Making health information technology a reality in the U.S.:

A key missing ingredient in health reform proposals

A POSITION PAPER FOR
INITIATING PUBLIC DISCUSSIONS

ALLIANCE FOR ADVANCING NONPROFIT HEALTH CARE
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A variety of proposals are being introduced at the federal government level from both members of the Congress, the Administration, and coalitions of private health care and other groups to expand access to health care. Many of these proposals would supplement and support the efforts of the individual states, the "incubators" for health financing reform and innovation in the U.S., through such measures as:

- Renewing or even expanding the SCHIP program for children in low-income families.
- Creating special federal income tax incentives for small businesses or low-income adults and families to purchase private health insurance coverage.
- Giving states additional flexibility in the design and administration of their Medicaid programs.
- Providing grants to states for health financing reform innovations.

All of these efforts are to be applauded, but most are missing a key ingredient. They address only one-half of the equation—health financing. Without simultaneously addressing the other half—health care delivery, they will not be sustainable and will ultimately fail. Health financing reform alone would merely spur greater demand and use of services in a system already suffering from efficiency, quality, and patient

safety problems. The inevitable result would be even greater health care cost inflation, leading to a new wave of health care affordability problems for most Americans.

Health information technology (HIT) provides the essential infrastructure that is currently lacking to improve health care delivery. Like many public and private organizations at the national, state, and local levels, the Alliance for Advancing Nonprofit Health Care strongly supports the goal of a fully wired health care system in America.[1] President Bush has set a timeline of 2014 for achieving this goal. However, supporting a goal is not the same as achieving it, and we are far from achieving it. Health reform plans must address how HIT will become a reality in the U.S., and as quickly as possible.

The purpose of this paper is to stimulate dialogue among public and private sector leaders at the national level on incorporation of HIT in health reform. The paper summarizes the case for HIT and important initial steps that have been taken, describes major shortfalls and obstacles, and sets forth recommendations on key public policy actions that must be taken in order for the nonprofit health care sector to become fully wired and to be able to assist affiliated physicians in the same regard.

In brief, as a vital component of health care reform, the recommendations call for strong federal financial support for HIT, analogous to the Hill-Burton program in the post–World War II era. Then we needed an infrastructure of health care facilities to meet the needs of communities and patients all across the U.S. Now we urgently need one for HIT. For nonprofit health care providers, the necessary investments are substantial, entailing more than initial acquisition of hardware and software. They involve reengineering of administrative and clinical work processes, updating of hardware and software, and significant initial and ongoing staff and physician training. Most nonprofit health care providers cannot afford to make all of these HIT investments, as most of the financial returns inure to payers and patients. Yet, unless and until these investments are made, none of the following can be achieved:

- Efficient and effective regional, state, and ultimately national health information networks.
- Efficient and effective methods of measuring, reporting on, and improving quality and patient safety.
- Effective value-based purchasing arrangements between health care providers and payers.
- Efficient, effective and user-friendly clinical and administrative processes within health care settings.
- Efficient and effective research on the costs and benefits of existing and new medical technologies in treating specific health problems.

The Alliance is eager to meet with interested public and private sector leaders to discuss these recommendations and refine them as appropriate as part of health care reform efforts.

The case for HIT

The Center for Information Technology Leadership has reported estimated annual savings to the nation associated with electronic health records (EHRs) and interoperability of 12.5 percent or more of annual health spending. To reap such substantial savings per year, an estimated $150–$300 billion of capital will need to be invested.

The estimated time required to achieve full wiring and cost savings, assuming that capital and operating resource investments are made expeditiously, is 5–15 years, the latter based on the assumption that actual changes in work processes will take considerable time.

These estimates have been derived largely from expert opinions and experiences with automation in other sectors in the economy, rather than empirical evidence of HIT adoption in a variety of health care settings. Nonetheless, it makes only common sense that by reducing medication and other medical errors, by eliminating unnecessary work procedures and paperwork, and by giving health care professionals, public health officials, and patients all of the key information they need when they need it (e.g., patient health and family histories, current treatments and test results, reminders and prompters related to evidence-based best practices), we will achieve substantial improvements in patient safety, quality, and efficiency. Generically, the types of HIT tools being developed and refined are essentially no different than those that have been successfully adopted in other sectors of the economy.

