Moving the Needle on Interoperable Health Information Technology

PART 2 OF *IMPLEMENTING HEALTH SYSTEM IMPROVEMENT*

PREAMBLE

During the 2016 election season, the Council of Accountable Physician Practices (CAPP) urged political candidates at all levels to focus on three critical health policy issues to support a better health care delivery system.[1] These issues – or platforms – can support a better health care delivery system and should be at the top of every policymaker's and thought leader's health care agenda:

- **IMPROVED AND HARMONIZED QUALITY MEASUREMENT AND REPORTING**

- **ROBUST AND COORDINATED USE OF HEALTH INFORMATION TECHNOLOGY**

- **VALUE-BASED PAYMENT**

In this brief, the second in a three-part series entitled "Implementing Health System Improvement," the physician leaders of CAPP provide more detailed guidance to elected officials, members of the administration, and other thought leaders about how to move forward on one of these issues: coordinated use of health information technology, focusing specifically on interoperability.

KEY POINTS

- Fragmentation in the U.S. health care delivery system is perpetuated by a lack of interoperability in our health information technology (HIT) systems. Different HIT vendors' systems were not designed to speak to one another, and, as a result, information about a single patient may be scattered across multiple health systems and providers. In the absence of easily accessible and complete information about patients, health care providers are challenged in their efforts to coordinate care, eliminate redundancy, and ensure positive health outcomes.

- With the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, Congress ensured that nearly every doctor and hospital in the country now has an electronic health record (EHR). But the Act did not go far enough, focusing too narrowly on electronic recordkeeping, rather than on the

meaningful sharing of information. The result has been an increased administrative burden for health care providers without a concomitant improvement in the flow of information throughout the delivery system.

- A patient- or consumer-centered view of HIT is critical to advancing interoperability. Stakeholders must agree that health information belongs, first and foremost, to the patient, not to the provider or EHR vendor. Accordingly, full information must follow patients – and be readily available to them wherever they receive care.

- Policymakers can help accelerate the movement toward interoperability by continuing to play the role of convener, bringing stakeholders together to find solutions to issues such as improved metrics of EHR functionality, reducing providers' documentation burden, and implementation of unique patient identifiers.

- In addition, as the Office of the National Coordinator for Health Information Technology moves forward with implementation of Meaningful Use Stage 3, the agency should shift its focus from interoperability process measures (e.g., counting the number of times mandated standards are used) to outcomes measures, such as whether all necessary patient information is available at the point of care.

INTRODUCTION: INFORMATION TECHNOLOGY MUST HELP US SEE THE WHOLE OF HEALTH CARE

One of the greatest threats to our country's health care system – and indeed to our health – is our continued, collective inability to view health care as a whole, rather than as a series of loosely-connected pieces and transactions. This fragmented approach to care is perpetuated, to a great extent, by fee-for-service payment that rewards volume over value. However, payment alone is not to blame. In part, we can't view health care as a whole because there is no part of the system that has the technical capacity *literally to see it all*. With few exceptions, each doctor, hospital, pharmacy and health plan has access to only a limited piece of the picture of a patient's care experience.

With the passage and rollout of the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, Congress ensured that the overwhelming majority of physicians and hospitals now use electronic health records (EHRs)[2] – a remarkable achievement, giving providers access to necessary information at the point of care. But the HITECH Act did not ensure that such information painted a complete clinical picture. Different vendors' systems were not required to speak to one another, and so, naturally, they didn't. As a result, relevant information about a single patient may be scattered across multiple health systems and providers – not to mention stored in the patient's own electronic device or personal records – and there is no way to bring it all together. Without complete information, the health system is hampered in efforts to keep patients safe, eliminate wasteful and redundant care and ensure positive health outcomes.

This brief represents the insights of the Council of Accountable Physician Practices (CAPP), a coalition of America's highest-performing medical groups and health systems. Care coordination, and the sharing of information upon which it depends, are deeply ingrained in the infrastructures of the CAPP member groups. Many of us have strong cultural and organizational ties to hospitals and other partners, which have allowed us to develop interoperable HIT across the spectrum of

care within our systems. Others of us operate in geographic areas where many providers use a single EHR vendor, thus allowing a certain level of interoperability among systems. But the kind of interoperability upon which we and our patients rely is far too scarce around the country.

