Department of Health & Human Services
Office of the National Coordinator for
Health Information Technology

HIT Policy Committee

Health Information Exchange Workgroup

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Information Exchange Workgroup Members

Co-Chairs:

- Deven McGraw, Center for Democracy & Technology
- Micky Tripathi, Massachusetts eHealth Collaborative
- **Members:**
- Judith Faulkner, Epic Systems Corp.
- Connie Delaney, University of Minnesota, School of Nursing
- Gayle Harrell, Former Florida State Legislator
- Charles Kennedy, WellPoint, Inc.
- Frank Nemec, Gastroenterology Associates, Inc.
- Michael Klag, Johns Hopkins University, Bloomberg School of Public Health
- Latanya Sweeney, Carnegie-Mellon University
- Martin Laventure, Minnesota Public Health
- Dave Goetz, Tennessee Department of Finance and Administration
- Jonah Frolich, California Health & Human Services Agency
- Steve Stack, American Medical Association

ONC Lead:

- Kelly Cronin

Agenda

- Health information exchange today
- Barriers that prevent the market from moving forward
- Why federal intervention is needed
- What type of federal intervention would be most beneficial
- Recommendations

The state of health information exchange today

- **Health reform goals of higher-quality, more affordable care will not be met without broader and deeper information exchange across the entire health delivery system**
- **The current state of health information exchange today is spotty and piecemeal**
  - **The vast majority occurs in a narrow set of transaction silos, such as labs and medication prescriptions, and even here, penetration is very low (4% of eligible prescriptions and 12% of office-based prescribers, for example)**
  - **Direct exchange of data between EHRs and exchange through organized state/regional health information exchange entities also occurs, but penetration is extremely low and highly variable across implementations**
  - **Electronic reporting for public and population health measurement and improvement is almost non-existent in the market today**

Health information exchange occurs in the market today, but penetration is very low and non-uniform

Barriers that prevent the market from moving forward

- **The main barriers to health information exchange today are:**
  - **Too much uncertainty about legal issues**
  - **Too little business and clinical imperative to exchange more information**
  - **Too much technical and organizational difficulty of setting up and maintaining business- and clinically-relevant electronic exchange**
- **Getting over these barriers will require:**
  - **Incentives and/or penalties to help increase business demand for exchange and encourage a plurality of exchange architectures that are cost-effective and sustainable**
  - **Actionable standards**
  - **Monitoring and enforcement mechanisms to ensure adherence to standards**

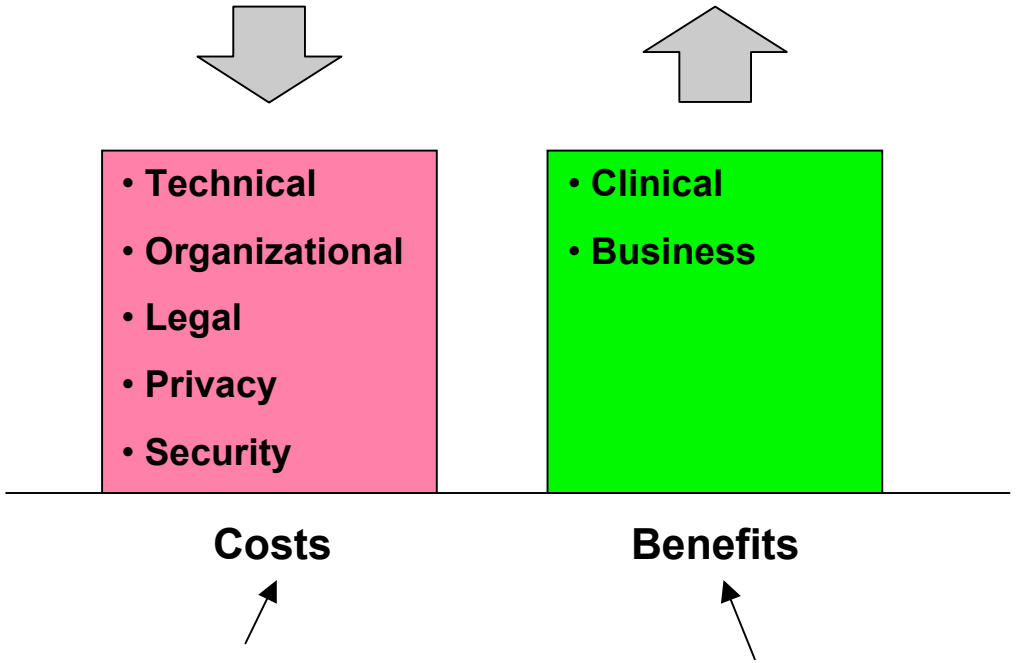
There are many barriers to health information exchange today, and there is thus no single solution to getting more exchange

