

Putting Health IT on the Path to Success

William A. Yasnoff, MD, PhD

Latanya Sweeney, PhD

Edward H. Shortliffe, MD, PhD

THE PROMISE OF HEALTH INFORMATION TECHNOLOGY (HIT) is comprehensive electronic patient records when and where needed, leading to improved quality of care at reduced cost. However, physician experience and other available evidence suggest that this promise is largely unfulfilled.

Comprehensive records require more than having every physician and hospital use an electronic health record (EHR) system. There must also be an effective, efficient, and trustworthy mechanism for health information exchange (HIE) to aggregate each patient's scattered records into a complete whole when needed. This mechanism must also be accurate and reliable, protect patient privacy, and ensure that medical record access is transparent and accountable to patients.

However, when it comes to HIE, often implemented by regional health information organizations (RHIOs), the lack of progress is particularly discouraging. In December 2010, the President's Council of Advisors on Science and Technology noted that HIE efforts through the states "will not solve the fundamental need for data to be universally accessed, integrated, and understood while also being protected."¹ A survey of 179 HIEs found only 13 (covering just 3% of hospitals and 0.9% of physician practices) were capable of meeting stage 1 meaningful use criteria (which do not guarantee comprehensive records). Of those 13, only 6 were reported to be financially viable. More importantly, none of the HIEs surveyed has the capabilities of a comprehensive system as specified by an expert panel, calling "into question whether RHIOs in their current form can be self-sustaining and effective."²

Not surprisingly, multiple HIEs have been shut down, eg, Washington, DC; Kansas; Tennessee; CalRHIO; and CareSpark (Kingsport, Tennessee, once touted as a national leader). According to the Office of the National Coordinator for HIT, in 32 states more than 90% of hospitals have not even exchanged a single patient record.³ Moreover, no patients currently receive their care with guaran-

teed availability of comprehensive information from all sources.

One consequence of these failings is that HIT has yet to decrease health care costs; in fact, costs are increasing because of the improved documentation produced by EHRs. Cost savings from HIT will be realized largely by eliminating duplicate tests and avoiding medical errors; this requires comprehensive records for each patient, not just clinician or organization-level EHRs such as those implemented within large hospitals or health systems or in multispecialty group practices.

Why are the results from HIE efforts so discouraging? Recent funding has been substantial: starting in March 2010, \$564 million in federal funds were allocated to states to develop HIEs. The key obstacles have been clearly and repeatedly identified—privacy concerns, lack of stakeholder cooperation, and minimal financial sustainability⁴—but these barriers have yet to be overcome successfully.

The problem is that health IT is on the wrong path. The current approach involves trying to use HIT to replicate existing manual processes for contacting other clinicians or health care organizations to get patient records instead of creating a single unified record for each patient as has been done for years with paper records within single hospitals and clinics. In other words, institution-centric systems are being built, often leaving patient information where created and then retrieving and integrating it in real time only when needed.

This approach is seriously flawed for several reasons:

1. *Complex and expensive.* It requires that all EHR systems be online 24/7 responding to queries, as well as implementation of new systems for real-time reconciliation of records from multiple sources. It is extremely difficult to accomplish without a unique patient identifier (which is both politically impractical and a privacy threat). Further, an expensive 24/7 network operations center must constantly monitor and ensure availability of all possible sources of information.

2. *Prone to error and insecurity.* A recent simulation study showed that, in comparison with a central repository, the

Author Affiliations: NHII Advisors, Arlington, Virginia (Dr Yasnoff); Johns Hopkins University, Baltimore, Maryland (Dr Yasnoff); Harvard University, Cambridge, Massachusetts (Dr Sweeney); Arizona State University, Tempe (Dr Shortliffe); and Columbia University, New York, New York (Dr Shortliffe).

Corresponding Author: Edward H. Shortliffe, MD, PhD, Health Solutions, Arizona State University, 500 N Second St, Phoenix, AZ 85004 (ted@shortliffe.net).

