Panel 2: Exchange Service Providers Questions

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In addition to specific answers to your questions, I've attached an Interoperability Status report from the Epic customer community as of July 2014 as reference.

- What exchange use cases do you support? What challenges are inhibiting or slowing your ability to broadly deploy/support these use cases?

  Often when we discuss interoperability we focus on the more narrow use case of patient summary document exchange. Before that discussion, I'd like to address the broader definition of interoperability.

  Epic maintains strong support for traditional interfacing within health systems to third party modular systems. These interfaces connect customers to pharmacies, specialty and immunization registries, lab systems, radiology systems, billing systems, etc. Epic interfaces take many forms, ranging from HL7 version 2 and 3 feeds, NCPDP transactions, ANSI X12 transactions, to web services, to public APIs for consumer apps. Today we process over 20+ billion data transactions a year through 12,000+ interfaces between Epic and 600+ other vendors' systems as well as:

  - 88 Public Health Agencies
  - 18 Research Societies
  - 51 Immunization Registries across 46 states
  - 17 Research Registries

  For Meaningful Use planned transitions of care exchanges we support the ONC S&I Framework Direct protocol.

  Additionally, for broader uses of planned and unplanned exchange of patient summary documents Epic supports the eHealth Exchange standards which allow CCDA and CDA exchange with a wide variety of trading partners including the Federal government (VA, DoD and SSA). The Epic Care Everywhere network uses these standards and sees over 4.6 million exchanges per month and growing fast.

  We currently exchange approximately 480,000 CCDA documents with other vendor products per month. This number is also growing rapidly as other vendor products become exchange ready under Meaningful Use Stage 2 certification and their customers are mandated to share their data.

  Users of our software that participate in this type of exchange operate in all 50 states and include over 900 hospitals and 20,000 clinics. Another 85 hospitals and 3,000 clinics are installing. Participants exchange with each other as well as:

  - EHRs developed by 26 vendors including all of our major competitors
  - 21 Health Information Exchanges (HIEs)
  - 29 Health Information Service Providers (HISPs)
  - 28 eHealth Exchange members with 20 more installing

This includes the Department of Veterans Affairs, the Social Security Administration and the Department of Defense. According to HealtheWay, more Epic users are connected to the VA than users of any other vendor.

eHealth Exchange standards allow Epic users comprehensive support for the "Query or Pull" model of exchange. When a patient presents unexpectedly at an emergency department, the EHR can query for her record from another health system and then pull the information into the local EHR. The Direct standard supports the "Push" model of exchange where a primary care physician would push a summary of a patient record to a specialist that she is referring her patient to for care. In addition, we also support our customers as they are required to push every encounter to a private, local or state-based HIE.

Impediments to broader and faster adoption of interoperability: Our data show that the lack of the following items impedes broad scale interoperability:

- Point of care authorizations
- Phone book containing all exchange-ready participants
- Single trust authority
- Simplified governance when patient data is ONLY used for treatment
- Stronger ONC support for the eHealth Exchange which supports unplanned transitions of care

Implementing a simple phone book, certificate authority, and including Rules of the Road as an automatic part of Epic implementations beginning in 2007 has been instrumental in achieving industry-leading levels of standards based interoperability among the Epic user community. A national effort around these items would dramatically increase broad adoption of interoperability across the nation.

In the last 12 months, the Epic user community has done 29,000,000 standards-based exchanges of patient records and our projections for this time next year look to be in the 60,000,000 range as more standards-compliant systems come on line with Meaningful Use requirements for users of those systems to share their data.

We suggest that full support in Meaningful Use Stage 3 for unplanned transitions of care using the established standards of the eHealth Exchange (run by HealtheWay) would further advance the nation's information exchange.

- What policy, trust, and technical requirements do you require be met before agreeing to exchange with another exchange service provider? What if any assurances do you require that your trading partners are adhering to these requirements?

  Our customers each make their own decisions in what requirements must be met since they will ultimately be held accountable for protecting the PHI in their custody. Generally, trading partners must:

  1. Have systems that can communicate securely using appropriate standards.
  2. Sign on to Rules of the Road, which govern appropriate use of the exchange. Currently rules and assurances vary – they can be one to one relationships, regional HIE

membership agreements, or built into joining large exchange networks, like the eHealth Exchange, Surescripts CI Network, and the Care Everywhere network.