Smaller physician groups in particular – those without resources or financial incentives to invest in interoperability – may be dangerously cut off from critical information about their patients. And in many cases, such as accountable care organizations and other value-based payment arrangements, providers are now being held responsible for achieving quality and cost targets for patients also receiving care elsewhere, with no way to access information about that "outside" care. We believe value-based payment is the right direction for our health system, but it can't be fully realized without a vastly improved flow of information among providers and between providers and patients.

In this brief, we illustrate how the nation's multi-billion-dollar investment in HIT has fallen short by focusing too narrowly on electronic recordkeeping, rather than on sharing information in a meaningful way. We discuss what policymakers and other thought leaders can do next to help us move toward greater HIT interoperability that enables us to see the whole of each patient's care, thus improving value, safety and convenience.

HOW DID HITECH FALL SHORT?

The HITECH Act provided over $30 billion in incentives for providers to develop EHRs, and by all accounts, it has been successful in that respect; by 2015, over 75 percent of office-based physicians had adopted a certified EHR, and over 95 percent of non-federal acute-care hospitals had done so.[3] However, we believe that in the rush to use the federal incentive dollars, the immediate goal of "electrifying" paper records became more important than the longer-term goal of ensuring coordinated, integrated and safer care.

The HITECH funds, and the Meaningful Use (MU) regulatory structure by which they are distributed, focused too narrowly on specific functional targets within EHRs, relying on process measures to ensure documentation of activities, rather than ensuring that those activities result in complete, usable information. For example, MU Stage 2 requires that each time a provider transitions or refers a patient to another setting of care, the EHR must generate a care summary record to accompany the patient. However, a lack of clear standards about what must be included in that summary limited the effectiveness of this approach. One provider might choose to include almost everything clinically relevant about a patient (medications, diagnoses, allergies, immunizations, progress notes, etc.), while another provider could decide to share only the bare minimum, but still meet the legal requirements.

Also largely ignored in the rush to implement EHRs was optimization of the clinical user interface. Many practices now have fully MU-compliant systems that are difficult and inordinately time-consuming to use and detract from the patient-physician interaction. One recent study found that physicians in ambulatory care settings spent two hours on "EHR and desk work" for every hour of direct "clinical face time" with patients. Even more surprising, while actually *in the exam room with patients*, these physicians spent just over half the visit on direct clinical face time, and almost 40 percent on EHR and desk work.[4] These findings are consistent with what we hear from physicians every day – that while they appreciate real-time availability of patient information in the EHR, they are burned out by the effort needed to document and access that information.

Ultimately, the last few years of HITECH implementation have left us with a system that is, at best, transitional, given its focus on documentation rather than clinical use.

DIAGNOSING THE PROBLEM: THE NEED FOR PATIENT-CENTEREDNESS

At one level, interoperability is a technical problem. We have no doubt that with proper incentives, innovators would step forward to solve many of the technical challenges that have made interoperability difficult. However, at another level, a true commitment to interoperability from all sectors of the health care industry requires a shift in thinking. Specifically, we need to think about health information as belonging, first and foremost, to the patient; it is stored by providers and their EHR vendors, but those parties do not (or should not) own it. This shift in thinking requires that full information follow patients – and be readily available to them – wherever they may receive care.

EHR certification for Meaningful Use initially required systems to enable the patient to view, download or transmit a fairly limited set of information through a patient portal. Fortunately, the Department of Health and Human Services has added to this information set over time. Of course, some physicians and hospitals can and do make available more than the minimum required information. Many of the CAPP groups are already implementing, or moving toward, "open notes," or the practice of making full visit notes available to patients.[5] Such practices have been shown to help patients feel more in control of their care and to improve medication adherence.[6] When notes are open, the act of documenting care in the EHR becomes more about improving patient engagement, and not solely about regulatory or administrative compliance. In this way, the use of open notes and patient portals reminds us daily that the data we use belong to our patients. If all health care stakeholders had a similar shift in thinking, we believe greater HIT interoperability would follow, as patients themselves sought seamless ways to bring together all of their relevant health information in one place.

