMS to aggressively pay providers to invest in interoperable EHR systems.

We are seeing real progress on many fronts and are beginning to see how we can move forward. However, we have not seen similar progress on funding the infrastructure or aligning incentives to establish viable business cases. At some point, this gap will either grotesquely misshape the implementation plans in order to do it on the cheap or will derail meaningful progress.

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