3. Monitor and control appropriate use of and access to the exchange.

Appropriate trading partners are validating using digital certificates.

Being able to trust the identity and commitment to protect health information is a key aspect of exchange. We strongly suggest ONC and CMS simplify and eliminate any economic barriers to establishing such trust. Currently, organizations that deliver healthcare are not always able to afford options such as DirectTrust, which is priced for large scale HIEs or HISPs, to validate their identities. We recommend that ONC consider supporting a simplified and vibrant market that competes on cost to provide trust validation services to individual provider organizations. A plurality of trust verification services would be in the best interest of accelerating exchange.

An additional aspect that could either accelerate or impede national interoperability is the management of consent and record segmentation. We strongly recommend that ONC push for a simple entire opt in or opt out for patient control of interoperability. Should a patient desire a more fine-grained approach to sharing only selected portions of his record, risking significantly reduced physician trust in interoperability, he could use PHRs to control exchange of a subset of his records. To impose a higher degree of segmentation on the medical community would dramatically impede interoperability at this time. In addition, further facilitating patients to consent at the point of care, using language drafted by the record holder, will be important to enhancing national interoperability, especially in unplanned transitions such as emergency department visits.

- What factors are limiting the exchange of health information?

  Our customers have reported that state and local HIEs have asked for significant payments that are not aligned with their use of or need for such HIE services given that they can also connect directly with other providers to share information on patients they both treat.

  Some of these HIEs seek legislative support to control public health and immunization registries forcing all participants to pay the full HIE fee even if only the immunization registry access is needed.

  We strongly recommend that states provide immunization and public health reporting as free services supported by the state without requirements to pay for the use of a single monopolistic HIE in order to comply with Meaningful Use. If states choose not to do so, then ONC and CMS should consider that as an exception for those specific MU requirements for those health systems that operate in those states.

  As described above, a national phone book of exchange-ready organizations and providers, a simplified and affordable trust validation service and straight-forward Rules of the Road would dramatically improve exchange.

- What, if any, actions should be taken at the national level to help address the governance challenges that are inhibiting the exchange of health information across entities or to mitigate risks to patient safety and/or privacy when exchange is occurring? What role should ONC or

other federal agencies play? What role should states play? What role should the private sector play?

Create a national phone book of Meaningful Use participants as a requirement of receiving stimulus payments. Also permit organizations or individuals who do not participate in Meaningful Use to voluntarily submit their addresses.

Create a simple and affordable trust model to bring down the cost of trust validation as compared to the more expensive HIE and HISP model currently supported by DirectTrust.

Create a simple Meaningful Use Rules of the Road for data exchange strictly for use in treatment. Protecting PHI from secondary use and sale will increase patients' trust in a national system of exchange.

Do not complicate exchange with artificially complex segmentation rules, given that the vast majority of those who currently use exchange services have chosen to share their entire record.

- Would it be beneficial if ONC monitored the information exchange market to identify successes, challenges, and abuses? If so, what methods of monitoring would be effective; and, what actions should ONC take based upon findings from monitoring?

  The presumption of abuse by vendors seems to be based on a false and disingenuous narrative of unidentified origin. We strongly recommend ONC exercise extreme care in differentiating political agendas and commercial competition from actual facts and real accomplishments in this area at this important time in our healthcare system's evolution.

  There are already control mechanisms in place for the Meaningful Use and ONC certification programs. Existing mechanisms should be deployed conscientiously and fairly without introducing unnecessary additional mechanisms.

  CMS has required a 10 % transition of care exchange rate to comply with Stage 2. CMS's current Meaningful Use audit process should be sufficient to identify fraud in the EHR incentive program.

  Regarding certification, should an EHR product not be able to demonstrate compliance with 2014 Edition criteria, then the product will not be certified.

  Should a healthcare organization not meet the MU requirements, they should not be paid any incentive and should have appropriately reduced payments based on the original HITECH legislation.

  We'd recommend that healthcare systems be allowed to voluntarily report their interoperability statistics to ONC. Many healthcare systems would not consider this a burden and would like to educate ONC and other government agencies about the current state of interoperability in the country.