Ten Rules for Developing A Health Info Exchange

BY JOYCE FRIEDEN

WASHINGTON — If you're trying to develop a health information exchange to share electronic health record data with other providers in your area, Dr. Larry Garber has some advice for you.

Dr. Garber, an internist who is medical director for informatics at Fallon Clinic, in Worcester, Mass., outlined his 10 rules for developing a health information exchange (HIE) at the eHealth Initiative Conference:

10. Remember that patients are lousy historians. "It's up to our information technology infrastructures that we build to deliver the vast majority of health information to providers at the point of care," rather than relying on patients to deliver the data, said Dr. Garber, who is also vice-chair of the Massachusetts eHealth Collaborative.

9. Don't let physicians and patients become a bottleneck to HIE. "It's hard enough to get emergency room physicians to look at something right under their noses, let alone to start thinking about a consent process," he said. "And patients cannot be expected to use their personal health record as a way of controlling the flow of data."

8. Create a statewide enterprise master person index (EMPI). Each state should have statewide universal consent forms that a patient can sign once and that apply throughout the system, Dr. Garber said. But to ensure that the consent form that John Smith signed applies to him whether he is in his primary care physician's office, a specialist's office, or the hospital, an EMPI is needed to make sure all the John Smiths are the same person.

The EMPI also helps with reconciling continuity of care documents. "What do I do when I get 20 medication lists and 20 allergy lists?" he said. "You can only [solve that problem] if you have an EMPI recognizing that these are all the same person."

7. Don't promise to segregate specially protected information such as HIV status or mental health issues. "In order to make that work … the systems will have to err on the side of not sending information, and as a result we will have a true Swiss cheese of data being exchanged," Dr. Garber said. In Massachusetts, health care organizations tried an HIE in which emergency departments filtered out potentially protected data. "It turned out that the resulting medication lists were useless and the project had to be stopped," he said. "You're either all in or all out. It's dangerous [to withhold information], and patients don't understand the implications of not letting certain data flow."

6. Keep the overhead low. The local HIE that Dr. Garber helped start had its software written internally in order to avoid paying licensing fees. The HIE also hosts its servers in its own data center, and the exchange members did not create a legal entity—such as a regional health information organization—in order to avoid paying attorneys' fees. As a result, the exchange's operating expenses are $7,000 annually, he said. "This may take a little more [money] in other communities, but the bottom line is that you have to lower operating fees if you want the HIE to be sustainable."

5. Store the data based on the content, not on the source. "When the data is stored, you need to file it properly," Dr. Garber said. "If you have outside electronic documents coming in, don't put them in an 'Outside Records' folder. They need to be integrated with the rest of the data. If I want to find the last MRI of the brain, I want to look in the imaging section and find the last MRI regardless of where it was done. File labs with labs and radiology with radiology."

4. Make the electronic health record (EHR) "one-stop shopping." "I only want to go look in one place for information. I don't want to have to go outside the EHR to a different portal to look for things," he said. "I want one place with one common user interface."

3. Re-use data. The beauty of an EHR is that you can take the data and repurpose it, according to Dr. Garber. For example, the clinic uses claims data to populate medication lists, past medical history, and past surgical history.

2. Don't require people to think. "If you want some process done consistently correctly, you have to kind of take the brain out of [it]," he said. For example, if a hospital needs to have patients sign consent forms for HIV testing, "when patients are checking in and being registered, don't ask the registration clerk to check if they have consented or need to consent. Let that process happen automatically—the consent form appears when it's appropriate, it doesn't appear when it's not appropriate." The same should be true for ordering health maintenance and disease management tests.

1. Remember that this is the real world. "Don't forget that we're dealing with the real world and real people," Dr. Garber said. "Our patients are our friends and ourselves. Everything we do affects real people and their health and their happiness. That also includes the physicians and nurses and staff that work in these organizations. Everything we do affects [them] as well."

No one should expect physicians and staff to be filling out forms "just for the sake of collecting data so someone can do some analysis on the back end. Data collection should be a byproduct of the care that we give. So remember everything we build is affecting real workloads of real people."

