

**The Nationwide Health Information Network
The Future of American Health Information Technology
An Interview with the Leaders of EHRVA**

by Eric Fishman, MD

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Don Schoen, Chair EHRVA

The Electronic Health Record Vendors Association (EHRVA) is at the forefront of the health information technology revolution. Don Schoen and Hugh Zettel, Chair and Vice Chair of EHRVA, respectively, explained the organization’s efforts to accelerate the development of a Nationwide Health Information Network (NHIN).

After spending just an hour speaking with Schoen and Zettel, I realized how complex NHIN development is going to be, and just how important it is for the health of the nation’s healthcare system to have dedicated, visionary groups like the EHRVA leading us on the path.

The potential benefits are phenomenal, and, as evidenced by evaluations of multiple stakeholders, there may be savings of as much as 10%, or almost \$200 billion annually, of the national healthcare expenditure. With potential savings of this magnitude, resources and thought processes are being dedicated to speeding NHIN development in order to take advantage of these savings as soon as possible. While we are closer to establishing a NHIN today than we were previously, we are not arriving at the nirvana of an interconnected health information highway as soon as many would like.

Issues to be Addressed

Interoperability

First, there is the technical issue of interoperability – having information in one EHR company’s software be interpreted by another company’s software. While it might appear that this is a tremendous obstacle to overcome, Zettel does not see it that way. On the subject of interoperability, Zettel stated, “No, it’s not a technology hurdle at all. As a matter of fact, many vendors have been implementing something very similar to it through other private sector organizations.” Zettel also explained how the Healthcare Information Technology Standards Panel (HITSP) is working to establish a consensus process that people can accept. He went on to state that one of the leading factors that will speed its implementation is the transparency agenda that the Department of Health and Human Services (HHS) is implementing based on the President’s Executive Order issued in August 2006. For more on this Executive Order, see <http://www.whitehouse.gov/news/releases/2006/08/20060822.html>.

The purpose of this order is to ensure that healthcare programs administered or sponsored by the federal government promote quality and the efficient delivery of healthcare through the use of health IT. The order defines “recognized interoperability standards” as those accepted by the Secretary of HHS and instructs each agency that implements, acquires or upgrades health IT systems used for the direct exchange of health information between agencies and with non-federal entities to utilize health IT systems and products that meet recognized interoperability standards.

With this Executive Order, President Bush is essentially using the purchasing power of the federal government to encourage independent EHR vendors to utilize technology that will enable a more rapid attainment of the NHIN.

“Anyone who provides healthcare or does business with healthcare-related government organizations like the Department of Defense, the Department of Veterans Affairs and the Office of Personnel Management has to follow what they call the ‘Four Cornerstones’ of transparency,” said Zettel. “There is a whole section devoted to this on the HHS site. The first thing stated is that you have to use standards that the federal government recognizes.”

“Our association is very concerned with making sure that there is a single standard and not multiple standards that will allow for the sharing of information between systems,” said Schoen. “That will ultimately serve the purpose of the patient, and that alone will result in tremendous savings for patients. I think that’s where vendors are coming from, so that’s what the association’s efforts are geared toward.”

Standards

When discussing which standards will be utilized going forward, I mentioned that there seems to be potentially competing concepts in this regard, including HL7 and the Continuity of Care Record (CCR), among others. While it appears that there may still be confusion outside of EHRVA, it appears as if those ‘in the know’ understand clearly the direction that this will take. Zettel stated, “When you look at the type of content that is in the CCR, you recognize that HITSP worked through a consensus and decided to use the combined harmonized HL7 ASTM Continuity of Care Document, or CCD, which was approved by HITSP last month (March 2007). That will be the standard used to convey transition of care and medical summary information over the wire.” He continued, “Recognizing that this accepted government standard will find its way into future CCHIT interoperability requirements, ERHVA is providing education and developing other tools to help its members incorporate these standards into their products.”

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Hugh Zettel, Vice Chair EHRVA

Funding

With the declining income that physicians have been facing, affording this rather expensive technology – frequently estimated at \$33,000 per physician – is not an easy hurdle. Despite the expense, there remain many beneficiaries of its implementation.

The most obvious beneficiaries are the patients themselves. It is widely believed that better quality healthcare can be provided, and it is likely to be provided by physicians who appropriately use health IT. However, patients themselves pay for a very small percentage of their medical care, and it is unlikely that they will be inclined to pay their physicians more because of an EHR. While it is true that physicians who utilize one particular facet of an EHR – a patient portal – are able to take advantage of ‘virtual office visits,’ it is unlikely that this will provide enough revenue to meaningfully improve the return on investment for most physicians who utilize this technology.

Another group of beneficiaries is the insurance industry. As mentioned, it is anticipated that widespread adoption of health IT will substantially lower medical costs in the U.S. As such, both the federal government as well as private third-party insurers are likely to reap substantial financial rewards once it is implemented. This brings up two concepts: one is that third-party payors could potentially finance the acquisition costs of this technology, and the other is that physicians who are utilizing health IT will be compensated more than those who do not.

