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Subcommittee on Technology and Innovation
United States House of Representatives

Is 'Meaningful Use' Delivering Meaningful Results? An Examination of Health Information Technology Standards and Interoperability.

November 14, 2012

INTRODUCTION

Good morning, and thank you for inviting me to participate in today's discussion. My name is Rebecca Little and I am here on behalf of Medicity, a Health Information Exchange –commonly referred to as an HIE--technology company headquartered in Salt Lake City, Utah. Medicity is a wholly owned subsidiary of Aetna.

We are an HIE. And what that means is we supply the "plumbing," the intelligent plumbing, rather, that allows electronic medical records, electronic health records, lab services, pharmacies, hospitals, doctors' offices, and other providers to connect with one another.

To continue with the metaphor, it doesn't matter what Electronic Medical Record (EMR)—or fixture—a provider uses. Whether a provider is using Health Information Technology for the first time, or has been using it for years, we can accommodate their needs at any state of readiness or sophistication. The Medicity HIE plumbing can connect any type of fixture to another so that health information and patient data can be safely and securely transmitted.

This matters to you, as policy makers, because Medicare and Medicaid costs are unnecessarily greater when the lack of information leads to bad outcomes or repetitive testing and procedures. The results translate directly into lower health costs. Improved use of diabetes medicines can cut risk of hospitalization by half; diabetics who take their medicines less than 80 percent of the time were 2.5 times more likely to be hospitalized for a diabetes or cardiovascular-related condition in the next year[1]. In total, poor adherence results in 33 to 69% of medication-related hospital admissions at a cost of roughly $100 billion per year[2]. These are costs that are absorbed by taxpayers in Medicare and Medicaid, and they cannot be addressed effectively without robust patient information. This is why interoperability across providers is so important.

Our plumbing is truly interoperable, allowing for the safe exchange of patient health information across public and private HIEs; across multiple provider systems; between small and large physician practices; and across and within hospital systems.

True HIE interoperability— the seamless flow of health information data in a secure framework— is the necessary ingredient to transforming patient care and creating a more effective, efficient and, ultimately, less-costly health care system. Because once the electronic connections are established across providers and networks and the patient health data begins to flow, other

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[1] D.T. Lau, "Oral Antihyperglycemic Medication Nonadherence and Subsequent Hospitalization Among Individuals with Type 2 Diabetes," *Diabetes Care*, 27 (2004): 9, 2149-2153.

[2] Osterberg L, Blaschke T. Adherence to medication. *N Engl J Med*. August 4, 2005;353(5):487–497.

health information technologies can be put to work to turn that data into useful information for physicians and patients--savings lives, reducing medical errors, and substantially lowering costs[3].

These successes are happening today. A recent Health Affairs article demonstrated the success of a Medicare Advantage pilot in Maine, where the provider collaboration relied on shared patient data in conjunction with patient coordination. The result of using patient data to improve patient outcomes and lower costs could not be more clear: the patient population had 50 percent fewer hospital days, 45 percent fewer admissions. And the corresponding costs were 16.5 percent to 33 percent lower than costs for patients not included in the pilot[4].

But these types of successes could not be achieved without robust standards for interoperability **and** data sharing. Even though health information exchange is a requirement for demonstrating "meaningful use" under the HITECH Act, health information exchange is really about preparing providers and health care organizations for the future of healthcare as delivery models and reimbursement constructs continuously evolve.

This exchange of healthcare information—across providers, hospital networks, and between different HIEs--holds the power to improve patient care and improve efficiencies by fostering care collaboration and lowering administrative costs. We're already seeing encouraging outcomes of how patient data can be turned into actionable information for physicians to use to improve clinical outcomes for patients.

The rest of my written testimony provides examples of how Medicity and Aetna are meeting providers at their state of readiness to employ low-cost technology solutions that will drive toward efficient, low cost, high-quality patient care.

HOW MEDICITY WORKS

Medicity's technology provides the foundational technology and capabilities to securely exchange patient health information in a vendor-neutral manner specifically we do this regardless of which electronic medical record a provider may be using and regardless of where the provider organization is along the technology adoption curve.

For example, Medicity currently connects healthcare providers using more than 150 unique clinical technology solutions. This gives doctors and other authorized and authenticated users involved in the patient care process timely access to current, accurate and actionable information. With current information, providers can make better decisions that often translate into better outcomes, higher quality and lower costs.

In 2007, the Delaware Health Information Network (DHIN) deployed the Medicity solution to successfully connect the major health systems and Labcorp to physicians (including the federally qualified health centers) across the state. Today, 100% of the hospitals in Delaware, all commercial labs are connected, and many of the free-standing diagnostic imaging centers; 10 Million results and reports are delivered to physicians annually where 26% of those clinical results are delivered electronically and directly into the practice's EHR. There are 1.5 Million unique patients in the DHIN system. The Delaware Health Network also collaborates with public health for electronic lab reporting, reporting of immunizations, etc.

