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Update on HIT in California

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Last Fall, ITUP released a report for the California Research Bureau entitled "Health Information Technology-Electronic Health Records: A Primer". The report provided an overview of the definitions, costs, and barriers to health information technology (HIT) adoption, and summarized the current status of implementation.

HIT has gained significant momentum in the national spotlight as a crucial element of federal health reform. We felt it would be helpful to provide our colleagues with an update on recent activity as well as share recommendations for the future of HIT in California. The issues of cost, interoperability, and privacy are specifically addressed in this report in order to recommend next steps for California to best implement this important building block for health reform. For further information, refer to the additional resources that accompany this update.

HITECH Act

As part of the American Recovery and Reinvestment Act (ARRA, H.R. 1), the Health Information Technology for Economic and Clinical Health Act (HITECH) makes a significant investment (up to $36 billion) for the wide scale adoption of electronic health records (EHRs) to improve quality and efficiency in the health care system. Wider EHR adoption rates must be facilitated. Public and private sectors must collaborate in order for California to take full advantage of the new funds; much of the funding will be contingent on health information exchange (HIE) capabilities promoting the interoperability of EHR systems. In addition, California must be able to monitor and comply with any new privacy provisions.

Soon after the passage of ARRA, President Obama appointed David Blumenthal, a Harvard Medical School professor and director of the Institute for Health Policy at Massachusetts General Hospital, as National Coordinator for HIT. This month, Dr. Blumenthal released a perspective in the *New England Journal of Medicine* outlining the HITECH program to expand HIT and EHRs:[i]

Health Information Technology for Economic and Clinical Health (HITECH) Act

- Codifies the Office of the National Coordinator for Health Information Technology (ONCHIT) within the federal Department of Health and Human Services (HHS)
- Provides $17B for health information exchange infrastructure and incentive payments for adoption
  - $40,000-$65,000 per physician, up to $11M for hospitals for *meaningful use* of a *certified* EHR
  - Funds to States for low interest loans and grants to adopt EHRs and facilitate HIEs
- Provides $2B to the ONCHIT to provide physician and hospital technical support systems
  - Establish a new HHS entity, the Health Information Technology Research Center (HITRC), and HIT Regional Extension Centers (RECs) to provide local level technical assistance particularly in underserved areas
- Incentivized by penalties on Medicare reimbursements after 2014
  - -1% in 2015, -2% in 2016, -3% in 2017 and beyond
- Strengthens HIPAA privacy rules, restricting sales of patient information (including to Google and Microsoft)
- Establishes HIT Policy Committee and HIT Standards Committee

Adoption & Cost

Financial barriers remain the greatest limitation in wide scale EHR adoption. A recent *NEJM* article found that only 1.5% of acute care hospitals have a comprehensive system (hospital-wide), while just an additional 7.6% have a basic system (in at least one clinical unit). Physician use totaled 13% for a basic entry system, with only 4% reporting a comprehensive system (including order entry and decision support) citing implementation, training, and maintenance costs as the largest obstacles to implementation.[ii]

California receives approximately 14% of Medicare/Medicaid spending, and CHCF estimates California could receive up to $3 billion of the federal incentive payments beginning in 2011 if sufficient electronic systems are introduced. As there will be specific EHR requirements to obtain the payments (based on use and breadth of EHRs), California should take steps now to foster adoption and compliance. Below are several recommendations from the California HealthCare Foundation (CHCF) in order for California to establish an effective infrastructure.

Recommendations

- California Health and Human Services Agency (CHHSA) should engage with HHS to encourage development of California-appropriate definitions of *meaningful* EHR use.
- The California Department of Health Care Services should establish policies, procedures, and information systems required to facilitate Medi-Cal incentive payments for EHR adoption.
- State of California should develop programs to apply for EHR loan funds that:
    - Prioritize least-advantaged providers and clinics
    - Incorporate existing loan fund sources.
- California should develop partnerships with private and public organizations to meet federal requirements for matching funds to develop Regional Extension Centers.
- California should direct health profession education program (nursing programs, community colleges, universities) to apply for Workforce Training Grants.
- The legislature should find matching funds for California to take full advantage of the HITECH Act.

