American Hospital Association

Summary of selected IT policy issues			
Policy	**Description**	**Benefits**	**Issues**
Relaxing Stark and anti-kickback laws	The Stark law prohibits physicians from referring Medicare and Medicaid patients to an entity with which they have a financial relationship. The anti-kickback law limits the remuneration physicians can receive from hospitals, including software, hardware, and other IT products. A limited exception to Stark has been crafted for community-wide health information exchange, but it has significant restrictions.	• Providing an exemption to Stark and safe harbor from anti-kickback would allow hospitals to extend their IT systems to local physicians and organize local information exchange.	• Exceptions/safe harbors cannot be conditioned on meeting standards for interoperability because they do not yet exist. • Need to keep such protections from being seen as THE solution for physician adoption of IT. • Will this create expectation for hospitals to provide IT to physicians?
Developing standards for interoperability	• Most IT systems in use have unique ways of describing and organizing data, which makes it difficult to share across providers. • Achieving interoperability requires agreement over messaging, vocabulary, and content standards. Getting there will not be easy, but is necessary for efficient data exchange. • There are different levels of interoperability. For example, many systems can share data as XML messages that can be viewed, but cannot become integrated into another systems without data entry.	• Standards for interoperability make investments in IT more attractive because information generated in one place (e.g., lab and pharmacy data) can be accessed where clinical decisions are being made. • Greater sharing of information will increase the availability of information at the point of care, which could improve quality and coordination of care, ease the process of care for patients, and lead to reduced need for duplicate testing.	• All stakeholders need to agree to standards. Standards need to be supported by detailed implementation guides and use cases. • Interoperability across providers and the nation is not needed for hospitals and systems to benefit from IT. Interoperability across departments and members of a system is. This can be achieved by purchasing "enterprise systems" or by requiring interoperability as part of a "best of breed" procurement strategy. • Full interoperability is years away and has the most benefit for reducing global costs of the health care system, and improving public health surveillance and research.

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Developing regional health information organizations (RHIOs)	A major focus of the federal government is the creation of regional health information organizations that can facilitate information exchange among local health care entities (including payers, providers, state agencies, etc.). The vision is of a national network of local RHIOs that will allow data exchange across the nation. Few RHIOs exist today, but many are under consideration.	• RHIOs can facilitate the transfer of information needed for treatment, public health surveillance, and research. • RHIOs could ensure that development costs for information exchange networks are shared among stakeholders and serve as a focal point for receiving grants, etc. • RHIOs can facilitate adoption of IT by pooling expertise and purchasing power, and by providing technical assistance.	• The roles and responsibilities of RHIOs are not yet well defined. • The few RHIOs that exist today are "homegrown" and may have to make significant changes to connect as part of a broader national network. • RHIOs require considerable cooperation among stakeholders and require development of governance structures, legal relationships, and financial responsibilities. • As largest health care providers in markets, hospitals may bear considerable burden in organizing and financing RHIOs. • Effective sharing of information among participants in a RHIO (and outside) requires adherence to common standards for interoperability that do not yet exist.
Providing grants and loans to RHIOs	To spur the development of RHIOs, the government and foundations are providing development and implementation grants (AHRQ last year; eHealthInitiative; ONCHIT if funded)	• If appropriate organizational structures can be developed, grants and loans to RHIOs can help speed formation	• Can RHIOs effectively bring stakeholders together? • Is it better to focus on adoption by individual providers? • Federal efforts (e.g., relief from Stark and anti-kickback laws, grants and loans) could be conditioned on participation in a RHIO.

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Pay-for-performance that includes IT	Many insurers and the Medicare program are beginning to differentiate payment based on measures of quality. Some of the measures are more easily achieved through use of IT. Other measures, such as hospitals using CPOE, actually require use of IT.	• Pay for performance can recognize and reward better quality care. • Additional payments may partially cover costs of investments in IT.	• Pay for performance does not address the significant up-front costs of IT investment. • Pay for performance could limit hospitals' willingness to share lessons if it is zero-sum. • Pay for performance may crate additional advantages only to organizations able to fund the significant up-front costs.
Providing grants and loans to providers	Some providers may not have the means to invest in IT without financial assistance.	• Programs to provide assistance could help providers that might otherwise not adopt IT.	• Grants and loans could be conditional on participation in a RHIO or use of technology that is either certified or that meets interoperability standards. All of these restrictions could be problematic in the short term, as RHIOs, certification processes, and standards are developed.
Certifying IT products	Purchasing IT products can prove daunting. Certification would provide independent verification that products meet certain standards for functionality, security and reliability, and interoperability.	• Having a "good housekeeping" seal of approval indicating that a given application does what it claims to do could help buyers in the market. • Setting out certification criteria provide vendors with guidance on what to incorporate in products.	• Certification will be a minimal set of standards. To achieve vendor buy-in, the floor may be set too low to be meaningful. • Federal efforts could be conditioned on use of certified products, which may be problematic if certification does not yet exist for all applications or if the certification process does not meet needs of buyers.
Providing technical assistance	IT investments can be risky; successful implementation is not guaranteed. Navigating the IT market requires contracting and IT knowledge that some providers do not have (particularly physicians in small offices and smaller hospitals).	• Technical assistance can help ensure that investments in IT are not wasted.	• Federal technical assistance efforts will likely focus on physicians first. Should it also target smaller hospitals / rural hospitals?
Federal pre-emption of state and local	States and localities may have privacy laws that are more stringent that HIPAA standards. Requirements can also be part of accreditation	• Federal pre-emption with HIPAA as the ceiling would provide a single set	• Privacy advocates want HIPAA to be a floor, not a ceiling.

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privacy laws	standards, licensure requirements, etc. The multiplicity of laws can create confusion and a reluctance to share information needed for treatment for fear of litigation.	of rules.	
Creating a single patient identifier	Sharing of information and use of electronic records requires an ability to match identities: does the record on your computer belong to the patient in front of you? Are you sending lab data for the right person? We don't have a single number to identify a patient.	• A single patient identifier would facilitate exchange of information and diminish the likelihood of mistakes due to incorrect matches of records to patients.	• Politically charged. • Some organizations are working on algorithms to triangulate information and make matches on demographic data.
Personal health records	In addition to EHRs maintained by providers, many advocate personal health records (PHRs) for consumers. These can take the form of patient access to provider EHRs, or be independent of providers (some are hosted by a web company, others are completely in the consumers' control).	• PHRs can be tools to increase patient involvement in care and compliance. They can include access to educational materials and allow patients to enter information unknown to providers (e.g., whether medications are taken, exercise regiments, daily weight, etc.). • PHRs allow family members to access information about children/parents for whom the are caregivers.	• How will PHRs interact with EHRs? • Does patient access to provider-owned EHRs lead to misunderstandings due to use of medical lingo, increased demand for explanation, or increased liability?