

Comments on the Florida Health Information Exchange Plan Overview  
Issue Date: 5/8/09

Commenting Organization: Department of Health  
Organization Address: Tallahassee, FL 32308  
Comment Date: May 20, 2009

-----Original Message-----

From: Meade\_Grigg@doh.state.fl.us [mailto:Meade\_Grigg@doh.state.fl.us]

Sent: Wednesday, May 20, 2009 2:50 PM

To: Turner, Carolyn

Cc: Nye, Christine

Subject: FW: Comments on AHCA's May 7, 2009 document on Florida Health Information Exchange

Carolyn,

Below are comments from Dr. Richard Hopkins our State Epidemiologist regarding the draft of the HIE plan. Richard is a national public health figure who has been on many national groups dealing with HIT and public health. His comments are so thorough and summarize this issue from a population health perspective that I thought that I would let his comments stand for our comments.

Thank you for the opportunity to comment. If you have any questions or need any further information, please contact me.

Meade

C. Meade Grigg

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<http://www.floridacharts.com>

-----Original Message-----

From: Hopkins, Richard S

Sent: Sunday, May 17, 2009 5:02 PM

To: Grigg, Meade

Cc: Luce, Christie; Gill, Julia; Kline, Jean L; Hamilton, Janet J (EPI)

Subject: Comments on AHCA's May 7, 2009 document on Florida Health Information Exchange

Not surprisingly for a document written by a state agency, it takes a statewide perspective, and tends to reflect AHCA's interests in health care cost containment and acquisition of statewide data of various kinds. In general it takes a top-down approach, starting with (A) a statewide multi-payer and medicaid health information exchange, and then identifying how various participants can supply it with data and get

data from it. An alternative approach would be to start with the needs of the various participants, many of which can be met with RHIOs that serve market areas, and then build the state system on a network of these regional systems. They imagine that many or even most health care providers will connect with the state level health information exchange directly, rather than through what they are calling "(C) local health information exchange gateway" service providers. Their statewide focus is reflected by putting the state level HIE in the center of their diagram. (page 4).

I believe this document would be strengthened considerably if it were more specific about (1) what the expected benefits are of implementing this system, from various perspectives; and (2) why this overall architecture is preferred to a more distributed architecture.

I believe that there are five main perspectives on HIE, each quite legitimate:

- patient
- health care provider (including hospitals, doctors, and others)
- health care payers (both public and private)
- health care regulators (those who set standards for and license hospitals and other facilities as well as those who license practitioners)
- population health (those who are concerned with how to improve the health of the whole population, both in and out of the health care service setting)

The document would be strengthened if a few sentences could be dedicated to describing example scenarios: how would achieving more or less complete HIE based on electronic health records benefit each of these perspectives? Is this architecture better for some of these perspectives than for others?

Of these five perspectives, the associated claims that have attracted the most attention are that HIE based on EHRs will improve patient care outcomes and that they will reduce health care costs. These claims are just barely mentioned in the Vision statement on the first page and not otherwise discussed at all. Why is this the best architecture from a patient perspective? Is there any tension between the architectures that will make the most sense from different perspectives? Overall, my sense is that this proposed architecture is designed to support payers, particularly Medicaid, and to reduce health care costs.

For example, a straightforward implementation of the architecture on page 4 would require that one practitioner querying records in the possession of another practitioner always go through the state level HIE, unless both are members of the same local health information exchange organization; and allows local providers to participate in HIE without participating in their local HIE organization. Is that the best plan? What kinds of scaling issues are there here? Or should all local providers have to belong to a local organization in order to benefit

from the services the HIE offers? Local HIEs are like fax machines: they are close to useless if only a few providers are participating, and most useful if they have 100% local coverage.

On page 5, there are short lists of types of data that will be available in years 1 and 2. From a public health surveillance perspective, we are very interested in the laboratory results that will be available in year 2. We have some very specific requirements, which are set nationally, not just in Florida, for what laboratory results should look like to satisfy our disease reporting requirements. These differ in some important ways from the requirements of doctors looking for a clinical result on their patient, and from those of laboratories which are exchanging orders and results with each other. On the one hand, it would appear to be advantageous to us to be receiving laboratory results from dozens or hundreds of laboratories all from one aggregator, and not have to manage that large number of connections. On the other hand, if the majority of the labs are not following the standards that have been set for the reportable disease component of biosurveillance, we -- or someone at AHCA or their contractor -- will still have to work with the individual laboratories to get their data streams into a standardized format and coding scheme, and to test the resulting data feeds. How much help can we anticipate from AHCA, or from the managers of the state-level HIE, in making sure that the data feeds we are interested in are stable and of acceptable quality for our purposes, and to monitor for local changes in preparing the HL7 lab result messages?

There is no mention in this document of two important technical challenges: data security and privacy, and deduplication. If solutions to these challenges are documented elsewhere, this document should address them. How will we assure that information about multiple people is not mixed together in what is supposed to be a single person's record, and that information about a single real person is not scattered across records with several different IDs?

For population health (surveillance) purposes, systems that require patients to actively opt in to have their records available in the HIE are very very poor. We much prefer an opt-out model. This important design issue is also not mentioned that I can see in this plan document. For public health surveillance purposes, we need to have access to all reportable disease diagnoses and results, not just those from people who have opted in to have their data included in the system.

Box E, on population health, has language about public health surveillance. It is important that public health be involved in the design of this system from the beginning, so that we can help assure that the correct data are collected and that they are exchanged and presented using the correct coding systems, not just to have a plan for accessing the data.

Thanks for listening.

Richard S. Hopkins, MD, MSPH

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