

## HCA/HIIAB Interim Report (January 2009)

### I. Background

The development of a health information technology infrastructure has enormous potential to improve the safety, quality, and efficiency of health care delivery for consumers in Washington State. Today, consumers receive treatment in a health care system heavily dependent on paper-based records, with health information stored in individual provider practices. No existing institutions make comprehensive medical records for every person available at any point-of-care. As a result, the quality and efficiency of care is affected: tests are duplicated; providers act on incomplete information; medical errors and adverse outcomes occur; and without complete health information, consumers are not in control of their health care.

State leaders recognized the importance of taking action to address these problems in 2005, enacting Substitute Senate Bill 5064 directing the Health Care Authority (HCA) to "establish and collaborate with a Health Information Infrastructure Advisory Board" (HIIAB) to "develop a strategy for the adoption and use of electronic medical records and health information technologies that are consistent with emerging standards and promote interoperability of health information systems."

The HCA reviewed and evaluated these issues in close consultation with its newly-established Health Information Infrastructure Advisory Board (HIIAB), as well as a larger committee broadly representative of healthcare stakeholders, and submitted its final report in December, 2006. The report concluded that interoperability of health information systems coupled with consumer control would significantly improve availability of information to consumers and

providers. Its central recommendation was the phased implementation of a system that would allow consumers to have copies of key elements of their medical records from all sources deposited in a "health record bank" of their choice, under their control. These banks would allow aggregated copies of each consumer's medical information to be shared when and where needed with authorized providers, with the consumer's consent. The banks would also have the capacity to be queried for authorized public health and research purposes.

The HCA recommended \$9 million in additional funding to continue its work with the HIIAB in the 2007-9 biennium to 1) complete the plan for initial implementation, 2) implement the first health record banks, 3) engage consumers in the development of health record banking, and 4) promote electronic medical record (EMR) adoption in the health care provider community. In response, E2SSB 5930 chapter 10 was enacted providing \$4.4 million of funds to be allocated through the DIS technology pool. The requirement to go through the DIS process to receive these funds delayed the initiation of this second phase of the project for about six months. As a result, the planned pilot health record banks were funded in October, 2008, and their complete results will not be available until mid-2009.

## **II. Health Record Bank (HRB) Pilots**

Working with several Washington communities, the HCA is undertaking a "proof of concept" (pilot) of patient-managed health record banks. Once a consumer creates an HRB account, it will be populated with copies of key health information like prescriptions, allergies, lab results and immunizations from providers' records or other institutions that have this information. The overall goal is to learn what public policies need to be developed to support a consumer-centric health record bank and what the proper role of the state ought to be, including:

What needs to be done and what policies, protections, and incentives need to be developed to get consumers and providers to use a HRB?

1. How much and what health information is needed to provide value to the consumer or user of a HRB?
2. What are the next logical steps to increase greater provider participation?
3. How can timely copies of health information be obtained?
4. What needs to be done to earn the trust of the public with these pilot projects?
5. What needs to be done to earn provider trust and minimize provider barriers and obstacles to adopt this model?
6. How do we make sure that we do not widen the gap with health disparities and that we address special population needs?
7. What do we need to do to make sure that we develop ways to improve population health and public health surveillance?

Healthcare stakeholders were engaged across the state to provide input and comments to the plan for development of pilots. Meetings were held in several communities including Yakima, Wenatchee, and Spokane.

To educate consumers and get their input on HRB issues, we created a Web site called AccessMyHealth (<http://www.AccessMyHealth.org>). A group of consumers, doctors and others created the Web site to serve as one of the main vehicles for educating and gathering input from all kinds of Washingtonians. Everyone can get involved in helping us find out what consumers want and expect from a HRB – we even want citizens to sign up and take two online surveys. Survey results are also posted periodically and will tell us what we learn about consumer

preferences, concerns, and issues regarding health record banks.