Many other developed countries have moved further and faster than the U.S. without any rigorous cost-benefit evaluation. They are convinced by logic that HIT is an essential foundation for improving health care patient safety, quality, and efficiency.

Progress

The federal government has taken some important steps, such as:

- Establishing a National Coordinator, Office, and an overall advisory group (the American Health Information Community) for HIT.
- Spending over $150 million on over 100 projects spanning most states on HIT planning, development, implementation, or evaluation, with a proposed administration budget for 2007 of $169 million, another $50 million of which will be for grants.
- Assembling and funding panels that have begun work on standard-setting, certification of HIT products, network architecture prototypes, and security and privacy.
- Providing some positive incentives under the Medicare program for voluntary reporting of data on selected quality indicators, and experimenting with some pay-for-performance concepts.
- Establishing exceptions and safe harbors respectively under Centers for Medicare and Medicaid Services (CMS) and Office of Inspector General (OIG) regulations so that hospitals and other entities can provide HIT hardware and software to physicians in their practices without fear of violation of fraud and abuse and anti-kickback regulations.
- By executive order, beginning to require all federal agencies as well as all those parties doing business with the federal government to adopt and use the same HIT standards.

States are also getting involved. For example, in 2005 and 2006:

- One hundred twenty-one HIT-related bills were introduced, with 36 passed in 24 states
  - — Nineteen of the bills passed in 14 states called for the creation of commissions, panels, or other bodies to conduct studies or develop strategies and plans for HIT. Eight of these bills in seven states called for incorporation of financing strategies, such as grant or loan programs.
  - — Two of these bills set target dates for provider adoption of HIT.

- Ten executive orders were issued calling for the development of strategies and plans for HIT and health information exchange (HIE).
- One state, New York, is providing $53 million in grants for health information exchange mechanisms, e-prescribing, and electronic health records. A Rhode Island bill would earmark a state bond fund for a statewide health information exchange.

The private sector is also making some progress. For example:

- Eleven percent of hospitals are reported to have fully adopted EHRs, and 17–24 percent of physicians in ambulatory settings are estimated to use EHRs, at least to some extent.[2]
- Over 150 regional HIE projects have begun, some under the auspices of regional health information organizations (RHIOs), with the federal government providing $1 million per year support for five years for each of five statewide HIEs. At least three of the more mature HIEs are collaborating among themselves and with the federal government to serve as a prototype for a nationwide health information system.
- Some private payers are providing positive incentives for HIT adoption and/or are experimenting with some pay-for-performance/value-based purchasing concepts.
- A national coalition recently announced that it will provide all physicians in the U.S. with a free means of e-prescribing in their private offices.

Shortfalls

While all of the above is laudable, as a nation we remain far from the goal:

- The U.S. lags behind other OECD[3] countries in HIT by 4–13 years, even though our health care spending is 2.5 times greater and we have fewer physicians, nurses, and acute care patient days per capita.
- Most hospitals[4] and physician offices are not well wired. Although no data is readily available, the situation can only be far worse for community health centers, nursing homes, and home health agencies.
- Most state-level and regional health information exchanges are just barely getting off the ground, and cannot begin to realize their potential *unless and until* the vast majority of health care providers are themselves fully wired and participants in those exchanges.

Critical obstacles to achieving the goal

While there are many obstacles,[5] for nonprofit health care providers the most critical ones are financial, as the investments they would like to make are substantial, but the returns on those investments accrue principally to payers and patients:

- Depending upon the type of setting and size of the organization, HIT capital costs can run into the millions and tens of millions of dollars. Increased operating costs can run from 2–4 percent of total expenses. Even greater investments are needed if nonprofit health care providers, in particular nonprofit hospitals, are to assist their affiliated physicians in wiring their own offices. Costs involve more than just hardware, software, and new people. They involve reengineering of work processes as well as initial and on-going training of a variety of staff. Moreover, most of these investments cannot be spread out over many years. In order to avoid incompatibilities, HIT tools must be adopted together, as an integrated system.
- HIT investments are competing with other pressing priorities, such as: acquisition of new or improved medical technology; modernization, expansion, or relocation of facilities; and providing increased charity care to the uninsured, underinsured, and low-income patients.