There are already a few pilot programs in which individual insurance companies are paying for EHRs for a small subset of their physicians. However, this business model is rather uncommon, and there are currently no meaningful enterprise-wide installations being paid for by insurance carriers. When asked about a federal program to provide for more widespread funding of health IT for individual physicians, Schoen stated, “You know it would be great for the government to buy a system for everybody, but that’s not going to happen. The government is trying to incent or develop different ways to incent the hospital or doctors themselves to purchase systems.” Zettel added, “I think that with having a Democrat-controlled Congress ... they might be more amenable to doing more investment.”

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Results-Based Reimbursement / Pay for Reporting

The second method of third-party funding is the idea of paying physicians for using an EHR. This model has a variety of terms applied to it, including pay for performance or P4P. However, many in the industry are now referring to this as pay for reporting, P4R or results-based reimbursement. In this model, physicians who can document improved patient results are reimbursed an additional amount. The only reasonable method of documenting these results is with an EHR so, in effect, physicians are being reimbursed for using an EHR and providing better care. However, providing better care also requires physicians to provide better reporting. In addition to their normal documentation procedures, there is a methodology requirement for reporting to the entities that provide this additional reimbursement.

“Whether it’s AMA, the American College of Physicians or AAFP, they have all talked about the 1½ percent increase in reimbursement that is present in the marketplace being a very small amount relative to what physicians are being asked to do,” said Zettel.

Zettel continued, “EHRVA was asked by the AMA over a year ago to help in their process of working on a way to get metrics implemented in EHRs in a consistent fashion. That led

to the AMA creating a collaborative with CMS and NCQA, which they call their Quality Collaborative. EHRVA participates in this, and we’ve done several things. One is bring our concerns and ideas to the table relative to what it takes to implement this in an EMR system. But I think the biggest thing we’ve brought to the table is our customers’ concerns about the additional workflow impact of recording quality information. We’ve gently pushed back when an informaticist says, ‘Well, it only takes you an extra minute or two per patient.’ When you talk about a 40 or 50 patient panel, you’re talking about adding another one to two hours to a physician’s very busy day, which impacts their quality of life and quality of work. We brought this to the dialogue..”

So, EHRVA is clearly aware of the fact that increasing a physician’s gross revenue is not worth an extra five to 10 hours of work per week. When asked when this pay for reporting will be more widespread, Zettel said, “That’s a great question that I think is probably going to be addressed by this year’s Congress. They’ve postponed the SGR again, so they’re now looking at a cumulative 10 percent tuck. If they don’t do anything by the end of this year, I think they’re looking at least \$20 billion in cuts because of what they postponed ... So they have to have something meaningful done this year. Probably the biggest debate on the healthcare side is finding a real fix to the SGR that is workable with the physicians that practice, which is what I think is going to have to happen.”

Certification

“EHRVA is working on interoperability with CCHIT and HITSP so we can have that communication or that nirvana that is out there whether it be on a local, regional or national level,” said Schoen. Zettel continued, “I think the other piece that we clearly see telegraphed through CCHIT is that we can expect to have those standards be part of interoperability for moving from an EHR to PHR. That will probably be part of the 2008 requirements, so anyone who wants to participate in certification will see that coming within the next year.”



Bringing the concept of certification and funding together, we learn that the federal government is encouraging interoperability, albeit in a rather oblique fashion, through its regulations, including the Stark Law and Anti-Kickback Statute (AKS). In discussing financial issues as they relate to interoperability, Zettel stated, “I think the only area where the notion of CCHIT certification has come into play is in the Stark regulations. The updated Stark and AKS rules that came out relative to EHR and e-prescribing donations allow you to donate an EHR but only if it is interoperable. When you donate an EHR, there is a fairly robust definition of what interoperability means in the Stark and AKS regulations. You either have to prove you can meet that definition or donate an EHR system that has been certified by a recognized body. Last fall, Secretary Leavitt recognized CCHIT as a certifying body, so that’s where the CCHIT linkage exists today.”

EHRVA

It became clear after our discussion that, as Zettel stated, “I don’t think you can underestimate ... we do compete very vigorously in the marketplace, and yet there is an amazing amount of collaboration.” Schoen continued, “As we’ve evolved, we’ve had some demonstration projects where CIOs have been in discussion with a number of our member representatives. They’re blown away that vendors who are competitors can even be in the same room, much less go and work together in an organization where they are united in their efforts.”

So why does EHRVA collaborate to this degree? After a little contemplation, it became rather obvious. As President Kennedy stated, “A rising tide lifts all boats,” so an expanding marketplace for health IT will increase the sales of many EHR vendors. Zettel understands this quite well. “I would say that in the EHR industry we have what we had in radiology and cardiology in the past – we provide that same sort of anti-trust oversight and convene in a way that doesn’t create anti-competitive behaviors. I think that’s where radiology and cardiology were able to progress because they could go with one voice, discuss issues with the American College of Radiology, RSNA or American College of Cardiology, and come up with solutions that would help the entire marketplace. We want to have that same sort of impact for our customers and the EHR industry as a whole, which is going through a tremendous amount of transformation right now.”

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