

HIGH-TECH MEDICAL

BY KORY MERTZ AND DONNA FOLKEMER

CAN ELECTRONIC RECORDS TRANSFORM HEALTH CARE?

In the middle of a legislative session, a veteran legislator from an out-county district walks into the ER near the Capitol complaining of a headache and nausea. He is handed a stack of forms to fill out. Unable to recall most of this information, he is forced to leave many fields blank, including the names of his many prescriptions. To fill in all the missing information the doctor has to run a host of tests, some very expensive. The legislator is sent home to await the test results feeling no better than when he arrived. The state foots the bill.

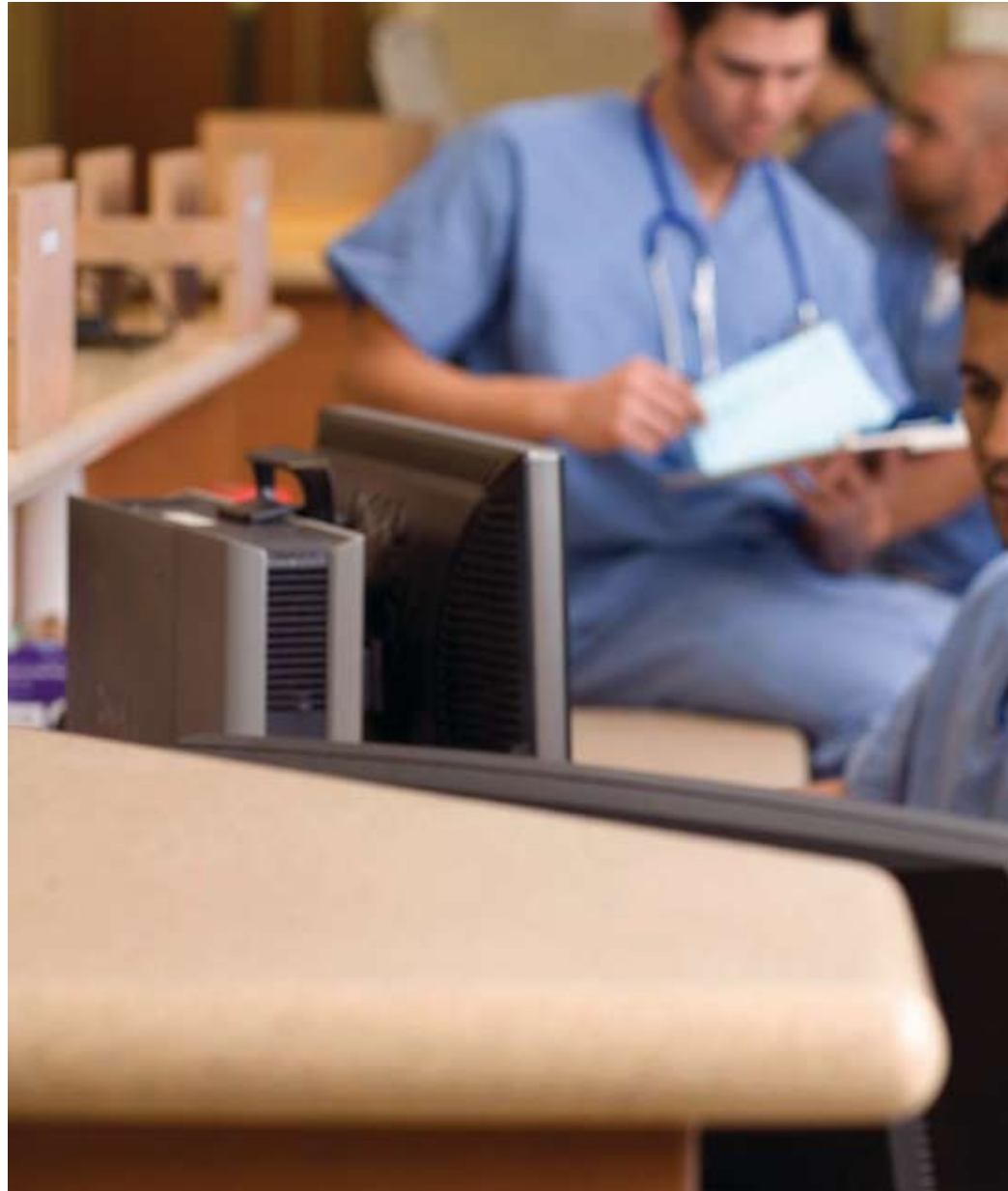
This is the current state of affairs in health care. Now envision this situation transformed by information technology.

