Health IT Policy Committee (HITPC) and HIT Standards Committee (HITSC)
Joint Public Hearing on Health Information Exchange
Panel 2: Technical and Business Barriers and Opportunities
January 29, 2013
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Thank you for the opportunity to contribute to the important dialogue on advancing health information exchange (HIE). The focus of my comments is on technical and business barriers and opportunities. I will attempt to respond to specific but not all questions posed to this panel within a narrative format which I believe will be more meaningful than a strict question and answer presentation.

As a matter of introduction, I have been CIO of Sharp HealthCare since 1996. Sharp is a leading San Diego County, California integrated delivery network, with more than 2,000 hospital beds, 15,000 employees, two organized medical groups, a health plan and 2,500 physicians on our medical staffs including the approximately 1,200 medical group physicians. Since California law prohibits the employment of physicians to provide patient care and we are not an academic setting, all our physicians are considered voluntary. As an early "hotbed" of managed care our patient population still includes approximately 280,000 patients covered on a capitated basis under contracts with several health plans. We are one of the Pioneer Accountable Care Organizations (ACO's) with approximately 32,000 attributed lives and have ACO agreements with two commercial health plans covering about 20,000 additional patients. We proudly received the Malcolm Baldrige National Quality Award in 2007. Our E.H.R. platform is primarily Cerner Millennium in the hospitals and Allscripts Enterprise in the medical groups. We are implementing a dbMotion enterprise HIE, intending to offer information exchange to all physicians serving our hospitals and to others through the community exchange under development. (Please note that I use 'HIE' as both noun and verb in this paper.)

I have actively engaged in HIE education, promotion and planning efforts since the appointment of the first National Coordinator in 2004. I have been a member of the CHIME Policy Steering Committee and its predecessor groups since their formation in 2004 and chaired the group in 2005. Sharp hosted one of the first ONC Town Hall meetings directed at HIE (then RHIO's) in the Fall of 2004. In 2005 I led a series of CHIME one-day HIE educational forums and co-chaired the CalRHIO Technical Planning Work Group. In 2009 I participated in California's HITECH operational planning and co-chaired the Regional Extension Center workgroup. I have served on the San Diego Beacon advisory group since 2010 and today serve as Board member and treasurer of the successor San Diego Regional HIE. I also currently serve on the Board and HIE Learning Network Leadership Council of the National eHealth Collaborative.

A great deal of progress has been made in E.H.R. adoption since the HITECH passage in 2009. While many providers, like Sharp, were implementing E.H.R. programs well ahead of HITECH, many other hospitals and physicians have since moved ahead with new or replacement systems. In San Diego all

hospitals and larger medical groups have implemented or are in some stage of implementing certified E.H.R.'s, while a significant gap remains among small physician practices. While the E.H.R. is not the specific topic of this hearing, it is important to note the barriers to HIE related to incomplete and unspecific interoperability standards and the cost of interfacing the E.H.R. with the HIE. It is not uncommon for providers to report interface cost quotes in the $5,000 - $10,000 and higher range, with some reported as high as $20,000, while vendors comment that every interface is different and requires custom development. Small practices just cannot afford such costs.

Despite significant federal investment, HIE is still in its infancy. There are few successful operating HIE's that can be readily replicated from community to community in our "all healthcare is local" environment. Few HIE's have attained a sustainable financial model. The lack of mature, agreed standards around interfaces, patient consent and patient identification are significant barriers to success. ONC is commended for its manner of nurturing the HIE space – narrowing the range of acceptable standards in moving to Stage Two of Meaningful Use, yet flexibly recognizing the role of both Exchange and Direct protocols, and Enterprise and Community operating models. However, the relatively short period of the HITECH funding necessarily resulted in many HIE pilots occurring simultaneously with limited opportunity for best practice models to emerge and be imitated across the industry or learning networks to share the better experiences among them.

