Health Policy and Technology (2014) 3, 149–156

Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/hlpt

Public and private sector roles in health information technology policy: Insights from the implementation and operation of exchange efforts in the United States ☆

Joshua R. Vest[a,b,*], Thomas R. Campion Jr.[a,b,c], Lisa M. Kern[a,b,d], Rainu Kaushal[a,b,c,d,e], for the HITEC investigators

[a]Center for Health Informatics & Policy, Weill Cornell Medical College, New York, NY, USA
[b]Department of Healthcare Policy and Research, Weill Cornell Medical College, New York, NY, USA
[c]Department of Pediatrics, Weill Cornell Medical College, New York, NY, USA
[d]Department of Medicine, Weill Cornell Medical College, New York, NY, USA
[e]NewYork-Presbyterian Hospital, New York, NY, USA
Available online 12 March 2014

KEY WORDS
American recovery and reinvestment act;
Policy making;
Medical informatics;
State government;
Federal government;
Health information exchange

Abstract

Objectives: In the US, the federal and state governments are supporting interoperable health information technology (HIT) and health information exchange (HIE) through policy interventions and financial investments. However, private healthcare organizations and partnerships have also been active in establishing exchange activities, promoting interoperability, and developing technologies. This combination of influence from different actors has resulted in a rapidly changing healthcare environment. In this context, we sought insights into the optimal roles for the public and private sectors in HIT/HIE policy development and implementation.

Methods: We leveraged the concurrency of federal and New York State initiatives to spur HIT/HIE adoption by interviewing HIT experts (n=17). Interviewees represented federal and state government agencies, healthcare providers, and exchange organizations. A semi-structured interview guide with open-ended questions covered the domains of organization, value, privacy, security, and evaluation. We analyzed transcripts using a general inductive and comparative approach.

Results: Interviewees assigned roles for standard setting and funding to the federal government and suggested states were better positioned to offer implementation support. Interviewees forwarded a public-private partnership model as a potential solution to the limitations facing the private and public sectors.

Conclusions: HIT/HIE policy is a complex issue involving standards, privacy, funding and implementation. When New York State began funding HIT, significant federal intervention did not

☆Source of Financial Support: This study was supported by the New York State Department of Health (NYS contract number C023699).
*Corresponding author at: Center for Healthcare Informatics & Policy, Department of Healthcare Policy and Research, Weill Cornell Medical College,
425 E. 61st Street, Suite 301, New York, NY 10065, USA. Tel.: +1 646 962 9420; fax: +1 646 962 0105.
E-mail address: jov2025@med.cornell.edu (J.R. Vest).

http://dx.doi.org/10.1016/j.hlpt.2014.03.002

exist. Since the launch of New York State's program and the subsequent federal Meaningful Use criteria, interviewees expressed distinct but complementary roles for both state and federal governments and saw an avenue to include the private sector through public-private partnerships.

Introduction

Beginning in the late 1990s, health policy leaders and reform advocates began arguing the need for US government intervention in the area of interoperable health technology (HIT), specifically to encourage the adoption of electronic health records (EHRs) and to foster health information exchange (HIE) [1-4]. While there was a growing recognition that the sharing of patient-level information between providers using common standards and data management rules can potentially improve the cost and quality of the healthcare system [5], HIT adoption in the US had lagged behind other nations [6]. More recently, the federal government and numerous states moved forcefully in the area of HIT with new policy and funding interventions. The promotion of accessible, mobile patient information is a key component of US healthcare policy and reform efforts [7-9], and through repeated action, the public sector has declared a vested interest in interoperable HIT and HIE.

Federal support is most pronounced in Meaningful Use program, an estimated US$27 billion federal intervention to encourage EHR adoption, introduced as part of the Health Information Technology for Economic & Clinical Health (HITECH) portion of 2009s American Recovery & Reinvestment Act [10]. The Meaningful Use Program helps eligible providers offset the cost of EHR adoption through a series of incentive payments either through the Medicare or Medicaid public insurance programs. Eligible providers and hospitals must use a certified EHR system to meet performance criteria (i.e. meaningfully use the EHR) in order to qualify for incentive payments. Stage 1 of the program went into effect in 2010 and more than 110,000 eligible providers and 2400 eligible hospitals qualified for incentive payments [11]. Stage 2 criteria were released in the summer of 2012, which increased the performance threshold for several measures and the expectations for data sharing to support transitions of care [12]. The program is slated to continue until 2016, after which it will switch to introducing financial penalties for providers who do not use EHRs. In addition, the federal government has also provided significant funding and guidance through the Office of the National Coordinator for Health Information Technology (ONC). The ONC has overseen the US$547 million State Health Information Exchange Cooperative Agreement Program to establish information exchange activity at a state level [13]. As even further demonstration of the importance of HIT, recent system reforms and newly introduced organizational structures, such as patient-centered medical homes and accountable care organizations, are predicated upon use effective use of HIT to improve care-coordination, improve decision making and improve efficiency.

Many states supported interoperable HIT even earlier. In 2007 alone, 34 different states enacted 54 various bills related to EHRs, HIE, or HIT standards [14]. Notable state examples include Delaware's Health Information Network in 1997 [15]; Florida's e-prescribing program for Medicaid in 2003 [16]; and the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) in 2005 which established a statewide HIT infrastructure for healthcare system transformation. HEAL NY is particularly noteworthy as it is the largest state-based public investment to promote EHR adoption and HIE development [17]. To date the investment in interoperable HIT and HIE in New York State is approaching US$800 million. A goal of HEAL NY is the development of the Statewide Health Information Network for New York (SHIN-NY) to facilitate data exchange. The SHIN-NY, overseen by the New York State Department of Health and the New York eHealth Collaborative public-private partnership, aims to connect Regional Health Information Organizations (RHIOs) in order to share patient data across the state.

However, not all HIT activities in the US have been shaped by public policy. In the private sector, HIT is now a multi-billion dollar sector of the economy [18,19] and recognized by healthcare organizations as essential to business operations [20]. The private sector directly influences the HIT landscape by product development, but also is influential in adoption and policy. The certification of HIT's abilities to meet capability and interoperability requirements began with private sector organizations [21,22]. Integrated delivery systems and payers encourage provider utilization of HIT through incentive programs or as membership requirements [23]. Also, industry experts routinely participate in the development of standards and regulations [24]. Lastly, public-private partnerships like state HIE in New York are not uncommon. One quarter of the designated entities funded by the ONC state HIE program are non-governmental organizations and more than half of those self-identify as public-private partnerships [13].

In this period of significant public and private sector interest in widespread HIT and HIE adoption, we sought insights into the fundamental question: what are the optimal roles for the public and private sectors in interoperable HIT/HIE policy development and implementation? The US has made great strides in HIT/HIE adoption in the past decade; however, the influence of multiple actors has resulted in a rapidly changing healthcare environment with some practically challenging features. For example, in terms of policy, regulations and standards around privacy and security can vary between states and with the federal government, creating complications for providers, organizations, and the developers of HIT [25]. In terms of operationalizing exchange, policy makers supporting HIE activity tend to have broad public and population health objectives.