The legislator enters the ER and a nurse pulls up his complete electronic health record within seconds. No forms to fill out, no prescriptions to remember. The doctor reviews the lawmaker's record and notices that his five medications were prescribed by four different specialists. After speaking with the patient, the doctor deduces the symptoms are likely the result of a bad prescription interaction. Checking her findings with a computer system that helps make clinical decisions, the doctor prescribes an alternative medication and updates the patient's record. The prescription is electronically sent to a pharmacy of the legislator's choosing. No paper, no agonizing wait for the legislator and no redundant—and expensive—testing.

Former Speaker of the U.S. House of Representatives Newt Gingrich and others see health information technology (IT) as key to fixing a dysfunctional health-care system. "Health information technology is essential if we are to make any meaningful change, from reining in costs to improving the delivery of care to expanding insurance coverage. We simply cannot continue to prop up a 1950s paper-based system and expect anything to change," says Gingrich, founder of the Center for Health Transformation.

Instant access to vital health information can save time, money and, ultimately, lives.

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When doctors see a patient's complete medical history, they can make better decisions by preventing harmful drug interactions and eliminating duplicate tests or procedures. The Center for Information Technology Leadership estimates that this kind of technology would save \$77.8 billion a year—or about 4 percent in a \$2 trillion health system.

But moving health care into the digital age will be far from easy.

First, doctors, insurers and especially consumers must embrace electronic health records that gather all of a person's health data from childhood to the present into one digital record. Many consumers fear that the transformation from a paper to a digital system will make them more vulnerable to unauthorized exposure. They fear that if their medical histories fall into the wrong hands, they'll face workplace discrimination

RECORDS

State Alliance for e-Health

States are working together on some thorny health information technology issues. The State Alliance for e-Health is crafting recommendations to help states with tough issues like how to best adopt health information technology and exchange the information.

The alliance is made up of governors, legislators, attorneys general and insurance commissioners. New Jersey Assemblyman Herb Conaway, Florida Representative Gayle Harrell, Massachusetts Senator Richard Moore and North Dakota Representative Ken Svedjan are members.

Throughout the past year, the alliance and its task forces have come up with answers to privacy and security concerns and found different approaches to investing in health information technology.

The group's first report, to be published soon, will help state governors and legislators decide what steps to take to encourage the use of health information technology. It suggests a streamlined licensing process for health professionals and recommends that states initiate electronic health information exchange efforts through Medicaid, SCHIP, public health and state employee health plans. Among the alliance's plans for the future is to shift from crafting recommendations to helping states implement them. It is supported by the National Governors Association and financed by the Office of the National Coordinator for Health IT. NCSL and the National Association of Attorneys General are partners. For more information go to: www.nga.org/center/ehealth



and a loss of insurance. Also, patients are concerned their private data will be used by various groups for marketing purposes.

"In the current health care 'system,' consumers have little or no understanding—let alone control—of the movement of their health information," said Alison Rein of AcademyHealth, a policy research organization. "As we enter a more data-rich, fluid exchange environment, a challenge will be to

figure out where and to what extent consumers should have more input into the process."

Paying for health IT is another barrier. Insurers and other payors can save money through electronic health records, but providers usually have to pay for the systems and staff retraining. Small practices, rural providers and community health centers are especially fearful of new costs.