If implemented judiciously, ARRA funding can help create a value proposition for health exchange

Need to either lower the technical, organization, and/or legal costs…

and/or

…raise the clinical and business imperative for more exchange



Certification, grants to states, RHITECs, and NHIN governance authority can all help to lower the difficulty of health exchange…

…whereas incentive payments (and penalties) tied to Meaningful Use can create a business imperative for more information exchange

Of all of the tools provided by ARRA, MU incentives are the most powerful lever of change

- Of the various levers available to the government, Meaningful Use criteria are by far the most influential
  - ~$45B in incentives vs ~2B in discretionary ONC programs
  - Directly affects the value proposition at the point of purchase
- While ONC doesn't have the ultimate decision on incentive criteria, it can create enablers for robust incentive criteria that would inform and allow robust incentive rules requiring health exchange
  - Meaningful use criteria (objectives and measures) that require standards-based exchange
  - Definition of core requirements for exchange to meet recommended meaningful use criteria
  - Certification of interoperability components that adhere to such requirements

Strength of health exchange objectives in current version of MU rises substantially by 2013

Meaningful Use objectives requiring health exchange

2011

- Lab results delivery
- Prescribing
- Claims and eligibility checking
- Quality & immunization reporting, if available

Increases volume of transactions that are most commonly happening today

- Lab to provider
- Provider to pharmacy

2013

- Registry reporting and reporting to public health
- Electronic ordering
- Health summaries for continuity of care
- Receive public health alerts
- Home monitoring
- Populate PHRs

Substantially steps up exchange

- Provider to lab
- Pharmacy to provider
- Office to hospital & vice versa
- Office to office
- Hospital/office to public health & vice versa
- Hospital to patient
- Office to patient & vice versa
- Hospital/office to reporting entities