- Operating margins and reserves over multiyear periods tend to be thin for most nonprofit health care providers, which directly affects their cost of borrowing. For some, increased indebtedness is not even an option. By definition, nonprofit health care providers have no access to equity markets. In addition, because HIT is not as tangible as new medical equipment or a facility, private donations for HIT have been generally lacking.
- For their own economic reasons, major public and private payers are generally unable or unwilling to help nonprofit and other health care providers with their up-front costs of HIT. Public programs don't have the funds. Individual private insurers don't want to put themselves at risk for benefits that cannot be easily quantified or at a competitive disadvantage by helping providers with these investments when others not doing so would share in the ultimate benefits.
- Payment arrangements with major public and private payers generally do not promise sufficient back-end returns to nonprofit and other health care providers on HIT investments, in the form of expected financial rewards for improvements in efficiency, patient safety, and quality (e.g., decreased testing, reduced visits, lower lengths of patient stays, reduced admissions and readmissions):
  - — Traditional payment systems (e.g., per-diem-based, itemized charges) lack adequate rewards for HIT investment and can in fact penalize providers as reduced utilization decreases revenues.
  - — "Per case" (e.g., DRG) payment systems potentially offer such rewards, but they are only well developed for inpatient acute care (and to a lesser extent for skilled nursing facility care) and are used almost exclusively by the Medicare program and some nonprofit health insurers. Even under Medicare, nonprofit and other hospitals have little faith that rates won't be ratcheted down as cost savings become apparent.
  - — Capitation-based payment systems may offer the greatest potential rewards for HIT adoption by nonprofit and other health care providers. Episode-of-illness payment arrangements also hold some promise. However, the use of these payment systems will tend to be restricted to well-integrated health care systems for a variety of reasons, both organizational and technical. HIT is a prerequisite for effective pricing and care management under these systems.
  - — Pay-for-performance (value-based purchasing) systems hold promise, but are far from being fully developed[6] and tested across the wide spectrum of medical care, much less embraced by all major payers. Consequently, nonprofit and other health care providers cannot depend on them to provide an adequate return on HIT investments. Here again, HIT is a prerequisite for structuring appropriate performance standards and reward systems.

In summary, most nonprofit health care providers do not by themselves, and under current payment arrangements, have the financial wherewithal to become fully wired. Wishing that the states or the invisible hand of the marketplace can somehow finance this huge and complex undertaking will not get the job done.

Recommendations for making HIT a reality as a vital component of health care reform

From the perspective of nonprofit health care providers and their affiliated physicians, we are essentially in a state of HIT gridlock. The federal government, representing all the people and the largest health care payer, must intervene, much as it did 60 years ago when it created the Hill-Burton program to

modernize and expand the nation's supply of public and private nonprofit hospitals and other health care facilities.[7] The national health care capacity issue then was facilities. Now it is HIT.

Sustainable health care reform will not be possible without this technological base, and the Alliance proposes that the federal government undertake the following actions under a new Hill-Burton-like program for HIT:

1. Offer long-term, interest-free federal loans, on a matching basis, to nonprofit health care providers to help cover their capital and initial operating costs of HIT adoption and those of affiliated physicians whom they need to help.
   a. The release of loan moneys to the individual provider should be phased in accord with the achievement of milestones in a work plan accompanying the loan application. EHRs purchased with the loan moneys must be CCHIT-certified.
   b. Repayment of loans should be delayed, recognizing that cost savings and any financial benefits to the provider will not be realized during the initial years of investment.
   c. The percentage match, and the length of the loan repayment period, should vary by type of nonprofit health care provider (e.g., hospital, nursing home, home health agency, community health center) or by payer mix characteristics in order to account for differing financial capabilities to match and repay loans in a timely fashion.
   d. Loans may be repaid either in cash or in the form of above-average portions of care being provided to low-income, uninsured, or medically indigent patients. The criteria for determining the latter should vary by type of nonprofit health care provider.
2. Provide tax credits to individuals or organizations making private donations to nonprofit health care organizations earmarked for HIT development, acquisition, implementation, or operations.