Notable Developments

As the market continues to expand, the price of EHR systems will continue to drop, says HHS spokesperson, Jenny Backus. Wal-Mart plans to team up with Dell and eClinicalWorks to provide a low-cost EHR package including hardware, software, installation, maintenance, and training. The service is expected to be available this spring, at a cost of under $25,000 for the first physician in a practice and $10,000 for each additional physician.

Interoperability

Much of the HITECH's infrastructure investment will be used to support interoperable HIE projects adhering to nationally recognized standards. It will be crucial for California to facilitate data exchange between health care providers in order to meet the requirements for federal funds. HITECH will allow these investments to be made through state or state-designated bodies of multi-stakeholder, nonprofit organizations as both planning and implementation grants. Below are recommendations from CHCF and Molly Coye, Chair, CalRHIO[iii] Board of Directors.

Recommendations

- The governor should appoint a Deputy Secretary of Health IT within CHHSA to facilitate a comprehensive HIE strategy.
- The state should take immediate action to select a qualified public-private entity to apply for HIE implementation funding.
- The state should actively participate in HIE services that demonstrate a high likelihood of Medi-Cal savings and foster local and regional RHIOs particularly focused on underserved populations.
- The state should direct additional funds in the ARRA, in consultation with the FCC, to expand rural broadband access programs.

Notable Developments

CalRHIO recently received tax-exempt status from the IRS, making the organization eligibly for tax-exempt bond financing for health information exchange development.

Open source EHR software has been suggested as a solution for providers to be able to modify and connect electronic systems to best suit their individual needs. The ONCHIT recently made available its open source software for download and public use at no cost. The software, called Connect, provides a gateway to the National Health Information Network (NHIN) and is used to facilitate health information exchange nationally. The network was initially demonstrated in 2008 for information exchange between federal agencies such as the Department of Defense, the Department of Veterans Affairs, the Social Security Administration (SSA), the Centers for Disease Control and Prevention, the Indian Health Service, and the National Cancer Institute. In February 2009, Connect was used for the first time in a pilot program to exchange health data with an HIE, MedVirginia, and the open source code is now available to the public.[iv]

Privacy

There are numerous concerns regarding the privacy of electronic medical information that will need to be addressed. Unease regarding "secondary uses" of patient information remains, and Hall and Schulman point out in a recent *JAMA* commentary that the ownership language of electronic information needs to be clarified.[v] Ownership is tangible when paper records are present, most often in the hands of clinicians and insurers. The case is not clear for digital information. The authors state that patients should always have rights of privacy and access to their digital records, but clearer (and adaptable) laws are needed to assign economic value to the access and use of such information. They suggest a system where patients having initial control of the records could ease some concerns while also stimulating market mechanisms for larger investments in the use and exchange of electronic information.

Through the HITECH Act, HIT vendors and business associates will be directly regulated under HIPAA privacy rules and mandated to notify the public of unauthorized acquisition of health information. The Act also includes a new, tiered penalty system and establishes patient rights to audit information trails. It will be important for California to clarify these laws, especially in regard to overlap with state-level privacy policies.

Recommendations

- CHCF recommends that the Office of Health Information Integrity should actively disseminate guidance and recommend best practices, clarifying federal law and addressing California privacy legislation – SB 541, and AB 211.
- The Office of Health Information Integrity should make efforts to educate patients and consumers on their rights

as well as demonstrate safeguards and protections.

