Perspectives from the Field Interview Series

Interview with Guy Collier, JD, MPH

Partner at McDermott, Will & Emery LLP in Washington, DC

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Interviewer: Jane Hyatt Thorpe

Questions:

1) Would you please tell us a little bit about your current position and how it intersects with health information exchange?

2) What do you see as the most promising efforts to reform the health care delivery system through greater use and exchange of health information?

3) What are the most significant barriers (legal or otherwise) to achieving these reforms?

4) What role does the law play in hindering or facilitating effective use and exchange of health information?

5) What strategies would you recommend to encourage greater use and exchange of health information across the health care system by physicians, patients, and payers?

Transcript:

Question 1

JHT: Welcome to the Health Information and the Law Perspectives from the Field interview series. Today, we're speaking with Guy Collier, who is a partner in the law firm of McDermott Will & Emery in Washington, DC. Welcome Guy, thank you so much for joining us today. Let's start by having you tell us a little bit about your current position, and how that intersects with health information exchange?

GC: Sure. I am a partner in the health industry advisory practice group at McDermott in the Washington office. My practice is exclusively health care and primarily large integrated provider systems and academic medical centers, including all components of the academic medical center. So, I encounter health information issues frequently on the transactions we are doing for our clients in those areas and also discrete regulatory issues that come up from clients regarding health information, privacy, security, and other things of that nature.

Question 2

JHT: So, in working with your clients on a variety of issues you have probably witnessed a number of efforts - some of which you probably are successful and some of which may not be successful to really transform health care delivery, the system and also to greater enable the use and exchange of health information. From your perspective, what are some of the most promising efforts to transform health care delivery and to make greater use of health information?

GC: Well, I think there are really 3 and they all have the same purpose, ultimately, which is to not only make care more seamless among providers, different provider locations and different provider types, but also to generate meaningful data around quality and outcomes -- obviously, something that we have been working on for 25-30 years as we head towards a system that is driven by quality and outcomes and not simply by unit of service. This becomes more important. What I see specifically are really three things. One is the widespread adoption of the electronic medical record by health systems across the country. Most of our clients fall into either the Epic camp or the Cerner camp depending on the nature of the beast. Academic medical centers tend to prefer one vender over another. It is very widespread at this point. Folks are really coming out of the implementation process and they've spent tens of millions of dollars -- hundreds of millions of dollars -- on this process. But it's a good thing. When you go into most academic medical centers today, they have a very fulsome Health IT platform. Everybody is using handhelds, and within that system people can speak to each other real time. I think that has been really encouraging. The second observation is the attempt to link community physicians to the Health IT platform through a variety of means. When health systems, hospitals, and academic medical centers purchase providers, when they employ providers directly, or when they structure contractual relationships, professional service agreements, and other sorts of contractual relationships with the individual practitioners, they are able to step out the Health IT platform to them, subject to some of the regulatory constraints. We'll talk about that, and I think that's tremendously helpful. Then, the third area is really in the ambulatory clinic space. It's in the community health center, federally qualified community health center, and non-federally qualified. Particularly, we see initiatives around linking community health centers with each other in a given geographic area. These are truly the safety net providers in an area. We were lucky enough to work on an initiative right here in DC, probably 4 years ago, with the DC Primary Care Association to implement a city-wide electronic medical record platform across the primary care providers, or at least in the health clinics. I think that is another very encouraging sign. So I think those are the things I see on the provider side that give me some degree of encouragement.

Question 3

JHT: That's wonderful, and obviously those have led to a number of successes in a number of areas. As you have been working through these issues with your clients I'm sure you've encountered some challenges or barriers to these reforms. Could you share with us what you think are some of the most significant barriers, legal or otherwise, to pursuing these reforms?

GC: Right. Well, I think the most significant barrier now is the inability to achieve full integration -- to link community primary care physicians and community health centers into a true, integrated system of care. It is still a very fragmented system. We may link the academic medical center components together, we may link a given nonprofit hospital system's facilities together, we may get their physicians into the system, but for the physicians not in the system who are out in the community delivering primary care, or those community health centers who aren't fully electronic nor fully linked to the neighboring hospital systems, it's still a fragmented system of care. I can go to my primary care provider at the University of Missouri Health System and it's terrific because he and all of his colleagues and every component at the University of Missouri is linked. So, they are on this wonderful electronic platform. I can access them by email, they can refill prescriptions, we can do everything electronically, but as soon as I step outside that system, I am really on my own in terms of other providers who are not part of the network -- other care sites who are not part of the network. They don't link; there is no way for them to link. The biggest barrier I see, Jane, is continued fragmentation.

Question 4

JHT: And obviously, thinking about these issues from a legal perspective, I think there are some ways that the law can help facilitate more effective use and break down some of these challenges, mainly fragmentation, that comes from the inability to integrate or be interoperable. In some ways, there are perceptions that the law can actually hinder these efforts. In your experience, what role does the law play in hindering these efforts, and on the flip side what role does the law play in facilitating these efforts?

