

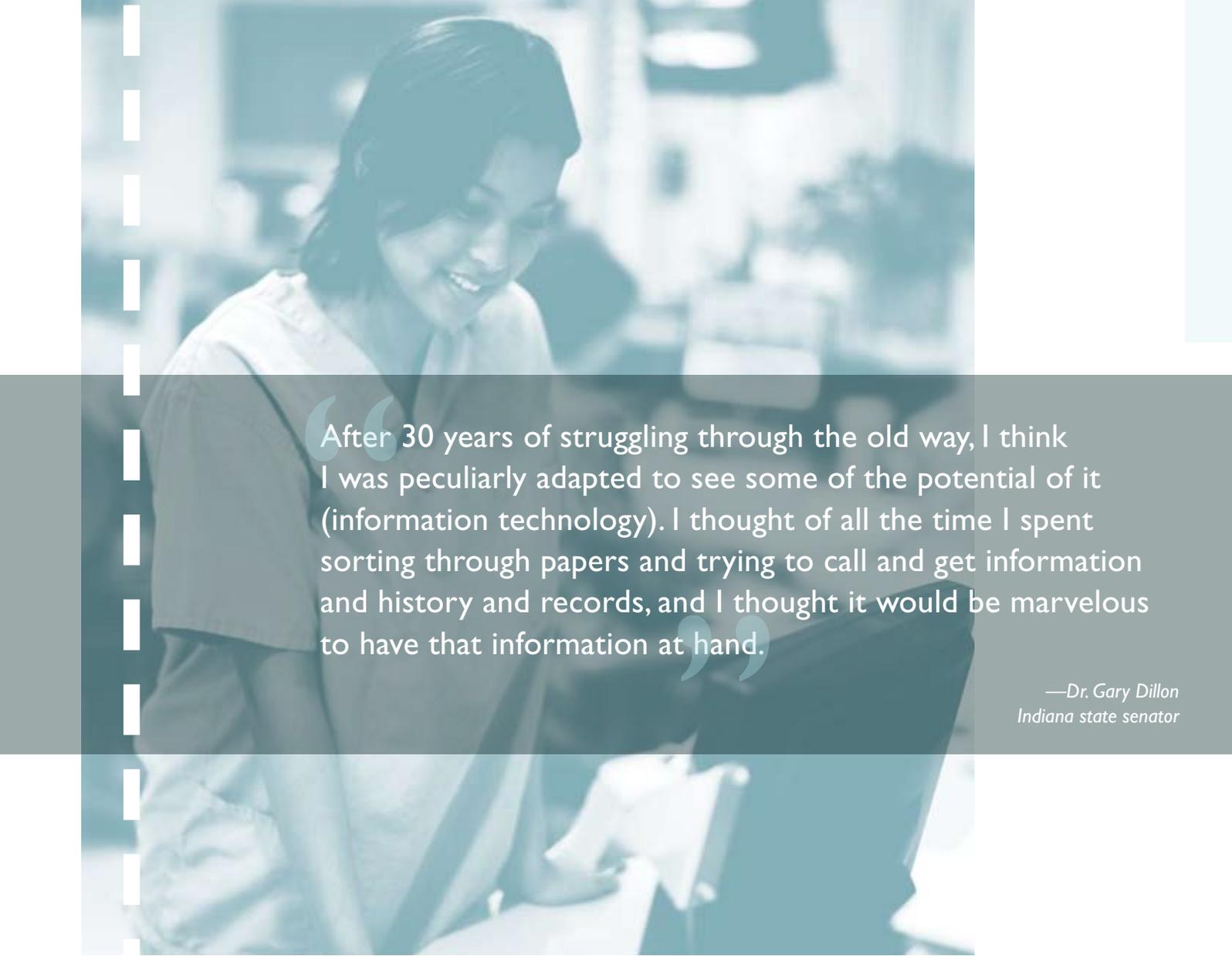
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CONNECTIONS

*States Make Plans for Health IT to Improve Quality,
Lower Costs*

State legislatures around the country increasingly are learning how information technology can reshape the future of health care. But states face numerous obstacles in their efforts to adopt health IT, including determining who pays for it and how the privacy of exchanged information is ensured.