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[3] Javitt, et al. "Using Claims Data-based, Sentinel System to Improve Compliance with Clinical Guidelines: Results of a Randomized Prospective Study," American Journal of Managed Care Feb.2005: 93-102
[4] Claffey, et al. "Payer-Provided Collaboration in Accountable Care Reduced Use and Improve Quality in Maine Medicare Advantage Plan," Health Affairs Sept. 2012, Vol 31.

In an independent evaluation study conducted in 2011, a variety of comprehensive analyses were completed and among the providers interviewed, there was consensus that data provided in the DHIN will have an impact on care delivery including reduction in duplicate tests[5]. This was supported with an analysis of test results for tests that are often high cost and high volume. The rate of test results per unique patient sent through the DHIN (as determined by the Community Master Patient Index), in June 2011 as compared to June of 2009 was 30 percent lower for radiology exams and 33 percent lower for lab results.

Using the DHIN structure, savings of over two million dollars has been realized by data senders with providers who utilize the DHIN as the primary method for receiving results based on the average cost to send results using traditional methods of fax and mail. Additional savings of one million dollars could have been realized for the same period if all DHIN member providers were committed to use the DHIN as their primary source of results reporting

THE VALUE OF INTEROPERABILITY

Through successfully integrated/interoperable Health Information Exchanges (HIEs), providers can improve care and effectively track and manage the health care of their entire patient population across a spectrum of care providers.

Interoperability is critically important, especially given the highly fragmented nature of our health delivery system. For doctors and nurses, interoperability produces information at the point of care to track cost and quality across different healthcare providers. This is important in care models such as ACOs and medical homes, where information sharing across team members is critical to holding down costs.

The “seed money” provided through the ONC State Health Information (State HIE) Exchange Cooperative Agreement Program has helped many states take positive steps toward advancing the exchange of health information among providers and hospitals. We are encouraged by some of the early successes of the program, and yet we also recognize the challenges that remain.

Michigan Health Connect (MHC) is a Regional Health Information Organization (RHIO) that promotes and manages Health Information Exchange (HIE) services in the State of Michigan. One of the issues Michigan Health Connect (MHC) hoped to tackle through HIE was the referral process, which created a significant workflow problem for physicians, and involved filling out and faxing forms, as well as numerous phone calls between providers.

Within 120 days, MHC rolled out an electronic Referrals application (which is by the way, compliant with the ONC’s Direct Project) to 100 practices — including 21 specialties — and is adding practices to the eReferral network at a rate of 9 practices per week. These practices are now able to replace the multiple phone calls and fax exchanges with secure, electronic care team networks that enable eReferrals, increase collaboration, and present a coherent picture of a patient’s health to all members of the care team.

For patients, especially people with chronic conditions such as diabetes and / or high blood pressure, many often receive care from many different providers. There are currently about 24 million adults and children with diabetes, and that number is expected to increase dramatically over the next ten years. One of every five health dollars are spent on these patients.

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[5] Report was prepared for: Agency for Healthcare Research and Quality U.S. Department of Health and Human Services; Prepared by: Maestro Strategies, LLC Roswell, GA 30076

For these individuals and their families, it is especially important that care providers are able to know whether the patient is adherent to their care plan because diabetics are at greater risk of hospitalization, amputation and lower quality of life when they are not. This may mean ensuring prescriptions are filled and taken and wellness visits are scheduled and kept.

This matters to you, as policy makers, because Medicare and Medicaid costs are unnecessarily greater when the lack of information leads to bad outcomes or repetitive testing and procedures. The results translate directly into lower health costs. Improved use of diabetes medicines can cut risk of hospitalization by half; diabetics who take their medicines less than 80 percent of the time were 2.5 times more likely to be hospitalized for a diabetes or cardiovascular-related condition in the next year[6]. In total, poor adherence results in 33 to 69% of medication-related hospital admissions at a cost of roughly $100 billion per year[7]. These are costs that are absorbed by taxpayers in Medicare and Medicaid, and they cannot be addressed effectively without robust patient information. This is why interoperability across providers is so important.

Fortunately, this is not a today problem with a tomorrow solution. Medicity supplies an army of doctors and other individuals involved in the care process with actionable information on diabetics today. But we could do much more if the Meaningful Use program were made more meaningful. This means solid, strong standards for interoperability sooner rather than later and a clearly defined role for HIEs in the program. We also believe that investing in new standards and protocols to replace existing, effective, and widely utilized protocols is not an effective use of tax dollars. Finally, we should include meaningful measurement in the technology, process and outcomes, so we are constantly improving, increasing standards, and providing patients with better health outcomes.

CONCLUSION

We appreciate the Subcommittee's efforts to reinforce the importance of health information exchange and interoperable exchange of health information, and I look forward to answering any questions you may have.

Thank you.

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[6] D.T. Lau, "Oral Antihyperglycemic Medication Nonadherence and Subsequent Hospitalization Among Individuals with Type 2 Diabetes," *Diabetes Care*, 27 (2004): 9, 2149-2153.

[7] Osterberg L, Blaschke T. Adherence to medication. *N Engl J Med*. August 4, 2005;353(5):487–497.