Interoperability Standards May Silence EHR Babel

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Contributing Writer

WASHINGTON — Eliminating "the stupid clipboard" may be the simplest, most straightforward benefit that would come from electronic interoperability standards designed to allow physicians' offices to communicate with hospitals, labs, insurers, and each other, according to Dr. John Halamka, the chairman of the Health Information Technology Standards Panel.

As reimbursement and quality are linked, electronic records will be indispensable for documenting measures expected by payers.

HITSP just delivered its first set of harmonization standards to the federal Office of the National Coordinator for Health Information Technology. The panel was convened just over a year ago by the American National Standards Institute (ANSI) under a Health and Human Services department contract to assist in the development of a Nationwide Health Information Network (NHIN).

The panel is developing a series of interoperability specifications that offer a road map for every vendor, hospital, and other stakeholder who wants to implement electronic health records that conform to a nationally recognized standard, Dr. Halamka said at a health care congress sponsored by the Wall Street Journal and CNBC.

For this first set, the panel sifted through 700 standards, a veritable hexadecimal soup including X12, HL7, NCPP, and the Continuity of Care record, whittling that down to 30. It was an emotional process that incorporated the best of all of those standards in what the panel calls a Continuity of Care Document, he said.

This is a work in progress, Dr. Halamka added. "As the industry begins to test these interoperability specifications we know there are going to be refinements. There are going to be areas of ambiguity that we need to clarify."

"What's going on at the [American Health Information] Community, at HITSP, at the Certification Commission [for Healthcare Information Technology] are essential ingredients to successful transformation of health care," said Dr. Michael Barr, vice president of practice advocacy and improvement at the American College of Physicians.

Unlike hospitals, small medical practices lack the resources to adopt electronic health records or other information technology, he said.

"There are knowledge barriers, there are cost barriers," said Dr. Barr, adding that it is difficult to figure all this out while running a practice.

But health information technology does pay for itself, and as reimbursement becomes increasingly linked to quality, electronic records will be indispensable for documenting measures expected by payers, he said.

Physician groups that have adopted EHR systems expect them to make it easier to adapt to new payment require-

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ments in the long run, but they offer the near-term benefits as well, said Bruce Metz, Ph.D., chief information officer for Thomas Jefferson University in Philadelphia.

The University's 500-physician group practice has spent the past 3 years implementing an $18 million electronic records system with an expected 16%-30% return on investment. Insurance companies are not yet ready to pay the group a premium for the efficiencies the system brings, but because of improved documentation, the system has already allowed significant upcoding, he said.

Although more physicians are becoming convinced of the benefits of EHR adoption, the government may be moving forward too aggressively, Dr. Barr said.

Congress wants Medicare to implement pay for performance now, although the industry is still struggling to identify appropriate measures. "The policy is well ahead of the practicality," he said.

If the experience with HIPAA Administrative Simplification proved anything, it was that having standards is only the beginning of the process, Dr. Halamka said. The next step is to work out a logical time frame for compliance, what are the incremental phases along the way and how to test compliance. ■

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