By Sean Slone



“After 30 years of struggling through the old way, I think I was peculiarly adapted to see some of the potential of it (information technology). I thought of all the time I spent sorting through papers and trying to call and get information and history and records, and I thought it would be marvelous to have that information at hand.”

—Dr. Gary Dillon
Indiana state senator

Health care providers and state officials believe they have seen the future of health care. It looks something like this:

- Doctors use electronic health records (EHRs) to compile the legal and permanent institutional records of patient care. No more paper files scattered around multiple doctors' offices.
- Prescriptions are created, processed and communicated electronically. No more worrying whether the pharmacist can interpret a doctor's notoriously bad handwriting.
- Physicians use easily-transportable, tablet-style computers to chart vital signs, access test results, get a list of recommended procedures and exchange information with other providers.

Patients also play a more active role in this brave new world. Personal Health Records (PHRs), which they can access online, hold the history of all their encounters with the health care system. Health data Web sites allow consumers to compare health care services, facilities and health plans by accessing quality and cost information. They can take online personal health

assessments, identify steps to healthier lifestyles and monitor their progress.

Several states are well on their way to realizing this future and to seeing the benefits of lower cost, higher quality health care. The benefits develop from:

- The creation of permanent health records that can't be lost in a natural disaster or emergency, which can help prevent duplicative tests and medicine interactions that contribute to 30 percent of annual wasted health care dollars;
- The personalization and standardization of preventive care; and
- The provision of greater access to information for health care consumers.

But states face numerous obstacles in their efforts to adopt health IT, including determining who pays for it and how, and ensuring the privacy and confidentiality of the information exchanged.

Kentucky's e-Health Network

Kentucky's experience with e-health began in 2005 with the passage of legislation that called for the creation of a secure, interoperable statewide electronic health network. No deadline for full implementation was attached. The law created the Kentucky e-Health Network Board—composed of leaders from government, academia, public health and the private sector—to accomplish this goal. The board was charged with making recommendations about various strategies for creating the network.

Since its creation, the board has been involved with long-term planning and smaller short-term projects such as a grant program to develop e-prescribing in the state. The board also completed an inventory and assessment detailing the needs and challenges facing the adoption of health IT and information exchange.

But perhaps the state's most significant project is the Kentucky Health Information Partnership.

“What we heard over and over again from experts around the country was that getting doctors and hospitals and other health care entities to adopt electronic medical records is really a long-term call,” said Trudi Matthews, senior policy adviser in the Kentucky Cabinet for Health and Family Services. “And if you put all your efforts toward just that, it's going to take you awhile to get there. But if you can, while you're working on that goal, also really focus on taking the information that's already available electronically—and there's quite a bit of it—and figure out how to exchange it, you can not only provide real value in a clinical setting but you can also move adoption of health IT forward faster.”

The partnership's efforts to marshal existing data from insurance claims forms will mean that at the end of two years, the state will have the foundation of a statewide health information exchange with information on more than 60 percent of Kentucky residents.

“No other state at this point has anything close to it,” Matthews said. “We've got a lot of additional work to do to get every person in Kentucky to have a fully functional, interoperable electronic health record. But we'll have a whole lot more information available with this project than we would otherwise.”

Indiana's Private Sector Approach

Just across the Ohio River from Kentucky, Indiana's electronic health initiatives have evolved in a different way.

The Indiana Health Information Exchange (IHIE) was created in 2004 to serve the five major hospital systems in Indianapolis. It provides physicians with a single source for clinical

lab and test results and hospital encounter information from all participating central Indiana hospitals. The IHIE currently serves only the central Indiana region but plans exist to extend the network and to add additional services.

“The hospital communities in and around Indianapolis had a real vision on health information exchange and they basically took the position that it makes a lot of sense to have a single entity be responsible for delivering all of our results,” said Thomas Penno, the IHIE's chief operating officer. “So they created the IHIE to do just that—to be the post office, if you will, to deliver the results.”

Penno said this clinical messaging service was an easy way to get the health IT ball rolling in Indiana.

