Health IT Interoperability Standards Progressing

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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.

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 Department of Health and Human Services 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 number down to 30, he explained.

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 and other large institutions, small medical practices have not had the resources to adopt electronic health records (EHR) or other information technology, he said. "There are knowledge barriers, there are cost barriers. There is just so much information to digest," said Dr. Barr, adding that it is extremely difficult for these physicians to figure all this out while running their practices.

But health IT does pay for itself, and as reimbursement becomes increasingly pegged 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 requirements 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 3 years implementing an $18 million electronic records system with an expected 16%-30% return on investment. Insurance companies won't pay 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. ■

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