

**Health Information Technology and Health Information Exchange Topical Area Meeting  
Clinical  
August 18, 2006**

**Vision**

What is the vision for how we want to use Health Information Technology?

- DNR
- Directives incurred
- Current and previous medical history; diagnosis; support with clinical decision making; online references, drug interaction programs, reminders and alerts about guidelines, formularies
- Alerts: may shut down many alerts; implementation choice  
Choice what doing with alert; degree of why ignore, what to do
- Sometimes with paper, there is too much information; how do I find what it is exactly I am looking for?
  - Get pertinent information on patient quickly  
Ex: If patient comes for heart failure, probably does not have to have information on previous substance abuse; is ALL previous medical history needed to have for what I am treating?
- ER Benefit: has ability to have access to data; data must flow within systems and between systems; between hospitals, hospitals and office; between sites of care
- Enter data once goes to wherever needed
- Transition paper uncoded text to code
- Who put information in and who takes out
- Who enters change; safeguards on change
- First responders tied to electronic system; ex. DNR
- E-prescribing: huge importance on functionality
- Duplication of effort; state web site; registry for pay-for-performance
- Ease of mandatory reporting-reduced
- Ease of chart reviews
- Master patient index
- National Patient Identifier
  - Algorithm

**Barriers to HIT Adoption**

- Administrative Data:
  - How to insure proper coding occurs
  - Real part of visit happened
- Money: adopt, purchase; workflow analysis; implement; training; update; transfer paper to electronic; and maintain
- Workforce barriers; people uncomfortable with computers; buy-in between sites/providers; physical layout of facilities; how people trained to document; fear of how impedes visit
- No capital budget, small practices

- Money: appropriate reimbursement; showing physicians return on investment to practice-pay better, reduce expenses (paper, supplies, storage), reduce staff/reassign to better patient care, increase personal time), stark changes-prescription whole cost (15% provider obligation), how share savings (especially to 3<sup>rd</sup> party payers); 3<sup>rd</sup> party pay for implementation – grants/loans; federal legislation changes; pooled purchasing assistance to lower cost publicity created tools
- System P4P needs work across all systems, number of different protocols per payer
- Might decrease turnover
- Better use of staff time
- Fear of Betamax: certification stands hope with vendors-18 ambulatory certified, inpatient next year
- Demands from new docs who want EHR: recruitment tool
- Patients enter data in visit, better visit

### **Barriers to HIE**

- Reluctance to share/competition/who owns the data
- Standards: a way to translate data between data sources; have for billing data; continuity of care; transmission protocols between systems
- Legal issues; what can be shared
- EHR and liability
- Infrastructure to Exchange: Bandwidth, cost to conflict, fall on same broad band collection
- Where is exchange going to happen?
- Cost to participate in exchange for providers?
- Patient identification for exchange
- Regulatory issues:
  - Telemedicine
  - Pharmacy Board-documentation physician, really prescribe, drug diversion
  - HIPPA-privacy security
  - Education-privacy security
  - Teen screening-privacy security

### **Policy Options to Address HIT Adoption and HIE**

- To get sharing: Community expectations, incentives, requirements, consumer/patients
- Need to develop exchange: where happen, what level, when
- Right of parents to see data