GC: Well, I think that's a great question and a complicated question. I think the primary barrier legally is not HIPAA. I think that HIPAA was long overdue and is an important set of protections both in terms of privacy and security. Yes, it was added cost to all providers, but there are so many common sense ways through the permissible uses under the statute through appropriate authorization and consent to really work around HIPAA. So, I don't see that as a barrier. HIPAA is a good thing, has been a good thing, and continues to be. But some of the regulatory statutes, Jane, that you and I have worked with over the years are still problematic. Particularly, when you go outside a closed system to step-out your health IT platform to independent community physicians who may be volunteer members of your medical staff but are not employees, we still face two issues. The cost is tremendous and I think cost is a significant barrier across the entire spectrum. We've got the regulatory barriers that come out of the federal program anti-kickback law and the federal ethics in patient referrals law, which, you know quite well, will prohibit remuneration to a physician unless it fits a designated exception under the ethics and patient referrals law. So, even with the attempted relief under these statutes two years ago where, basically, the feds tried to loosen those requirements and allow accessibility to a provider health IT platform, not prohibit it here, but still requiring a significant copay -- 15% if I recall -- it's still an impediment. The statutes are still an impediment and the cost itself is an impediment to really stepping this out to the primary care provider. So again, if you're an academic medical center and you've got 600 captive employed faculty practice plan physicians, that's fine. That works well. But, if you're an open staff model, as many of my clients are in the academic space, and you happen to have 2,000 physicians

who are not part of your faculty practice plan, you may get your health IT platform out to some but likely not all of them. So, again, I think that those regulatory statutes have not given us the sort of relief that would be necessary to achieve full integration here.

JHT: (Agreeing) And even with the continuation of those, I would believe it was last December, there's hope that they will give greater responsibility particularly to long term care. In some of the sectors of the industry that haven't increased their options as far as electronic health records like hospitals and physicians, but I agree with you it is still limited.

GC: Yes, and that's a great point. We didn't mention long term care, the whole post-acute sector whether it's free standing outpatient rehab, long term care, skilled and intermediate long term care facilities, they are in many ways largely outside this system. And that's where a lot of care -- particularly in the long term care setting towards the end of life -- is where a lot of care happens. So, yes, they are not nearly as integrated as we would have hoped.

Question 5

JHT: So, looking ahead, you understanding we've talked a lot about promising efforts, some barriers. When you're working with your clients and you're thinking about furthering the reform of the delivery system and greater use exchange of health information, particularly, both across the system as you were talking about but also breaking down that barrier of being able to share outside of the health care system, or a particular health care system; what strategies would you recommend or do you think hold the best merit for really advancing delivery system reform through greater use of health information?

GC: Well, that's a loaded question and a great one. We see our provider clients really going in full-bore for this. They have spent enormous sums of money and they take a year, a year and a half, two years to implement, and some have had a significant financial impact on those systems just because of the sheer magnitude of the cost here. But to really wrap in the disparate elements, the independent physicians who are not employed, the alternative site providers, diagnostic imaging, long term care, free standing rehab, I think it takes a couple of things. It takes statutory mandate to do that but it also takes money. I think we are looking at funding from the states, as the Medicaid "payor," and we know from health reform what a difficult task that is, since we had many states opting not to expand Medicaid because of the fear of cost escalation. We need contribution from the states; we need contribution from the feds, enhanced hard dollars, maybe flowing through the Medicare program to incentivize providers to get in to the game, the electronic information game, and from commercial payers as well -- who have their own set of concerns under health reform with what the exchange business will look like and whether they can maintain appropriate reserves and margins and so forth. But I think they've got to get into the game financially. So, I think we need to see, not to simplify it, but I think in many ways this is all about the money. And I think we need to see a real infusion of funds here because this is very expensive stuff. It's difficult enough for hospitals, but when you step down to the community health center or the long term care provider or the freestanding rehab clinic, this stuff is wildly expensive and may be prohibitive. So, I think we need much more in the way of financial resources.

JHT: That's really helpful and I think that we have explored that from a number of perspectives. It's interesting to focus on the financing, we obviously think a lot about the legal policy challenges or barriers but at the end of the day, this is an expensive proposition. While there is more funding than there has historically been, it's still limited in nature. As you said, in some situations, it even comes with restrictions in terms of how it can be used or how tools and resources can be shared. So, that's really helpful.

GC: Right. And I think that, just to sum up, Jane, if you take a step back and look at the environment now, we have these conflicting pressures because our clients are consolidating like crazy. They are acquiring each other; they are merging, academic medical centers getting out of the clinical business, staying in the academic and the research business but getting out of the clinical business, so we see tremendous consolidation. In large part it is driven by the fear of the unknown; the fear that under shrinking Medicare and clearly shrinking Medicaid dollars, it's going to be a very difficult environment for folks. We see combination, we see this need to consolidate and the fear of shrinking reimbursement, and at the same time, those very fears prohibit people from maybe putting the amount of resources into this that they need to. Folks look at things like days of cash on hand, and when a health system drops from whatever the number is, 230 days cash on hand to 100 days of cash on hand, they are nervous. The bond rating agencies are nervous, everyone is nervous. So, even though this is exactly what they should be doing, those same pressures that are driving consolidation sometimes lead them to back off from a wholesale adoption. Again, that's even more acute in case of these alternate site providers we talk about who just don't have the capitalization to do that. One footnote, we do see some significant private equity activity with alternate site providers and even specialty physician groups. With that private equity play, we may see some capital dollars free up for some of these providers. But, right now they tend to be clustered around some more lucrative specialties, as you might imagine, things like anesthesiology.

JHT: Right, right. Wonderful. Well this has been incredibly helpful; we really appreciate you spending time with us today.

GC: My pleasure. You guys are doing great work and it is an absolutely fascinating area and it's a large hill given the fragmentation of our health care system, the number of providers and the number of payers. It's a daunting task, as you know.

JHT: Yes it is. Wonderful, well thank you again.

Further Resources:

- District of Columbia Primary Care Association HIT Program
  - http://www.dcpca.org/health-information-technology
- Health Information & the Law Resources on Delivery System Reform
  - http://www.healthinfolaw.org/topics/52

- Health Information & the Law Resources on Health Information Technology
  - http://www.healthinfolaw.org/topics/58