“I just can't emphasize enough that you've got to go slow and tackle the easier stuff, the low-hanging fruit. And clinical messaging we think is one of them. For us, it (didn't) require a huge amount of capital to get going,” he said.

Penno believes clinical messaging is a model that can quickly pay dividends.

“You can quickly turn it into a cash positive, self-supporting service. Then what you've basically done is laid the architecture to connect the health information components ... Then you can start to look at layering on different services,” he said.

State government has taken notice of the IHIE as well as similar efforts like one in the South Bend area. State Sen. Gary Dillon sponsored legislation in 2005 to establish a medical informatics commission to study health information and communication technology in Indiana. The commission last year recommended the creation of a public-private corporation to facilitate the development of a statewide network.

“The commission felt that we should have an ongoing corporation that would go out, provide the expertise and encouragement and help develop standards so that all these entities can communicate with one another,” Dillon said. “So we took the approach that it would not be a state run entity ... We felt with all the expertise we had going that it made sense to assist these private efforts.”

Dillon, a physician, said he's an unlikely champion for health IT since he's not exactly a “techie” himself. But when it came to recognizing the possibility and the promise of health IT, he didn't need a lot of convincing.

“After 30 years of struggling through the old way, I think I was peculiarly adapted to see some of the potential of it,” he said. “I thought of all the time I spent sorting through papers and trying to call and get information and history and records, and I thought it would be marvelous to have that information at hand.”

What States Are Doing

State legislatures around the country increasingly are seeing how information technology can reshape the future of health care. During 2005 and 2006, more than 35 health IT bills were passed and signed into law. More than 65 bills have been introduced in 30 states in 2007 so far.

Some of these state initiatives are being generated first in the executive branch. Governors in at least 15 states have issued executive orders calling for the development of health IT strategies.

“I think governors play a critical role in all of this for a number of reasons,” said Janet Marchibroda, CEO of eHealth Initiative, a Washington, D.C.-based nonprofit that advocates on health IT issues. “When you think about what’s needed to drive improvements in our health care system, particularly with the use of health IT and mobilizing data across very fragmented entities whose incentives are sometimes not aligned, (it) requires leadership across the state.

“The governor’s involvement, whether it’s through the executive order or convening a steering committee to help with planning or simply putting money in the budget request to the state legislature, just plays an important role in supporting existing efforts as well as beginning ones where none exist.”

Many states have authorized a commission to provide leadership and advice on statewide IT adoption. Marchibroda says the commissions convene diverse groups of stakeholders to assess the health IT environment in the state. They then begin to divvy up their work in similar ways, with working groups focusing on issues like finances, governance, technical considerations, and privacy and confidentiality.

Legislation in many states has authorized studies, called for the integration of quality goals, instituted grants or loan programs, and set target dates for the adoption of EHRs.

“Some folks say we need a certification process or we need more regulations (about what states can do),” Marchibroda said. “(But) this is working very nicely organically. There is so much cross pollination and discussion and sharing of best practices across states.”

Building infrastructure is becoming a key objective for states as well, with many facilitating the creation of regional health information organizations (RHIOs) similar to Indiana’s IHIE. It is hoped these organizations will become the foundation of a national health information network.

“At the state level, you’re primarily seeing coordination, education, planning, sharing, figuring out the role of the state as purchaser,” Marchibroda said. “But what’s happening is the actual health information exchange networks themselves are cropping up around medical trading areas or regions, communities within the state ... What we found is, in order to get to sustainability, you really need to provide value within the local market.”

National Outlook

The momentum on health IT in state capitals has kept it near the top of the national health care agenda as well.

President Bush in 2004 called for most Americans to have an EHR by 2014. He established the position of National Coordinator for Health Information Technology and charged him with pursuing a 10-year strategy for the adoption of EHRs and the creation of a National Health Information Network (NHIN) to connect those records.

Bush also signed an executive order last year calling on the federal government to provide better information to consumers on the price and quality of health care. This federal transparency initiative also calls on the government to establish and utilize standards for quality and health information technology in its health care purchasing decisions.

Other federal action includes creation of a commission to validate health IT products for functionality, interoperability and security standards, as well as creation of a public-private partnership to develop interoperability standards with regard to health IT software.