See also pp 987 and 991.

institution-centric approach requires exponentially more transactions and is exponentially more likely to provide incomplete records because of EHR response failures.⁵ Decentralization of records also allows more security failure points.

3. *Increased liability.* Because patients have no opportunity to review or annotate data, the burden of data correctness falls on clinicians, institutions, and the HIE. Integration errors and an inability to propagate corrections to those who already received data further compound medical-legal risks.

4. *Not financially sustainable.* This is a widely acknowledged problem. Financial sustainability should not require clinicians and hospitals to underwrite costs (ultimately passed on to patients or insurers).

5. *Unable to protect privacy.* Leaving data at their source makes managing privacy preferences impossibly complex because patients would need to set and maintain permissions separately at each location providing care.

6. *Unable to ensure stakeholder cooperation,* because providing records is totally voluntary; requests for them are not from patients, leaving records incomplete and possibly misleading as a result.

7. *Unable to facilitate robust data searching,* eg, for research and public health purposes. Because each record must be obtained from all sources and integrated each time it is needed, search becomes sequential, which is prohibitively inefficient.

Even with high-speed systems, access to patient information is greatly facilitated by having that information in one place. For instance, although credit reporting systems are admittedly imperfect, they would be much less effective if they had to query all creditors when a report was needed, and it would be much more difficult for consumers to review or attempt corrections if records were not in a single location.

The good news is that at least 1 viable alternative is simpler, scalable, less expensive, and more secure and can provide lifetime records: patient-centric community health record banks (HRBs). Health record banks are community organizations that put patients in charge of a comprehensive copy of all their personal, private health information, including both medical records and additional data that optionally may be added by the patient. The patient explicitly controls who may access which parts of the information in his or her individual account.⁶ When patients seek care, they give permission for their health care provider to access some or all of their up-to-date health records. When care is complete, the new records from that visit or hospitalization are securely deposited into the HRB and made available for the future. This approach solves the problems of privacy (through patient control), stakeholder cooperation (because the patients request their own records, the Health Insurance Portability and Accountability Act regulations require every stakeholder to provide them electronically if available in that

form), and financial sustainability (with revenue from optional applications for patients and research use of the data with permission), and it coexists with institutions keeping their own local copies of records.

Although there have been a few largely unsuccessful commercial efforts using a patient-centric architecture (eg, Google and Microsoft), their scope has been nationwide, requiring patients manually to authorize each link to a medical information source.⁷ In contrast, the community focus of HRBs simplifies patient participation by automatically establishing electronic connections to all relevant medical information sources, resulting in truly comprehensive records (essential for clinical value). Local governance also facilitates the high level of trust necessary to engage a critical mass of patients and thus makes it worthwhile for physicians to modify their office procedures to incorporate routine access to HRB information.

The idea of HRBs is not new.^{8,9} What is new is appreciating how HRBs can help achieve the HIT vision while most current HIE pursuits cannot. It is time for physicians to insist that HIT be pursued with realistic, achievable, and measurable goals that will produce readily available, comprehensive electronic records that can actually improve patient care. To do so requires implementation of model health record banks and then refinement of those models to allow them to achieve the sustainability and scalability that have prevented the success of distributed HIEs. Otherwise, HIT may become its own sociopolitical, legal, and economic disease.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Yasnoff reported serving as Board Chair as well as President of the nonprofit Health Record Banking Alliance (HRBA), without receiving compensation. Dr Yasnoff reported being Managing Partner of NHII Advisors (an HIT consulting firm). Drs Sweeney and Shortliffe reported being uncompensated members of the Board of the HRBA. Dr Sweeney reported also leading an HRB-like effort called MyDataCan.org, funded in part by a grant from the National Institutes of Health.

Disclaimer: The views expressed in this article by Dr Sweeney are her own and do not reflect any positions of the Federal HIT Policy Committee, of which she is a member.

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