There are also turf battles. For this technol-

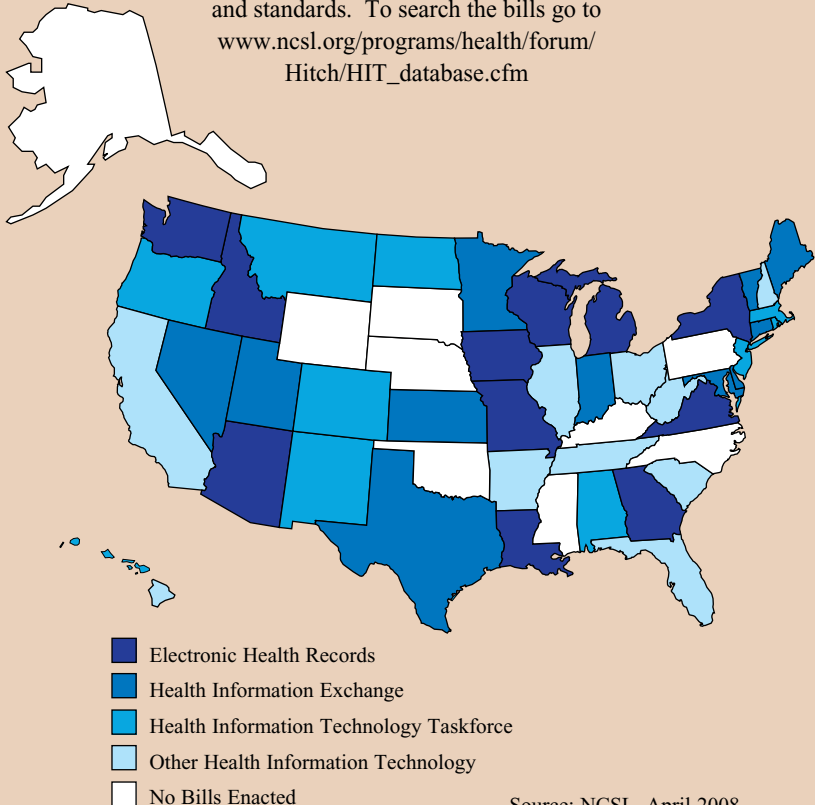
ogy to work, organizations must share data, and some health-care groups are reluctant to share what they have traditionally seen as theirs alone. They may believe that sharing will hurt their competitiveness. Another enormous obstacle is that many electronic health record systems were not set up to share data—they are not interoperable (the ability of differing electronic systems to work together)—and this stymies providers who want to share.

Health Information Technology

Enacted Legislation 2007-2008

Lawmakers introduced more than 300 health information technology bills during 2007 and so far this year. A total of 87 bills passed in 41 states and the District of Columbia. The legislation covered e-prescribing, electronic health information exchange, electronic health records, task forces, financing, updates to privacy laws

and standards. To search the bills go to www.ncsl.org/programs/health/forum/Hitch/HIT_database.cfm



Source: NCSL, April 2008.

GOVERNMENT RESPONDS

Many in health care are working on health IT but are counting on state governments to tackle thorny issues such as interoperability, privacy and security.

So what are governments doing?

At the national level, President Bush wants most Americans to have electronic records by 2014 and has set up the Office of the National Coordinator for Health Information Technology in the U.S. Department of Health and Human Services to organize the federal effort. The federal government also has contracted with outside groups to create standards for interoperability and to certify products. These efforts will eventually produce the Nationwide Health Information Network, which will support health information exchange across the country.

Medicare, which pays for care for more than 42 million Americans, has created a pilot program to provide incentive payments for

the use of electronic health records to some small- and medium-sized physician practices. Congress is looking at legislation to make e-prescribing in Medicare mandatory by 2011. To facilitate interoperability, the Centers for Medicare and Medicaid recently issued data standards that must be followed by providers who e-prescribe in Medicare.

New York and Florida have given out grants to establish health information exchange organizations or to enable small doctor practices, rural providers and community health centers to pay for the new systems. Nevada and Minnesota have updated their health data privacy laws to allow for health information exchange.

Other states have put Medicaid at the center of their efforts. According to the Office of the Inspector General, nine state Medicaid agencies have set up a limited form of electronic records using Medicaid claims data, and 27 other programs have plans underway.

The State Alliance for e-Health is a high-level state policy council that is looking at the entire range of financing, privacy and governance issues states are facing.

MINNESOTA MOVES AHEAD

In 2007, the Minnesota Legislature required all hospitals and health care providers to have interoperable electronic health records by 2015. The legislation includes no penalties for failing to meet the deadline and provides almost no direct funding for installation of the systems. Small grants and loans, however, are available for providers in rural and underserved communities.

“The participation of providers and payers in the negotiations (on the new law), and their agreement to the final product, means, I hope, that electronic claims submission and interoperability will be developed voluntarily without the need for heavy-handed bureaucracy,” Representative Paul Thissen says.

The mandate changed the dialogue in the state, moving providers from “should I adopt?” to “how can we work together to make this happen?” says Marty LaVenture, director of the center for Health Informatics in the Minnesota Health Department.