An RFP soliciting community pilot HRB project proposals was developed and released in May, 2008, with responses due in early July. An initial merit review was performed by an independent external panel of national experts along with two Washington State consumers, all of whom provided written assurance that they are free of real or perceived conflicts of interest. A secondary review was done by state officials to factor in the results from the initial merit review with program, policy, and budgetary considerations. Three pilot sites were funded: Wenatchee, Spokane and Bellingham. These first three health record banks are expected to be operational in Washington communities in early 2009. The Access My Health Web site will soon provide further information on how to get involved in the community health record bank pilot sites and share what we are learning with the pilots, providers and consumers.

There has been a careful assessment of the risks associated with this pilot program, as well as ways to manage these risks. The project has worked to avoid the two biggest risks: starting from scratch to create the technology infrastructure and gaining participation of patients and doctors. One of the reasons for a proof of concept pilot is to make sure that we work the bugs out of the system and learn what will work and what may need to be improved.

One major risk is that of having to develop and build the technology needed for the HRB model. It has been the intent of the HCA to solicit applications from communities with well-established technical infrastructures and systems to avoid building from scratch. The selected communities demonstrated that they have the technology and ability to facilitate a rapid enhancement of their systems and accomplish what needs to be done by the end of this year for implementation in early 2009.

The second key risk is “build it and they will not come.” Equally important in selecting communities with solid information technology infrastructure is the need to demonstrate that they have well established, credible, trustworthy, and effective organizations and partnerships to make the “people connections” necessary to engage and enroll community members in the pilots. By selecting communities with demonstrated experience and deep technical and people infrastructures we believe we are adequately managing these risks.

### **III. Evaluating the HRB Pilots**

The three community pilot projects are intended to test the usage and benefits of health information when managed by consumers in cooperation with their doctors. This proof of concept pilot program is probably the first in the country to use consumer-managed health record bank accounts. In this model, local communities through trusted and known organizations are in the lead and are partnering with national and regional vendors in building the HRB. This phase of the pilot is to see if the basic pieces of the community health record bank model work and if consumers can use and share their health information with providers, family members, and others involved in their health care (with consumer permission) to improve their health. Based on national surveys, informal surveys, as well as consumer and provider feedback, the initial focus of health information to be included in the HRB pilots was determined to be medications, medication allergies and advanced directives. All three pilot awardees indicated that they would also offer additional data and would include immunizations and lab results. Some pilot sites will offer more than this, but it is important to note that all pilots will offer more than the minimum required for the proof of concept.

The key purpose of the HRB pilots is to learn what policies and business practices need to be put

in place, how to gain support and trust of medical personnel as well as patients/consumers, and how to improve the flow of health information. In addition to these basic lessons, we want to learn what public policies need to be developed to support a consumer-centric health record bank and what the proper role of the state ought to be.

To address these issues, surveys will be done to determine the level of consumer and provider interest and participation in the HRB pilots. Governance, policy, operational, financial sustainability issues will be systematically collected and included in the final report of each pilot project. We are also on the alert to observe any potential unanticipated outcomes of the projects, either positive or negative.

#### **IV. Promoting EMR Adoption**

In order for health record banks to function optimally, there must be electronic sources for all the needed patient information; therefore, widespread EMR adoption is necessary. The first HCA/HIAB report concluded that continuity and availability of health information should be supported by providing incentives to accelerate the adoption and use of Health IT and EMR systems by providers in Washington State. The HCA recognizes that the health care system is not properly aligned to provide incentives for adoption of EMR systems, and reimbursement systems currently do not encourage adoption or incentives for providing quality care.

Based on the most recent information, barriers to EMR adoption fall into three major categories: financial (costs of installation and operation), technical (provider offices cannot support/manage the technical tasks needed), and practice (providers are not able to redesign and reconfigure their operations to accommodate an EMR). We are also planning to update our information about current adoption rates in Washington State to determine how much progress has been made, and

whether there are any important patterns developing that may have policy implications.

We aim to gain a deeper understanding of the barriers to EMR adoption to overcome them. The plan is to engage multiple healthcare stakeholders to provide input and feedback on both barriers and potential policy approaches to accelerating EMR adoption. In collaboration with the HIIAB, HCA will evaluate and prioritize these options and develop specific recommendations.