Every day that we fall short of the HIT goal, we all suffer directly or indirectly, in terms of the safety, quality, and efficiency of our health care system—and access to it. We are missing opportunities we can ill afford to miss.

About the Alliance

Founded in 2003, the Alliance for Advancing Nonprofit Health Care is a unique blend of nonprofit hospitals, other types of nonprofit health care providers and nonprofit health plans—all dedicated to preserving, while improving the performance of, the nonprofit health sector.

The Alliance has developed and disseminated guidance to nonprofit health care organizations on their governance practices and to nonprofit health plans on their community benefit practices. The Alliance has also reviewed and endorsed the overall recommendations of the Nonprofit Panel of the Independent Sector on reform of the tax exemption requirements for all charitable organizations.

In addition, the Alliance is also proposing reforms in the federal tax exemption requirements for nonprofit hospitals.

[1] Full wiring of health information technology by health care providers includes electronic health records (EHR), e-prescribing, physician order entry, and clinical decision support systems, as well as interconnectivity through a national health information network.

[2] "Health Information Technology in the U.S.: The Information Base for Progress," an October 2006 report prepared by researchers at the Institute for Health Policy at Massachusetts General Hospital and the School of Public Health and Health Services at George Washington University, under funding by the Robert Wood Johnson Foundation.

[3] OECD, the Organization for Economic Cooperation and Development, includes, for example, the U.S., Canada, Mexico, the United Kingdom, Ireland, western and many eastern European countries, Australia, New Zealand, Japan, and Korea.

[4] In February 2007 the American Hospital Association reported on the results of a survey of community hospitals indicating that: only 11% have fully adopted EHRs (even for large hospitals, teaching hospitals, and urban hospitals the percentages were only respectively 23%, 17%, and 16%); in only 10% are at least 50% of their medical staff using computerized physician order entry (CPOE) for electronic ordering of medications (16% for lab and other tests); only 10% have fully functioning electronic clinical guidelines or pathways; and only 1% have electronic access for patients to their medical records. The situation may be worse, as the 31% of all community hospitals that responded to the survey may be on average ahead of those that did not respond. *Modern Healthcare* also reported in February 2007 on the results of its survey of 344 hospital readers indicating that HIT spending as a percentage of operating costs had not increased and that HIT spending as a percentage of capital costs had actually softened somewhat. In addition, more executives planned to spend less on HIT over the next three years.

[5] For instance, the Government Accounting Office released a report to the Congress on September 1, 2006, noting that while the Department of Health and Human Services has made important progress in five important areas, "It still lacks detailed plans, milestones, and performance measures for meeting the President's goals."

[6] For instance, in the December 13, 2006, issue of the *Journal of the American Medical Association*, researchers reported that there was only a very small connection between 10 process measures as publicly reported by CMS under its Hospital Compare program and risk-adjusted mortality rates for patients with acute myocardial infarction, heart failure, and pneumonia.

[7] Beginning in 1946 with grants and then extended over time with loans and loan guarantees until 1975, the Hill-Burton program represented an unprecedented investment to improve the U.S. health care delivery system. It achieved its target of a national average of 4.5 staffed beds per 1,000 population, with 65,000 beds created and 6,900 hospitals assisted, at a federal expenditure of $5 billion unadjusted for inflation over 29 years. The quid pro quos for nonprofit health care providers receiving assistance under that program were minimum charity care and community service obligations. The implicit quid pro quos for nonprofit health care providers receiving HIT funding assistance as proposed by the Alliance will be constantly evolving requirements for these providers to publicly report, and have their payments be increasingly based on, their quality and patient safety performance, with much of the financial benefits related thereto inuring to public and private payers, employers, patients, and the general public.

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