While it is convenient to view HIE with trepidation as a Meaningful Use requirement in a regulatory sense, it is more productive to view it as a necessary enabler of health reform. The short list of ACO information technology requirements should include a master person index, E.H.R., analytics engine, patient portal and HIE. Information exchange is fundamental to ACO's, the patient-centered medical home, population health management and such similar care concepts. The highest quality, most cost-effective patient care requires a complete and accurate health record, based on consistent data definitions and patient identification. The health reform carrot may well be more effective than the regulatory stick in furthering HIE adoption.

With E.H.R. and HIE adoption occurring in parallel and without solid interoperability standards, it is inevitable that we are creating many of the data 'silos' we had hoped to avoid. Waiting for complete and perfect interoperability before implementing the first E.H.R. would have been unrealistic. The optimal course of action today is to remove barriers and facilitate the evolution. ONC can continue to nurture the maturation of HIE in a number of ways:

- Reinforce and refine the standards now promulgated in Meaningful Use Stage Two and the 2014 Certified E.H.R. definition. Allow both vendors and providers the opportunity to implement the standards in an orderly manner, limiting change to what is absolutely necessary to correct errors or recognize new medical practice. Ensure that future standards and certification requirements enable complete interoperability from the source E.H.R. to the destination E.H.R. in a manner that the received data becomes actionable in the receiving E.H.R..
    - As standards become truly standard, expect interface costs to come down.
    - Consider publishing each vendor's interface fees on a web site.

- Continue to emphasize HIE, not the manner of performing HIE, as the goal, recognizing diverse community-specific care models, I.T. infrastructures and politics.
    - Direct and Exchange protocols
    - Community, Enterprise and Commercial operating and business models
- Ensure that transaction types and outcomes indicators of the various federal programs and similar accountable care programs are consistently defined and can be reasonably automated. Work with vendors and providers for agreement on the appropriate indicators and reasonable implementation timetables. While this recommendation more closely relates to the E.H.R. itself, the data must be interoperable among ACO partners. Additionally, excess effort with such outcomes indicators impacts H.I.E. as such effort diverts resource that might be otherwise employed at HIE. It is a significant problem today.
- A complete and accurate patient record is essential to all of health reform. Accurate patient identification is fundamental to the HIE enabling such complete and accurate record. ONC should take every possible avenue to develop methodologies that achieve accurate patient identification at an optimal cost. While many favor a uniform patient identifier as the most reliable alternative, the industry will benefit from the methodology that is proven to yield highly reliable identification without requiring the patient to be present with a personal identifier at the time disparate records are matched.
- HIE organizations must achieve financial sustainability through revenues generated in their own communities, absent outside subsidies. ONC should direct discretionary grant resources elsewhere.
- Focus future HIE investments on continued standards development, solutions to the patient identification conundrum, refinement of electronically-captured outcomes measures, evaluation of the numerous programs previously funded under HITECH to identify any true, replicable successes and similar activities furthering or promoting HIE. Fund and engage learning networks for promulgation of identified best practices.
- Convene an industry panel to establish a uniform set of HIE performance parameters that address quality, service and cost. Encourage voluntary reporting into a national database and publish best results to foster improvement.
- ONC identifies a great deal of innovative technology in the normal course of business. Following successful proofs of concept it is tempting to oversimplify and underestimate the time and effort for hardening, interfacing with legacy systems and achieving widespread adoption. As a matter of practice ONC should convene forums of innovator, legacy software vendors and providers to realistically assess feasibility, cost and implementation/adoption cycles before proceeding beyond proof of concept.

With E.H.R. adoption proceeding rapidly, HIE is the necessary element to support high quality, affordable collaborative care. Until recently the challenges and timetable to achieve widespread HIE were greatly underestimated, and it will probably require another 3-5 years until HIE becomes pervasive. The amalgam of health reform carrot, meaningful use stick and ONC as catalyst will ensure the progress.