American Hospital Association

Best Information

Background Good information is the gateway to good care. With the right information at the right time, we can improve patient safety and increase efficiency by removing duplicative testing and unnecessary costs from the equation. Easy access to patient records and medical information improves the health care experience, and enables better care coordination.

Health information technology (HIT) is widely viewed as the tool that can bring us these benefits, and the AHA has been an advocate for the rapid adoption of electronic health records (EHR) and the use of national standards of interoperability. However, due to high costs and potential for disruption of care, the majority of hospitals have not implemented a comprehensive EHR. According to a recent *New England Journal of Medicine* report, less than 2 percent of hospitals use comprehensive EHRs, and an additional 8 percent use a basic EHR in at least one care unit that includes physician or nurse notes.

The cost of employing HIT has long been considered a primary obstacle to greater adoption, and the *American Recovery and Reinvestment Act* (ARRA) provides substantial incentive payments for physicians and hospitals to adopt or further advance HIT systems for the first time. The ARRA provides approximately $19 billion in funding to help providers adopt HIT. The states will be given close to $2 billion to fund loan and grant programs to help hospitals and physicians pay for IT adoption. Approximately $17 billion will be provided through special Medicare and Medicaid incentive payments to hospitals and physicians that have already paid for and adopted HIT.

The ARRA also codifies the Office of the National Coordinator for Health Information Technology (ONCHIT), and outlines a standards development and certification process for EHR systems that will further reduce the risks of moving forward with IT adoption for providers. The act creates two new committees, the HIT Policy Committee and the Standards Committee, to bring non-government expertise into the policy and standards setting process.

However, the ARRA also included troublesome privacy provisions that will need to be addressed during the regulatory process. Additionally, the legislation establishes very aggressive timeframes for setting standards for EHRs. Meeting the standards' objectives in a timely manner and implementing payment changes will push the limits of the Department of Health and Human Service (HHS), the Centers for Medicare & Medicaid Services (CMS) and ONCHIT regulators, as will adopting the technology by physicians and hospitals.

AHA View Information is the lynchpin of a world-class health care system. And as part of the *Health for Life* initiative, the AHA determined that an essential element of reforming

our health care system is to ensure that we get the best information to providers, patients and researchers. It is one of the five pillars of the AHA's framework for change. We have to accelerate the adoption of HIT by addressing the financial, regulatory and technological barriers, including inter-operability and standardization.

Since the enactment of the ARRA, the AHA has educated hospitals on how HIT standards and incentives are likely to be implemented. In addition, the AHA pushed for hospitals to be represented on the ARRA-created HIT Policy and Standards Committees. The ARRA provides parameters for the standards setting process, funding process and privacy requirements; however, many issues are unresolved and regulatory guidance is needed before hospitals will know how the ARRA provisions will be fully implemented.

There are three HIT provisions included in the ARRA that are of concern:

- identification and selection of HIT standards and product certification;
- methods for determining and distributing HIT incentives and funding; and
- privacy and security.

One of the most controversial issues is determining the definition of a "meaningful user" of HIT. Only hospitals that are deemed "meaningful users" will qualify for Medicare and Medicaid incentives. Additionally, if hospitals are not declared to be "meaningful users" by 2015, payment penalties will be applied to them for not adopting HIT. Meaningful use could have many different components – ***adoption*** of certified EHR technologies, ***use*** of EHR technologies by a significant percentage of hospital physicians and clinical staff, ability to submit quality data using IT, ability to protect and maintain privacy of patient EHRs, and ability to electronically exchange and share health information. Hospitals are at different levels in all of these categories of HIT adoption. **The AHA will work to ensure that standards are set in a flexible manner in early years to allow more hospitals to qualify for financial incentives.**

The AHA will be actively involved in the upcoming regulatory process to ensure that the hospital concerns and priorities are addressed. The AHA will urge the administration to set forth reasonable and achievable HIT adoption and implementation goals – including defining "meaningful user" in a way that allows hospitals to receive funding while they continually improve EHR systems in a comprehensive manner. **The AHA also will urge the Secretary of HHS to modify some burdensome privacy provisions.**

On the privacy side, the AHA is concerned about the ARRA provision that expands providers' responsibility to account for disclosures of personal health information. Under current law, hospitals must account to patients for disclosures of their personal health information, but ***not*** for disclosures made in the course of treatment, payment and health care operations — the most frequent disclosures. The ARRA expands

the "accounting for disclosures" responsibility to include disclosures for treatment, payment and operations purposes, which significantly increases hospitals' reporting burden. However, the ARRA shortened the look-back period so that hospitals will be required to account for disclosures for only three years, instead of the current six year requirement. Hospitals with new electronic systems will have to incorporate this expanded reporting requirement by 2011, while those with existing electronic systems will have until 2014 to modify their systems. The ARRA allows the Secretary some flexibility to delay these effective dates, which the AHA will pursue. The AHA also is monitoring the development of a new national standard for hospitals to use in notifying patients when their personal information has been breached.

Other HIT Issues. Achieving our national goal of having effective EHRs for all Americans also requires other integral issues to be addressed, including ensuring unique identification of patients for safe and accurate information exchange across providers, expansion of bar coding technologies for drugs and devices, and modernization of our nation's coding system.

The issue of how to match patients with their medical records remains unresolved despite the continued push for interoperability on a national scale. **The AHA continues to press for a resolution, and recommends the creation of a nationally unique identifier to connect records and to ensure that hospitals and physicians have the best information available when providing care for each patient**.

The Food and Drug Administration is expected to introduce proposed rules for the use of unique device identifiers for medical devices in 2009. **The AHA will continue to advocate for a uniform system of identification in order to streamline supply chain efficiencies, reduce costs and improve patient safety**.

In January, the Secretary released the final rule to replace the outdated ICD-9-CM coding classification system with the updated ICD-10-CM and ICD-10-PCS by October 1, 2013. This update was long overdue, and the AHA strongly advocated for it. Successfully transitioning to ICD-10-CM and ICD-10-PCS will require careful planning and coordination of resources, as many provider and health plan databases and applications will be affected. The AHA ICD-10 Resource Center will provide assistance as hospitals prepare for ICD-10 adoption.

While these are distinct issues apart from adoption of EHRs, they are critical components of a successful and modern EHR system.

Price Transparency. People deserve meaningful information about the price of their hospital care, and hospitals are committed to sharing information that will help consumers make important decisions about their health care. However, sharing pricing information is challenging because hospital care is unique. Hospital prices can vary

based on patient needs and the services they use; the services needed cannot always be determined ahead of time; prices reflect the added costs of hospitals' public service role to provide care 24 hours a day, seven days a week; and hospitals' prices do not reflect important information from other key players, such as the price of physician care while in the hospital or how much of the bill a patient's insurance company may cover.

But more can, and should, be done to share hospital pricing information with consumers. **To facilitate more meaningful price transparency, the AHA supports state efforts to report hospital pricing data and a requirement that insurers disclose estimated out-of-pocket costs to consumers.**