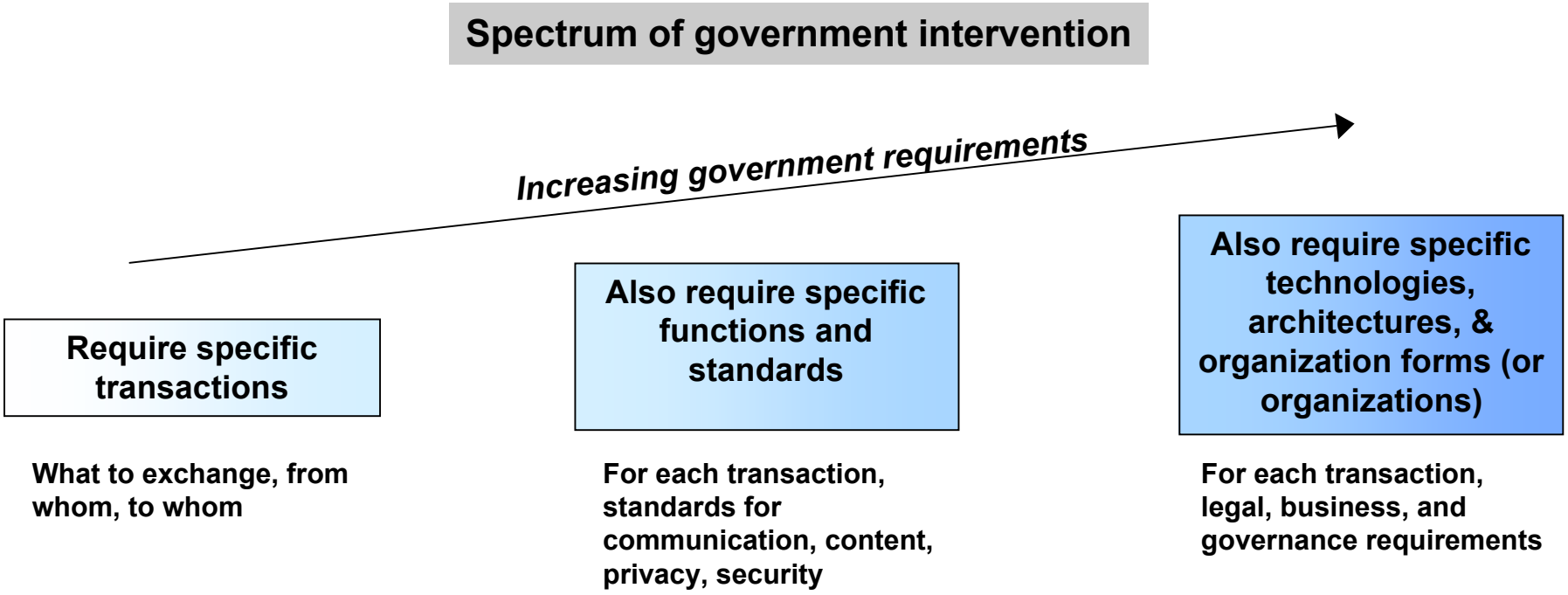
2015

- Access comprehensive data from all available sources
- Experience of care reporting
- Medical device interoperability

Starts to envision routine availability of relatively rich exchange transactions

- "Anyone to anyone"
- Patient to reporting entities

How much intervention should be applied to facilitate achievement of these MU objectives?



- Want to strike balance
  - Too little structure would do nothing to resolve some of the significant barriers that exist today
  - Too much structure would stifle innovation by locking in what exists today and artificially channeling product development toward specific technologies or architectures

Recommendations

Information exchange requirements	There should be core information exchange requirements that are technology- and architecture-neutral and would apply to all participants seeking to demonstrate meaningful use to CMS
Core Requirements	Consistent with the recommendations of the Certification Workgroup, these core requirements should be focused on the capability to achieve meaningful use and include interoperability, privacy, and security
Certification of interoperability components	Federal government should certify EHR and health information exchange components on these core requirements to ease burden on eligible professionals and hospitals for meeting and demonstrating adherence with meaningful use requirements
Aligning federal and state efforts and bringing existing efforts into alignment	Federal and state-government approaches should be complementary, and grants to states should require alignment with federal meaningful use objectives and measures

Additional Points

- **Setting criteria that all systems and components must meet allows eligible professionals and hospitals to have a choice among models of exchange while still qualifying for meaningful use incentives (for example, direct or through vendor-specific or transaction-specific hubs, or through national or subnational networks (HIOs)). For example:**
  - **Certified EHRs with robust interoperability standards**
  - **Certified components that have to meet same interoperability standards in order to allow space for market innovation and address transition from non-certified legacy systems**
- **Systems not seeking or required to be certified would have market incentives to adopt in order to be able to exchange data with certified systems or through certified components**
- **Consistent with Certification Workgroup recommendations, should be tied to capability to exchange to meet meaningful use criteria in 2011, with a clear pathway to more robust exchange in 2013 and 2015**

Additional Points

- Core requirements should be focused on exchange required to meet meaningful use and should include interoperability, privacy, and security
- (1) Interoperability – a basic level of the transport/communication, package and content standards that are necessary to ensure exchange can occur
  - Top priority: transport/communication standards plus container/envelope standards for key clinical payloads so all can at least send and receive human readable data
  - Top priority: measure definitions and semantic standards for clinical data required for 2011 CMS and public health reporting
- (2) Privacy and (3) Security
  - Meet requirements of current law & those enacted in ARRA that will need to be implemented over the next 1-3 years
- Policy Committee has a role to play in shaping these requirements and should provide clear guidance to the Standards Committee

Additional Points – Federal/State Interplay

- States may impose state-level requirements on information exchange to satisfy state-level meaningful use definitions. Such requirements should be complementary to federal efforts
- To qualify for meaningful use, information exchange in a state must meet federal requirements to qualify for Medicare meaningful use payments, and may also be required by a state to meet state-level requirements for receipt of Medicaid meaningful use payments
- The federal definitions and requirements of meaningful use should be a “floor” for state-level Medicaid meaningful use requirements

Clarification: Certification and HIOs

- We are not recommending a separate certification pathway for HIOS, with separate HIO standards
- We are recommending that health information exchange components be certified
- One role that HIOs have played in the past and may continue to play in the future -- along with other technologies such as those supplied by EHR vendors and new technologies still to come -- is providing the components that enable heterogeneous providers and systems to more easily exchange data