Patients' access to data is ensured under the 1996 Health Insurance Portability and Accountability Act (HIPAA) and subsequent regulations. As a result, individuals have long had the ability to obtain copies of their records and give them to others. However, technical advances have resulted in many new models for sharing and aggregating data. Within a few years, we expect it will be more common for individuals to grant durable authorizations to enable trusted third parties to help them manage a wide range of data. Many people in the U.S. already trust companies such as Amazon, Apple or Google with a great deal of information about their lives. Some of these companies (and other innovators) are making plans to integrate medical records with other health, wellness and device data.[7] This will become a dynamic marketplace, but it is, as yet, unproven. In the end, however, these consumer-centered efforts may serve as the catalyst for full HIT interoperability within the health system.

A CALL TO ACTION: POLICYMAKERS' ROLE

All health care stakeholders must play an active role in making HIT interoperability a reality. As the physician leaders of our country's largest and most prominent multispecialty health systems and groups, we seek to collaborate with policymakers and others, to share our experiences with HIT interoperability and help identify and overcome barriers. The Office of the National Coordinator for Health Information Technology ("ONC") has predicted that it may be 2024 before the nation's HIT systems achieve true interoperability;[8] to get there, we must keep interoperability at the

forefront of the health-policy agenda. We call on policymakers to help us do that, through both thought leadership and regulatory action.

Thought Leadership
Policymakers can have a tremendous influence on the industry by continuing to provide thought leadership on interoperability. We urge policymakers always to frame discussions of interoperability in terms of patient ownership of, and access to, their own data. This is a critical shift in thinking with bipartisan appeal.

Policymakers and leaders of the administration must also continue to play the vital role of convener – providing a place and a process for stakeholders to come together to find solutions that will propel us more quickly toward efficient interoperability. In particular, as the HITECH incentive money has been largely spent, now is a critical time to engage in dialogue about what has been left undone. We welcome the opportunity to engage with other stakeholders on issues such as the following:

- *Metrics.* We believe the most important metric of EHR functionality is whether it can make complete, integrated, usable information about the patient available to the patient and provider on demand. This type of metric is vastly different from those used today to measure interoperability.

- *Documentation.* We are confident that working together, providers, payers and others can find ways to reduce the documentation burden and increase automation in EHRs, allowing developers and users to focus more on patient-friendly interfaces, the fluid exchange of information and improved clinical workflows.

- *Unique patient identifier.* There is little disagreement that the lack of a unique patient identifier is a barrier to improved HIT interoperability. All stakeholders must work together to develop safe and secure means of overcoming this challenge while protecting patient privacy.

Regulation
Current law and regulation prohibit EHR vendors from intentionally blocking the transfer of patient data contained in their systems to the software of another vendor (and instances of vendors running afoul of this rule are fairly rare.)[9] However, failure to block data from being transferred is a far cry from facilitating such transfer.

The HITECH Act authorizes ONC to define interoperability standards for federally certified EHRs under Meaningful Use.[i] In the past, the agency measured interoperability by counting the number of emails sent by eligible providers. As the agency moves forward with implementation of Meaningful Use Stage 3, ONC has increased its focus on the transmission, receipt and consumption of data through electronic exchange.[10] However, successful interoperability will take different

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i   In fact, for providers participating in Medicare's fee-for-service Part B program, MU has been replaced with a new program called Advancing Care Information, as part of the Merit-Based Incentive Payment System (MIPS). Providers participating in Medicare Advantage (Part C) remain in MU. However, MIPS and MU programs use the same federally certified EHRs, incorporating the same technical standards.

forms for different providers; therefore many stakeholders have urged ONC to broaden its view of interoperability beyond simplistic, one-size-fits-all electronic exchange requirements.

We stand in agreement with other physician leaders who have stated that Stage 3 Meaningful Use should "focus on promoting interoperability, and little else,"[11] and that the program's success "hinges on a laser-like focus on promoting interoperability…. rather than [on the] … ill-informed check-the-box requirements of the current program."[12] Counting the number of transactions that exchange duplicate data extracts, or the number of times mandated standards are used, is no guarantee of improvement in the information available at the point of care.

 Short of (or in addition to) mandating greater interoperability, policymakers may consider ways to make interoperability more attractive for EHR vendors and data holders. For example, some stakeholders have advocated for allowing data holders to charge a fee for data exchange, a practice that might help to encourage innovation in this area.[13] While we do not endorse a specific proposal, we do encourage policymakers to seek out and consider ideas such as these from the industry.