Notable Developments

Kaiser Permanente is a national leader in HIT implementation. Their KP HealthConnect system integrates the entire network of physicians and patients, and is a good indicator for future trends nationally. Kaiser recently signed a contract with IBM to outsource data management, revealing potential cost-saving abilities.[vi] CIO, Phil Fasano, emphasized that IBM would not have access to patient records. A recent *Health Affairs* article highlights the impact of the Kaiser EHR system in primary care;[vii] between 2004 and 2007 office visits decreased by 25%, as many patients opted for non-traditional contact such as scheduled telephone visits, e-visits, and secure e-mail messaging. These findings show how a comprehensive EHR system could transform health care delivery and address the increasing burden on primary care physicians.

ITUP Thoughts and Recommendations

With funds dedicated through the economic stimulus package—the American Recovery and Reinvestment Act, combined with President Obama's recent "down payment" of $634 billion—health care reform is closer to becoming a reality. It is imperative to keep in mind that HIT and EHRs are not themselves a goal, but rather a means towards the ultimate aim of improving the value and quality of our health care system. With EHRs, duplication, waste, and error can be reduced and care can be coordinated to reach its highest level of effectiveness. California has an opportunity to take advantage of the Administration's willingness to support state efforts to improve HIT.

When drawing down federal funds, California should consider building on county, region or statewide efforts that show promise in HIT and have already invested some start-up costs. At the very least, the state should use these efforts to predict the obstacles they may encounter with initiating HIT elsewhere and the solutions to overcome them.

For instance, under California's Section 1115 hospital financing waiver, ten counties competitively bid to expand health coverage to more Medically Indigent Adults.[viii] A component of this waiver involved improving health information, which many of these counties interpreted as initiating or enhancing HIT. Orange County, for example, has made great progress using HIT. The County uses an electronic application system to enroll new patients in their program. Once in the system, the County uses electronic clinical data for case management, cross-checking this data with claims information to identify those at risk for chronic diseases like diabetes. In partnership with the University of California at Irvine and Share Our Selves Clinic, the county is also piloting telemedicine to improve access to specialty care. For those sent to specialists or referred by a nurse advice line away from the emergency room to primary care facilities, e-referrals are being utilized. Orange County stands out as a leader among counties investing in HIT. Orange County is participating as a pilot of CalRHIO, a statewide health information exchange effort. The Orange County Partnership for a Regional Health Information Organization (OCPRHIO) is looking at ways to improve the quality, safety, and efficiency of health care using HIT and the exchange of health information.[ix]

Los Angeles County is another large county launching HIT. Los Angeles has launched something similar to an EHR called an Electronic Summary Sheet. One barrier they have come across—and are currently overcoming—is interoperability among nearly 100 different clinics, i.e., using a patient identifier that is the same across all facilities and their electronic records systems.

Other counties both under this waiver and on their own are finding ways to electronically document and transmit clinical information, send e-referrals or e-prescriptions, enroll patients in insurance programs, or enhance case and disease management. Barriers arise, but counties are reconciling glitches among different vendors and patient identifiers and monitoring changes in utilization and cost savings and showing potential for a future using HIT.

Aside from specific counties or regions, the state must consider specific providers. As incentive payments will be made in 2011, the next two years are crucial for California providers to obtain qualified systems. To maximize funds for California, expansion efforts will need to prioritize which providers to reach out to over the next two years to encourage them to set up qualified systems. While some providers, groups, and hospitals may be unable and unwilling to make the switch, many should be willing if given assistance. For some, the 2011 deadline will be incentive enough, but providers in particularly underserved rural and urban areas may not have the means to transition and should be prioritized for outreach and assistance getting these systems up. California should support these providers by making grant and loan programs available and provide implementation and training support through the new HIT Regional Extension Centers.

Safety net clinics have also become increasingly motivated to adopt EHR systems. It is important for the state to recognize that clinics face even more obstacles than traditional practices based on the complex mix of delivery systems, payers and funding sources. The safety net will need considerable financial assistance, as clinics already face shortfalls and slim operating margins. It will be important to tailor customized HIT products and specialized support systems in order to address the needs of each unique clinic and their patient population. Technical support will be crucial, as clinics do not often have IT training and informatics experience.

