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Reflections on 2008 – Forecast for 2009

By Andrew Hurd

Healthcare organizations in 2008 that were eager to develop health information exchanges (HIE) and regional health information networks (RHIO) also developed creative ways to assemble requests for proposals (RFP); clarify vendor expectations, and manage and resolve governance issues. Vendors received RFPs from states that had high hopes for data interchange but minimal funding. Other ventures were stymied by unrealistic expectations and timetables for complex solutions involving physician and patient portals, e-prescribing and electronic health records (EHRs) in physician offices.

Competitive fear also slowed the growth of HIEs, according to the Center for Studying Health System Change, which reported that HIEs had not yet evolved into sophisticated data management platforms. Health Industry Insights (HII), a healthcare research arm of IDC, recommended that states take a major role in facilitating the development of a National Health Information Network (NHIN) and in closing the quality gaps among HIEs and RHIOs.

Conversely, 2008 also saw positive reports on the impact of HIEs and RHIOs. HIEs can lower care costs and improve safety, according to a survey of 42 HIEs conducted by the e-Health Initiative (EHI). Close to 70 percent of groups surveyed said HIEs could cut healthcare costs, while another 50 percent reported that HIE participation helped reduce medication errors and improve outcomes.

In 2008, three quarters of U.S. states indicated that they had already started developing some form of HIE, according to the State-Level HIE Consensus Projects, fueled in part by a larger push for healthcare reform, quality measurement and pay for performance. States including Utah, Nebraska, South Carolina and Louisiana have championed interoperable systems for sharing information among payers, providers and consumers.

Vermont, for example, has boosted funding for HIE projects via a quarterly tax on health plans, while other states such as Minnesota and Nevada have refined privacy laws to facilitate the exchange of electronic health information. Kentucky has moved forward with its plan to turn the state into a "national laboratory" for improving care and reducing costs, while Indiana continues to build on its status as "the country's epicenter for health IT" by saving $26 for each emergency department visit at an Indianapolis hospital. A collaboration of Indiana and Purdue universities and the Regenstrief Institute, the 5-year-old Indiana Health Information Exchange connects 40 hospitals and some 10,000 physicians across the state.

Meanwhile, growing numbers of providers are either involved in building their own networks or in participating in an HIE. Fifteen percent of respondents to an IDC-HII survey said they were already active in an HIE, while 35 percent reported actively planning to do so.

A Time for Realistic, Focused Planning

HIEs and RHIOs eager to retain and build upon their gains or start new programs should develop precise definitions for HIE/RHIO solutions and verify functionality. Organizations and states typically issue detailed RFPs for HIEs and RHIOs. Unfortunately, more than a few RFPs are laden with unrealistic expectations for comprehensive solutions, as well as demands for rapid implementation. In reality, an HIE/RHIO is no different than any other health IT project or program. It requires a rigorous process of needs assessment, vendor selection and tiered implementation involving team building, training, service, support, monitoring and evaluation.

Other RFPs dwell on specific projects such as a physician portal, an enterprise master patient index (EMPI), an interface engine or a patient portal for requesting appointments and sending messages. Still, functionality remains a barrier. While some HIEs deliver broadband connectivity, they fail to facilitate data exchange. Even though an HIE may feature an EMPI that allows for patient identification across the state or region, HIE participants may not use the EMPI to improve quality or manage chronic conditions. Only a handful of HIEs are mature, according to the EHI. Even the 69 percent that report their status as fully operational may fall short due to varied definitions of features and functionalities.

Organizations should create a reasonable HIE/RHIO plan with reasonable, appropriate goals or risk failure by attempting to create governance and security structures that embrace everyone. The most successful RHIOs and HIEs are limited in scope and focus on a discrete set of goals. Organizations must decide which solutions will have the most significant and rapid impact on patient care quality.

While almost everyone recognizes the potential of information sharing to improve quality of care, not everyone needs a system that spans a state or region. Organizations might want to follow the example of Jacksonville, Fla., where multiple physician groups are getting together and sharing information. Patients that are now referred from a primary care physician to a specialist and are within that set of physician groups can effortlessly communicate with one another. This kind of HIE improves care, reduces redundant testing and provides a new level of service through its connection with telemedicine.

RHIOs and HIEs have a greater chance of success if they focus on specific areas of care improvement, such as e-prescribing. Projects falter when they operate with wish lists so detailed and extensive that no government source could possibly provide adequate funding. It is most effective for organizations to reflect on the needs and priorities of the region and its patient population.

Initially, the Louisiana Health Information Exchange (LAHRIX) wanted to build in e-prescribing, telepharmacy and a patient portal. Fortunately, the people behind LAHRIX realized that 70 percent of its residents lived in rural, underserved communities, where area pharmacies often lacked computers and Internet access.

Organizations should look at RHIOs and HIEs the same way they look at hospital information systems. No single vendor can provide all required products and services, nor is such a request necessary. Organizations that seek to buy every piece of available technology often miss the opportunity to leverage the technology they already have. Payers already have systems to request online authorizations, while labs realize how they can obtain results electronically. HIEs and RHIOS must leverage these systems, without feeling compelled to replace costly infrastructure.

2009 Looks Promising

Here are some predictions for what could be a very promising 2009 for HIEs:

Successful HIEs and RHIOs are more likely to focus on the needs of smaller areas or community clusters rather than an entire state or region. These projects may focus on a variety of local problems, from lack of communication among primary care physicians and deficits in e-prescribing and telepharmacy, to high rates of heart failure, obesity or chronic obstructive pulmonary disease.

HIEs will increasingly focus on chronic disease management. LAHRIX, for example, responded to a specific disease-related problem. Louisiana was the number one state in the nation for death caused by diabetes due to lack of ongoing diabetic care. After examining statistics in several areas of the state, LAHRIX began to focus on underserved areas with telemedicine, distance learning and implementation of HIT applications.

HIEs will find new avenues for link-ups and collaboration. An early adopter of the RHIO and HIE, New York state provided funding for a regional HIE rollout. With HIEs now located in Brooklyn, Rochester, Buffalo and upstate New York, the state is searching for a way to link the four HIEs together. Each area of the state operates within a unique model that allows for the delivery of information to physicians across the continuum of care.

This year promises to be an exciting one for HIEs and RHIOs. The federal stimulus bill should provide states with the necessary financial resources for health IT implementation. **HMT**

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