Finally, if the next frontier in interoperability is to be consumer-centered exchange, such endeavors will require appropriate government oversight to ensure consumer protection and privacy. Some of this oversight may reside in the Department of Health and Human Services. However, if – as we expect – the future of HIT interoperability will involve a much more complex mix of technologies and modalities than we see today, the expertise of some agencies not usually connected to health care may be required.

MOVING THE NEEDLE

While the achievement of full HIT interoperability among all pieces of the health care system may be an audacious goal that is many years away, there are, nevertheless, steps we can and must take now to ensure we are moving in that direction. As physician leaders, we hope to bring to bear the resources and expertise of our respective medical groups and health systems to help policymakers and other leaders move the needle on interoperability. We consider this issue foundational to achieving a high-value, patient-centered health care delivery system in the U.S., and ask policymakers to keep it at the top of their health policy agendas.

WHAT IS THE COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES?

The Council of Accountable Physician Practices is a coalition of physicians leading the nation's highest-performing medical groups and health systems. We believe we are better together. Our organizations are places where doctors from all disciplines practice together and learn from one another, backed by integrated services, systems, data, and technology. We recognize the importance of the patient-doctor relationship and know that, together, we can achieve the highest quality and ensure that patients come first.

ENDNOTES

1   Council of Accountable Physician Practices. *What Every Candidate Should Know About Health Care.* 2017. Available at: http://accountablecaredoctors.org/wp-content/uploads/2017/08/capp_candidateprimer_2017.pdf.

2   Office of the National Coordinator for Health Information Technology. *Health IT Dashboard: Office-based Physician Electronic Health Record Adoption,* https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php (accessed 9/28/17); Office of the National Coordinator for Health Information Technology. *Health IT Dashboard: Adoption of Electronic Health Record Systems among U.S. Non-Federal Acute Care Hospitals: 2008-2015.* Data Brief 35, May 2016, https://dashboard.healthit.gov/evaluations/data-briefs/non-federal-acute-care-hospital-ehr-adoption-2008-2015.php (accessed 9/28/17).

3   *Ibid*

4   SIinsky, C; Colligan L; Li L; et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Annals of Internal Medicine,* 2016;165:753–760, http://annals.org/aim/article/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties.

5   See: www.opennotes.org.

6   Wright, E; Darer, J; Tang, X; Thompson, J; et al. Sharing Physician Notes Through an Electronic Portal is Associated with Improved Medication Adherence: Quasi-Experimental Study. *Journal of Medical Internet Research,* 2015;17(10):e226; Delbanco T, Walker J, Bell SK, et al. Inviting Patients to Read Their Doctors' Notes: A Quasi-experimental Study and a Look Ahead. *Annals of Internal Medicine.* 2012;157(7):461-470.

7   For example, the U.S. Patent and Trademark office granted patent 9723997 to Apple in August 2017, to integrate health information with portable devices. See: http://pdfpiw.uspto.gov/.piw?PageNum=0&docid=09723997&IDKey=4ADDDC76BA2D&HomeUrl=http%3A%2F%2F-patft.uspto.gov%2Fnetahtml%2FPTO%2Fpatimg.htm (accessed 9/28/17).

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9   Yaraghi, N. To Foster Information Exchange, Revise HIPAA and HITECH. *Health Affairs Blog,* September 19, 2017, http://healthaffairs.org/blog/2017/09/19/to-foster-information-exchange-revise-hipaa-and-hitech/ (accessed 9/28/17).

10   42 CFR Parts 412 and 495, Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule, www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25595.pdf (Accessed 10/3/2017).

11   Wachter, R. Meaningful Use: Born 2009 -- died 2014? *Healthcare IT News,* November 13, 2014, www.healthcareitnews.com/blog/meaningful-use-born-2009-died-2014.

12   American Medical Association, et al. Letter to Senators Mitch McConnell and Harry Reid. November 2, 2015, https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/meaningful-use-sign-on-letter-senate-02nov2015.pdf (Accessed 10/3/2017).

13   Yaraghi, N. *Health Affairs Blog,* September 19, 2017.