Playing Catch Up

Despite all the activity, the U.S. is far behind other countries in adopting health IT. According to a recent survey, only 28 percent of U.S. doctors use EHRs, compared with 98 percent in the Netherlands, 92 percent in New Zealand and 89 percent in the United Kingdom. Only 23 percent of U.S. doctors have access to computerized alerts about potentially harmful drug doses or interactions, compared to 93 percent in the Netherlands. And 40 percent of U.S. doctors say they find it “very difficult” or “impossible” to identify patients overdue for preventive care or tests.

As Kentucky Gov. Ernie Fletcher, a family practice physician, told the recent e-Health Summit in Louisville, “even though our diagnostic and treatment modalities have changed substantially, the process of delivering that health care has not significantly changed keeping up with technology.”

Moreover, the U.S. health care system lags most other economic sectors in adopting information technology.

“It’s estimated that most industries in America spend an average of about \$8,000 per worker on information technology,” Fletcher said. “That figure is just \$1,000 per worker in the health care industry. We’ve got a lot of catching up to do in investing in technology.”

Marchibroda at eHealth Initiative agrees, but remains optimistic.

“We’re way behind on all fronts,” she said. “We’re at a competitive disadvantage given the dollars we spend on health care and the quality of our health care related to other countries ... But I think we’re sort of approaching a convergence of a number of things that are going to move us ahead in the next five years.”

—Sean Slone is a health policy analyst at the Council of State Governments.

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Health IT: The Benefits and Challenges

Analysts say the cost and quality benefits of adopting health information technology are profound.

“Right now the best estimates are that we waste 30 percent of what we spend in health care because of duplicate tests, drug-to-drug interactions, preventable complications, missed tests and prevention opportunities, the mound of paperwork that providers have to deal with—all of this stuff does not enrich the patient care experience,” said Trudi Matthews, senior policy adviser in the Kentucky Cabinet for Health and Family Services. “We know we can do better.”

Electronic Health Records (EHRs) can help physicians prevent duplicative and costly tests, know what medicines a patient is taking, and provide personalized preventive care reminders to patients. They can also provide valuable information about a patient when he or she suffers injury or illness far from home.

Medical histories stored on EHRs would be less likely to be lost during a natural disaster as well. Many believe the displacement of residents after Hurricane Katrina further confirmed the need for a national health record system.

E-prescribing can help prevent medicine interactions, allergic reactions and medical errors.

Health IT can also help practitioners monitor overall public health. It can allow them to access diagnostic information on a confidential basis from a group of patients and detect trends in disease faster.

Many states also see health IT as an important tool in making health care price and quality information more readily available. Some are using state agency Web sites to publish data on hospital acquired infection rates and hospital errors.

Most importantly, health IT ideally allows physicians to spend more time caring for patients and less time searching for information or shuffling paper.

Barriers and Challenges

States contemplating the adoption of health IT face a number of hurdles.

Variations in state and federal privacy regulations must be worked out, and the transition to EHRs presents administrative challenges and manpower issues. But it’s the high cost of implementing EHRs and health information exchange that remains one of the biggest concerns. States are considering various ways to finance health IT, including through the appropriations process, state grants and contracts, and tax incentives for health IT users.

The numbers are daunting, however. The University of California-Davis recently reported that an effort to set up an electronic health record system there, which was expected to cost \$76 million and be completed in 2006, is only half complete and has cost \$85 million so far. A recent estimate said it will cost Florida \$51 million to build a secure data network for electronic medical information.

“Everybody agrees that e-health has value but figuring out who will help contribute to the effort, figuring out who benefits from a particular e-health application and therefore who should pay for it, is really diffuse,” said Matthews.

Indiana State Sen. Gary Dillon agrees.

“One of the problems is that the cost of getting systems set up is borne by the provider and the benefits accrue to the payers. So you have to work to develop some incentives for some of this to be done,” he said.

Although there are many issues to be resolved in e-health, many states are already making plans for a more high tech health future. In the process they’re making decisions that may lead to substantial improvements in the quality, cost and accessibility of health care.