

Health Information Technology and Health Information Exchange Topical Area Meeting
Health Information Exchanges
August 21, 2006

Key Points

- Decrease cost across the board (administration)
- Increase quality, consumer control and satisfaction
- Standards based system
- Real time access
- Seamless process: reduction of paperwork within and outside medical setting
- Health Information Exchange and Health Information Technology as a public good
- Education of providers and students in medical, pharmacy, and nursing schools

Vision

- Allow fluid exchange of information between hospitals
 - Lower barrier of entry
 - Reduce costs
- Introduce standards based non-proprietary
- Provider access to all patients
- Public health receives information in real-time
 - Information needed to protect and promote health of public
- Information available when and how they want
- Reduction in Costs
- Usefulness of data sharing
- HIPAA and State Law don't speak to everything
- EX: HIE with schools (immunization records, etc)
- Security:
- Privacy: who can see it
- Access: who has access data
- Authentication; making sure the person is who they say they are
- Public Utility: provided regardless of economic/population status
- Think beyond Ohio, surrounding states WV, PA, Michigan, FL (National Health Information)
- Increase in quality
- Increase consumer satisfaction
- Standards for interoperation ; regardless of history and existing structures
 - CCHIT
- Reduced costs for: Purchasers, Sponsors, Consumers, and Payers
- Researchers get better data
- Sustainable system/process

Barriers to HIE Adoption

- Money: redistribution
- Not everyone has a EHR
- Legacy Systems/Culture: how they have done it in the past

- Limited interoperability
- Unique Patient Identification across systems
- Inability to match patient events
- Lack of a comprehensive transition plan
- Training of employees
- Lack of provider acceptance; resistance to change (changing entire process)
 - Ownership of information by providers
 - Greater transparency in terms of community standards/standard of care
 - Workflow at individual practices
- Some legal barriers
- Poor education of future providers
- Potential for information overload
- No experience/lack of understanding about value added
- Vendors
- Free market with no standards
- No buying power
- Leadership-it's not on anyone's highest priority
- FERPA vs HIPAA vs ODH; conflicting statues and regulations

Opportunity

- Use gap between physicians who use e-mail and paper records
 - Internal digital divide
- Identify those motivated to make changes
- Process modeling: define the process and then come up with a standard process for successful business practices in medicine
- Medicaid
 - org. of state level so start "Right" now (HIE)
- Power of the state-ASP model?
- Buying power for larger purchases
- Ohio Super Computer Center and OBR work together
- Third Frontier
- Universal Access
- Multiple re-engineering of state agencies
- Existing successful RHIOs
 - Capitalize on existing, operating technology followed by community will
 - Ex: move up to Ohio Department of Education from Dayton Public Schools
 - Move up to OHA from HealthBridge & hospitals
 - Move local issues to state level
- HPIO should get agencies, professional organizations, businesses to sign off on "roadmap" before it goes on to the candidates and new administration

Policy Options to HIE Adoption

- Legislation and state dollars related to compliance issues
- Curriculum changes in medical schools/nursing schools, pharmacy to teach HIT & HIE

- Educated in use of systems in place
 - Basic literacy in IT
- Education /outreach to providers
- Adoption of incremental iterative process and use best practices that are replicable, repeatable, and economically accessible (public utility) and sustainable re: return on investment across the system
- Health information exchange and Health Information Technology as a public good; benefits equitably distributed
 - Define increments and steps to the end
- Priority needs to be on ambulatory care providers where 75% of care is provided
 - Maybe start with Medicare
- Identify template and tools that would be used consistently across the state
 - For ex: everyone in Ohio has a CCR(provider), PHR(patient)
- Set minimum requirements like IHE (Interoperable health exchange)
 - Translating standards ongoing
- House Bill 457 (pre HIPAA), suppose to bring together data from every state agency
- DAS communities of interest
- OBR-convener
- Mission/Vision Statement