The conference was sponsored by Ingenix, the American Medical Association, and several other industry groups and trade associations. Dr. Garber did not disclose any conflicts of interest related to his presentation. ■

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Government Workers Covered

Two-thirds of the nation's nearly 20 million state and local government workers got their health insurance through their employers in 2008, a much higher percentage than among private sector workers, according to the Agency for Healthcare Research and Quality. Premiums for one-person plans ranged from $4,560 to $6,631, while family plan premiums cost between $12,068 and $16,965 per year. New England government workers had the highest average premiums, and workers in New Jersey, New York, and Pennsylvania contributed the least to their premiums for both one-person and family coverage, the report said.

Seniors Hit by Drug Expenses

Medicare Part D enrollees who used high-cost, "specialty tier" drugs are much more likely than other beneficiaries to reach the "doughnut hole," when they must pay 100% of prescription costs until the totals they and the plans pay reach $6,154, according to a Government Accountability Office report. More than half of Medicare beneficiaries with drug coverage who took one or more of the high-cost drugs spent at least $4,645 out of their own pockets in 2007 and reached the high end of the doughnut hole, or catastrophic threshold, beyond which the government pays at least 80% of all drug costs. Meanwhile, only 8% of beneficiaries who did not use specialty tier–eligible drugs reached the catastrophic threshold. Specialty tier drugs include immunosuppressant drugs, those used to treat cancer, and antiviral drugs. Medicare supplement-plan sponsors told the GAO that they had little leverage to negotiate price concessions for most specialty tier–eligible drugs.

Public Health Funding Is Down

Federal funding for public health has remained flat for nearly 5 years and states have cut a total of nearly $392 million in public health programs in the past year, a report from the Robert Wood Johnson Foundation and the Trust for America's Health shows. That has left communities around the country struggling to deliver basic disease prevention and emergency health preparedness services, the report said. "Chronic under-funding for public health means that millions of Americans are needlessly suffering from preventable diseases, health care costs have skyrocketed, and our workforce is not as healthy as it needs to be to compete with the rest of the world," said Jeffrey Levi, Ph.D., who is the trust's executive director. States in the midwest received the least funding for disease prevention in public health in fiscal year 2009—a total of $16.50 per person, compared with $19.80 per person in the northeast, $19.22 per person in western states, and $19.75 in southern states.

Food Poisoning Cost Is Sickening

Each case of foodborne illness, such as from *Escherichia coli* and *Campylobacter*, costs an average of $1,850 in treatment and other health costs, totaling $152 billion for the nation annually, according to a study by the Pew Charitable Trusts at Georgetown University. Cases related to tainted produce cost $39 billion in just medical costs per year. "Although this study only addresses the health-related costs of foodborne illness, the total cost of foodborne illness also includes … costs to industry and government from outbreaks," according to the report. According to the Centers for Disease Control and Prevention, 76 million new cases of food-related illness result in 5,000 deaths and 325,000 hospitalizations in the United States each year.

Massachusetts Care Still Short

Despite the 2006 passage of health care reform in Massachusetts, some groups—including young adults, low-income residents, and Hispanics—still have low rates of annual checkups and limited access to providers, according to the CDC. Overall, insurance coverage in the state increased from 89% in 2005 to 97% in 2008 as a result of the reform law, providing coverage for an estimated 300,000 additional individuals. Hispanics benefited the most from the law, with a 14% increase in insurance coverage, the report said. But that group and some other traditionally underserved groups still lag behind in basic health care: Only about 75% of Hispanics, men aged 18-34, people in low-income households, and those with less than a high school diploma reported having a personal physician in 2008.

FDA Warns on Food Labels

The Food and Drug Administration has notified 17 food manufacturers, including Gorton's Inc. and Nestle, that labeling for some of their food products violates the Federal Food, Drug and Cosmetic Act. Violations cited in the warning letters include unauthorized health claims, unauthorized nutrient-content claims, and the unauthorized use of terms such as "healthy," the FDA said. Nestle, for example, was warned about using "100% juice" to describe a product that had added flavors, while the FDA told Gorton's in its letter that its fish fillet packages need to disclose high levels of sodium, saturated fat, and total fat to accompany the claim of zero trans fats.

—Jane Anderson