Collaboration will be key for the safety net as well, where clinics can organize into buy-in pools to increase purchasing power. The ability to communicate on individual experiences and offer suggestions can also reduce potential clinician resistance and ease implementation difficulties.

The federal government will eventually provide EHR qualification standards for what it defines as a *certified system*. It will be important for physicians, hospitals, and clinics to include language in their HIT contracts with vendors that requires meeting these standards, effectively committing to a "seal of approval".

It is important for providers to understand that HIT implementation is a continuous process and should not be seen as an overnight conversion. This fact should help reassure those daunted by such a considerable transition. It also indicates that the technology will continue to mature and systems should be updated accordingly.

Data exchange and interoperability are essential to realize the true health benefits and cost savings with HIT. California should prioritize expansion efforts on those providers and counties most willing and able to participate in regional systems as opposed to simply digitizing a particular hospital or doctor's office. One key way would be to continue to develop local and state RHIOs, learning from the efforts of counties like Orange.

Additional Resources

- iHealthBeat website: http://www.ihealthbeat.org, a daily digest reporting on health IT
- *Health Affairs*: Stimulating Health IT, March/April 2009, Volume 28/Number 2 at: http://content.healthaffairs.org/content/vol28/issue2
- CHCF, *An Unprecedented Opportunity: Using Federal Stimulus Funds to Advance Health IT in California*, February 2009, at: http://www.chcf.org/topics/download.cfm?pg=chronicdisease&fn=AnUnprecedentedOpportunity%2Epdf&pid=511630&itemid=133864
- California Center for Connected Health, *Connecting California: The Impact of the Stimulus Package on Telehealth and Broadband Expansion*, April 2009 at: http://www.connectedhealthca.org/pdf/CCCH-StimulusPackageIB04022009.pdf
- CHCF, *Snapshot: The State of Health Information Technology in California,* January 2008, at: www.chcf.org/topics/chronicdisease/index.cfm?itemID=133552
- Molly Coye, MD, MPH, *Health Information Technology: Current Trends, Future Opportunities*: Testimony to the California Senate Committee on Health, March 2009, at: www.calrhio.org/crweb-files/docshie/2009.03.19%20Coye%20hearing%20testimony.pdf
- Wulsin and Dougherty, *Health Information Technology-Electronic Health Records: A Primer*, September 2008, at: http://itup.org/Reports/Solutions/08-013-1.pdf

Endnotes

[i] Blumenthal D., Stimulating the Adoption of Health Information Technology, *NEJM*, March 2009 at: http://content.nejm.org/cgi/content/full/NEJMp0901592
[ii] Jha, A, et al, Use of Electronic Health Records in U.S. Hospitals, *NEJM,* published at http://content.nejm.org/cgi/content/full/NEJMsa0900592, March 25, 2009
[iii] California Regional Health Information Organization (CalRHIO), a nonprofit public-private organization dedicated to state-wide clinical data exchange
[iv] NHIN Connect website: http://www.connectopensource.org/display/Gateway/CONNECT+Community+Portal
[v] Hall, M., Schulman, K., Ownership of Medical Information, *JAMA,* 301:1282-1284, 2009
[vi] Chris Rauber, Kaiser-IBM deal, other moves to eliminate 860 IT jobs at Kaiser, San Francisco Business Times, March 16, 2009
[vii] Chen, C., et al, The Kaiser Permanente Electronic Health Record: Transforming and Streamlining Modalities of Care, *Health Affairs,* 28:2:323-333, March/April 2009
[viii] Pizzitola, R. (2008). California's coverage initiative: Year one challenges and successes and a forecast for year two. Retrieved April 7, 2009 from http://www.itup.org/Workgroups/PublicPrivate/Pizzitola.pdf
[ix] Thielst, C. (2007). Regional health information networks and the emerging organizational structures. *Journal of Healthcare Management*, 52(3): 146-150.