

Commentary

Why RHIOs Aren't Working: Views from an American Who Can See White Rock, British Columbia, from His Backyard

David E. Garets, FHIMSS

The problems with RHIOs (often referred to as health information exchanges) in the United States have as much to do with the structure of the American health “system” as they do with non-existent business models for funding them after the grant runs out and lack of interoperability standards.

Misaligned Incentives

Our “system” is “distinguished” by an incredible lack of aligned incentives.

- Insurance companies want to keep their insured consumers from engaging in expensive procedures or showing up in expensive venues (emergency departments) and have a reputation for looking for creative ways to not pay for medical services.
- Hospitals think they're the centre of the medical universe and make their money getting most of the sick people and providing as many services for them as are reimbursable by the tight-fisted insurers.
- Most American physicians are independent business people trying to maximize their incomes and attempting to gain leverage from hospital competition in their communities.
- Pharmaceutical companies, for the most part publicly held manufacturing firms, are intent on maximizing their profits and have figured out how to be successful – spend billions of dollars lobbying the US Congress to keep price controls and imported drugs out of the country while marketing directly to consumers.
- US residents, 47 million of whom are uninsured (approximately 16% of the population), are left to fend for themselves with competing doctors, hospitals, pharmaceutical companies eager to have them “ask your doctor whether whatever drug we're pushing today is right for you.” In the United States, the costs for this madness are escalating far faster than inflation and presently comprise at least 15% of the US gross domestic product, a far higher percentage than in any other developed country, with poorer outcomes.
- And finally, employers, who fund a large percentage of the healthcare costs for employed Americans and their families, are furious at the increasingly large bite employee and retiree healthcare costs are taking out of their profits, making it increasingly difficult for many of them to be globally

competitive. They're trying to get a handle on containing those costs. In large part, they attempt to manage this by shifting more of the costs to their employees.

I don't mean to be cynical, but RHIOs are the least of our worries!

Let Me Count the Hurdles

Let's look at what RHIOs are trying to do with that "system" in mind. As Professor Protti writes, they're trying to "facilitate the secure exchange of healthcare information to advance the effective and efficient delivery of healthcare for individuals and communities." A noble goal, but what's in the way? Let me count the hurdles:

1. About half the hospitals in the United States are located in communities where there are one or more competing hospitals in town. They mostly don't like each other and don't trust each other. I've had CEOs of competing hospitals tell me that they've spent millions of dollars building their electronic medical record systems (EMRs), and not for the purpose of sharing data with their competitors.
2. Private practice physicians want the best for their patients, but not to the extent of implementing ambulatory medical records systems to make the care they give more efficient, effective and safer. The overall penetration of those systems in the United States is below 20% in most of the studies of ambulatory EMR adoption. So that means that somewhere north of 80% of physicians in the United States still have paper clinical records (almost all of them have practice management systems to get their claims and bills out). Participating in a health information exchange or RHIO where the expectation is that the clinical data will be in digital form is a non-starter for many physicians, especially those in individual or small group practices.
3. The entities that benefit from the information a RHIO would provide aren't always the ones that are expected to pay for it, as Protti points out.
4. The lack of interoperability standards and the unwillingness of our legislators to mandate them cause problems for consumers. First, what comprises a personal health record (PHR)? Is it just laboratory test results and some demographic data? Or is it the Continuity of Care Document? Does the consumer have to key most of that information into the web-based and/or employer-provided PHR? For the majority of people who have PHRs, including me, the answer is yes.

Second, because many of the systems in American health-care organizations (HCOs) are proprietary and there's no controlled medical vocabulary standard in the country, the data coming out of one HCO's systems won't be easily understood by an RHIO's federated or centralized databases.

Progress is being made, but it's slow. The losers? Consumers/patients.

The information exchanges that will succeed are the ones that have their incentives aligned. One reason that Indiana's initiative works, and the ones from Tennessee and Louisiana show promise, is because they're providing services to not just cities, but in large measure to rural portions of their states. That's one source of the "supply" of patients needing specialized cancer treatment, for example, provided by larger urban and academic medical centers. They're not so much trying to hook together competing HCOs as they are facilitating supply chains that align limited services with people who need those services, a pragmatic solution.

The other type of information exchange that will be successful is the model proven by Inland Northwest Health Services in Spokane, Washington. In my opinion, they're not a RHIO, but rather a services provider, delivering healthcare IT services among others. They run a regional MEDITECH data centre more efficiently than the independent hospitals that are their customers could possibly manage on their own. They're an outsourcer to hospitals, and because they specialize in one hospital information system and have the ability to interface and integrate other existing applications owned by their customers for community access, they are able to facilitate the exchange of data between their hospital and physician office customers *who wish to exchange data*.

RHIOs and health information exchanges must focus on collecting and sharing minimal data sets that solve real health-care delivery issues quickly and effectively. Then these can be incrementally expanded as successes are achieved. Most are trying to do too much too soon, exacerbating the mistrust among the stakeholders.

Be Thankful!

Be thankful you have a healthcare system as rational as it is. Your system of regional health authorities and a centralized, national funding source for innovation in healthcare IT (Canada Health Infoway) makes eminent sense. I think it's the model for other nations globally. Now if the United States would just get closer to the way you do it ...

About the Author

David E. Garets, FHIMSS, is the president/CEO of HIMSS Analytics



CGI healthcare professionals: members of your community that share your values and vision of quality healthcare

We understand the increasing demand for accessible, efficient and quality patient-centric care. For more than 30 years and for clients including federal and provincial governments, hospitals and healthcare regions, our dedicated people from coast-to-coast deliver IT services and solutions that never lose sight of the shared goal to improve patient outcomes.

Contact a CGI healthcare professional to help you:

- _ Accelerate transformation to EHR
- _ Facilitate secure health information exchange
- _ Automate administration for hospital providers
- _ Align IT environments with business requirements
- _ Manage applications and IT environments

www.cgi.com/healthcare