Evaluation criteria for policy options will include: 1) practicality (can it be implemented?); 2) effectiveness (will it work?); and 3) cost (is the cost within acceptable range?).

In 2008, the federal Centers for Medicare and Medicaid Services (CMS) announced a new demonstration initiative to foster the implementation and adoption of EHRs and health information technology (HIT) more broadly. Over a five-year period, the project will provide financial incentives to as many as 1,200 physician practices that use certified EHRs to improve quality as measured by their performance on specific clinical quality measures. Additional bonus payments will be available, based on a standardized survey measuring the number of EHR functionalities a physician practice has incorporated. To further amplify the effect of this demonstration project, CMS is encouraging private and public payers to offer similar financial incentives consistent with applicable law. In June, 2008, CMS announced the selection of 12 community partners for the demonstration project. Recruitment of physician practices in the first four Phase I sites will begin in the fall of 2008. Recruitment for Phase II sites will begin in the fall of 2009. However, none of the community partners are in Washington State or the Northwest.

Meanwhile, HCA continues to participate in the Washington Health Information Collaborative to assist providers in evaluating, implementing, and connecting EMR systems. An important

component of this effort is the help offered to provider groups, particularly small groups, in redesigning workflows during and after implementation to reduce waste, improve productivity, and enhance clinical quality.

EMR adoption recommendations will be included in the final HCA/HIAB II report in mid-2009.

In a fiscally constrained environment, it is likely to be difficult to develop policies that can overcome EMR adoption barriers, particularly those that are inherently financial. Also, it is difficult to predict whether specific policies will actually be effective in accelerating adoption. We hope to mitigate these risks by engaging extensively with the key stakeholders and leveraging the potential for increased EMR value to providers that may be possible with the establishment of health record banks.

#### **V. Roadmap for remainder of HIAB II**

The ongoing implementation of the three HRB pilots will continue, with careful ongoing monitoring and evaluation. Through collaboration among the pilots, efforts to develop tools, policies, and infrastructure will be shared and adopted by other pilots as appropriate.

Potential EMR adoption acceleration policies will be assessed with extensive collaboration and input from stakeholders. Specific recommendations will be developed.

Potential public policy changes will be considered and recommendations developed. Specific areas to be considered include: 1) reaffirming each individual's right to privacy and control of their health and medical information; and 2) ensuring that every individual can receive, at no additional cost, a copy of their newly-generated electronic medical information at each healthcare encounter.

Recommendations will also be developed for those activities needed to complete the health information infrastructure development and evaluation work of HIIAB I and II, including:

1. Continuing and broadening stakeholder participation
2. Recommending strategic action for further HRB development
3. Recommending additional strategic action to accelerate EMR adoption
4. Evaluating how to develop reliable methods for highlighting the most relevant and important subset of clinical information to providers (selected from comprehensive electronic records) at each encounter
5. Evaluating how to develop, deploy, and evaluate clinical decision support for providers

## **VI. Conclusion**

Health information is just part of health care reform. Making comprehensive health records available at every point-of-care is a critical and necessary change to improve the quality, safety, and efficiency of care. The failure of our current system to consistently provide comprehensive medical information leaves us with very limited options for improvement. But information alone is not sufficient -- it must be wisely used in order to make a difference. This means we must not only make such comprehensive information available, but also ensure that providers and patients are ready, willing, and able to use it.

Together, health record banks and EMRs can provide comprehensive electronic information at the point of care. EMRs are the tools that can collect the information in electronic form in the first place, allowing it to be transmitted, stored, and delivered when and where needed. Health record banks provide the mechanism for efficiently aggregating each person's records under their

own control, and delivering it to the point-of-care while assuring privacy. EMRs then can also become both the conduits for delivery of comprehensive patient information and the focal point for the availability of decision support, thereby insuring that clinicians always have the benefit of the latest evidence-base knowledge to aid in making personalized judgments about each patient's care.

Through the ongoing efforts of HCA in collaboration with the HIAB and other healthcare stakeholders, Washington State is in the forefront of empowering consumers with their health care information. We are committed to the continuing efforts that are needed to finish implementing the vision and assuring its sustainability.

DRAFT