The Minnesota e-Health Initiative, a public-private group of consumers, providers, purchasers, and public health and government officials, is in charge of making the new law work. The group plans soon to release its first report, which will explain how the requirements affect health organizations and what immediate actions they need to take.

Before diving head first into exchanging clinical data, insurers and doctors will first exchange administrative data on such matters as coverage and payment information. These data are to be exchanged in a standardized format statewide by 2009. After that, there will be no more paper claims, which according to America’s Health Insurance Plans, cost roughly twice as much as electronic claims.

While the electronic health records man-



REPRESENTATIVE
PAUL THISSEN
MINNESOTA



date captured the headlines, lawmakers also addressed an equally important issue: reform of the state's health records privacy laws. "We wanted to strike a proper balance between the huge advantages of real-time exchange of information and protecting the confidentiality of health records," says Representative Thissen.

The law provides a legal definition of the technically complex but enormously important "record locator services." These locator services enable the treating physician to see the names of the providers whom the patient has seen in the past. No other medical data will be available under these services, but the current provider can then ask the previous ones for clinical information.

The law allows a provider to submit patient consent for medical records electronically so he or she can obtain those records in real time.

Lawmakers cleared a legal path for the exchange of health information in real time by allowing providers to electronically submit patient consent. Previously, a provider had to send a written form, signed by the patient, to the earlier provider. To protect patient privacy, record locator services may be liable for inappropriate disclosures of patient information, and they must maintain an audit log of providers who use its services. Also, patients may opt out of the system.

Now that the path for the real-time exchange of health information is clear, and providers and purchasers are on board, the final piece of the puzzle was an organization to set standards to allow groups with different health records to exchange data. The Minnesota Health Information Exchange will decide how information will be shared, who can use it and how

it can be used. It is expected that the exchange will serve more than 3 million patients when it goes live this year, making it one of the largest in the nation.

TEXAS TAKES SOME STEPS

"Rather than one giant bill, we took a number of individual steps leading to the goal of a connected system of health care," says Texas Representative Dianne White Delisi. This methodical approach has been very successful in the state.

"We made progress toward resolving these issues, in part, because we got so many of the stakeholders to become involved in hashing them out. I operated from the perspective that government can't, and shouldn't, try to do it all. If we impose one-size-fits-all 'solutions,' we may provoke a backlash that sets this back," says Delisi.

In 2005, the Lone Star state, like many others, created a task force to get the ball rolling. This group's recommendation provided a foundation for future work. A 2007 law set up the Texas Health Services Authority, a non-profit, public-private organization designed to promote the seamless exchange of data.

"There is a benefit for doing this that is shared among a lot of stakeholders, but there are also challenges," says Delisi. One of them is getting all of the parties to work together. "The creation of this group was one mechanism to keep everyone working together to move the issues forward," she adds.

The services authority is not getting public funds, but instead is seeking grants and financial gifts with the goal of moving toward transaction fees later. Figuring out a business model that can sustain health information exchange is a key hurdle across the country.

Developing Expertise

The National Conference of State Legislatures' Health Information Technology Champions (HITCh) Project is developing state legislative policy expertise on health information technology.

"As legislators, we need to understand the importance of investments in systems such as electronic prescribing, computerized physician order entry and electronic health records. They can help us spend limited—especially Medicaid—dollars more effectively and offer real benefits to our constituents," says HITCh Co-Chair Senator Richard Moore of Massachusetts.

The project is funded through the NCSL Foundation for State Legislatures. For more information go to the project website at www.ncsl.org/programs/health/forum/hitch



REPRESENTATIVE
DIANNE WHITE DELISI
TEXAS

Texas is working on electronic health records for its foster care kids, a pilot group of children covered by Medicaid, its criminal justice population, and mental health and substance abuse clients. The state is working on building data bridges between health agencies that serve the same population of individuals.

Modern medicine is fragmented. Different doctors treat many conditions in a single patient. All of the members of the team don't necessarily communicate. A mobile society makes continuity of care difficult. This fragmentation can result in negative consequences ranging from drug interactions to duplicated tests. And the bigger problem is the lost opportunities that coordinated care—a system of connected health—could bring patients.

"We could just do a better job of keeping people healthier if all of the fragmented pieces of modern medicine could come together into a usable whole. Medical IT provides a tool to do that," says Representative Delisi. ■