

Executive Summary — USMI Roundtable Discussion



Sharing Information To Improve Access

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Federal agencies lead the nation and indeed the world in sharing medical information through the electronic health record (EHR) systems they have developed and continue to enhance and interface. Their efforts are paving the path for the anticipated National Health Information Infrastructure and serve as a benchmark for the private sector.

To examine progress that has been made in using EHRs to improve patient care in federal agencies and see what lies on the horizon, the nonprofit **U.S. Medicine Institute for Health Studies** convened a roundtable discussion involving federal, beneficiary and private-sector participants. A significant concern during the discussion centered on the issue of “return on investment” and the need to capture for policymakers and appropriators — as well as for patients and providers — the intangible benefits of EHRs. It is hard to prove the value in cost-avoidance of x-rays not needed, drug interactions averted or diabetic crises prevented. Conventional business-case analysis does not encompass such benefits, and consequently, the value of EHRs in improving quality, informing decisionmaking and avoiding costs often is not evident to analysts. “We need to determine a better metric. The right metric to tell this story is important.”

EHRs facilitate patient-centered care, as is being demonstrated through the Veterans Affairs Department’s My HealtheVet Initiative. EHRs also offer the opportunity to improve public health through analysis of the large amounts of data collected.

Background

The Defense and Veterans Affairs Departments, two of the largest healthcare systems in the world, have EHR systems that can exchange data on a circumscribed basis and are far ahead of most of the systems — or non-systems — that exist elsewhere across the globe. Records from DoD facilities on 3.5 million separated servicemembers have been sent to and can be read in VA medical centers, promoting “seamless” transition from active-duty to veteran status. Now, this capability is being made bi-directional, with DoD phasing in the ability to read records from VA medical centers. Currently, 15 major military facilities can do this, a capability especially advantageous as Guard and Reserve troops are re-called for deployment.

The bi-directional real-time record sharing includes outpatient pharmacy data, anatomic pathology and surgical reports, laboratory and radiology reports and food and drug allergy information.

In addition, DoD and the Indian Health Service have initiated efforts to adopt VA’s VistA imaging system, which integrates medical images and scanned documents into the EHR, meaning all three agencies will be able to share imaging.

VA’s My HealtheVet program, piloted by 2,000 veterans, is expected to be implemented on a voluntary basis nationwide by the end of the year. In the process, veterans will be empowered to assume more personal responsibility for their care.

Oversight of the EHR collaboration between VA and DoD takes place at a high level through a Health Executive Council that serves as a forum for strategic planning and discussion of issues to be worked out. “We identify and resolve issues as we move forward.”

Summary of discussion

While the roundtable examined other types of sharing — staff members, facilities, logistical support — most of the discussion focused on sharing data as a means of enhancing quality and access for beneficiaries and allowing providers to deliver more informed care.

Roundtable participants urged that a means be found for incorporating the value of EHRs in cost-benefit calculations that traditionally govern the allocation of resources, especially as there is evidence of continuing skepticism among policymakers. Session participants noted that VA's VistA system is considered to be in the forefront of electronic records, with its ability to aggregate and display text and imaging data across the VA system. Analysis of data from VA's HER Health Data Repository — it currently includes 6.5 billion data elements — has enabled the discovery of new medical knowledge such as the seasonal variation in blood pressure. DoD uses EHRs to guide the care and evacuation of casualties from the battlefield to definitive care. The Indian Health Service assumes a public-health approach, for example, working with state immunization programs to ensure that children receive required immunizations and avoid duplicate ones.

Roundtable participants said data information exchange efforts among federal agencies can transform into a NHIO (National Health Information Organization) and function like a RHIO (Regional Health Information Organization) and can then be interoperable with the other RHIOs now being set up around the U.S.

Additional points made during the roundtable discussion:

- The VA-DoD medical center being established in North Chicago — the first one to have joint management — will use VA's EHR system, since the facility will have more of a "VA flavor." As other jointly managed VA-DoD facilities are established, their EHR systems will be selected based on the "flavor" of the agency whose patients predominate.
- Only about 15 per cent of private-sector providers have electronic record capabilities. Tri-Care contractors similarly are not prepared at present to send electronic records of patient encounters to DoD facilities.

Currently, VA scans in paper records from contracted care and includes them in the EHR as adjunct information that is not integrated electronically into the record. "We want to see the private sector enter the electronic age." Because VA, DoD and IHS have the most experience in exchanging data, "Our lessons learned can drive national standards."

- EHR interoperability between DoD and VA has proven more complex than initially anticipated because the business processes of both entities had to be accommodated. However, the "bottom line" is that interoperability is "do-able," and the federal agencies have evidenced this potential for the private sector. "The federal sector can push the national agenda."
- Building a single system, rather than making the VA and DoD systems interoperable, was determined to be impractical. "If the information can move, you don't need the same system." A robust network is a better solution than a single system, because it is more "nimble" and allows each agency the particular emphases it requires. For example, DoD has security concerns that would be difficult to address through a single system.

"Our systems can share where it makes sense."

- Systems must remain flexible and able to support new requirements.

Participants in this roundtable: George Anderson of AMSUS, Dave Baker of Humana Military Healthcare Services, Galen Barbour of the Uniformed Services University of the Health Sciences, Cynthia Bascetta of GAO, Jean-Paul Chrétien of the Defense Department, John Class of MOAA, Kenneth Cox of the Defense Department, Col. Kenneth Cox of the Defense Department, Theresa Cullen of the Indian Health Service, Adam Darkins of the Veterans Health Administration, Susan Edgerton of Vietnam Veterans of America, Cliff Freeman of the Veterans Health Administration, Joel Gaydos of the Defense Department, Fred Hannett of the Virginia Board of Health, Bart Harmon of the Defense Department, Rob Kolodner of the Veterans Health Administration, Angela Louis of Humana Military Healthcare Services, Ray Pryor of Humana Military Healthcare Services, Fred Sanford, Jack Smith of the Defense Department, Harley Thomas of Paralyzed Veterans of America. The roundtable was moderated by James Peake of Project Hope. USMI Managing Director is Nancy Tomich [www.usminstitute.org].

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