

Perspectives from the Field Interview Series

Interview with Bruce Siegel, MD, MPH

President and CEO, America's Essential Hospitals in Washington, DC

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Interviewer: Jane Hyatt Thorpe

Questions:

- 1) Please tell us a little bit about what you do and how it intersects with health information exchange?
- 2) Besides using information directly for patient care, what other potential benefits are there in health information exchange for public hospitals and the health care system in general?
- 3) What are some barriers or challenges to fully realizing that potential, especially for public hospitals?
- 4) What do you see as the most promising long-term solutions to these challenges?
- 5) In the meantime, do you recommend any strategies that public hospitals and other health care providers can use to maximize the use and exchange of health information, both for patient care and for overall improvement of the health care system?

Transcript:

Question 1

JHT: Welcome to the Health Information and the Law Perspectives from the Field Interview series. Today we are speaking with Dr. Bruce Siegel, President and CEO of America's Essential Hospitals. Bruce, thank you so much for joining us today. Would you please tell us a little bit about your current position and how it intersects with health information exchange?

BS: Sure. I am the head of America's Essential Hospitals and we are a trade association based in Washington, DC, that champions hospitals who care for the most vulnerable. So, our hospitals can be hospitals with lots of Medicaid patients, lots of uninsured, who are really serving a safety net mission in their community. For them, health information exchange is a very big deal and is something that could bring really enormous benefits. Our hospitals are all working diligently to achieve the benchmarks and milestones of Meaningful Use. Actually, some of them were the early adopters. The first electronic health records in hospitals in our country probably started either at Eskenazi Health in Indianapolis or at Boston Medical Center in Boston. Our member hospitals have been really at the forefront, really have been the early adopters of health information technology and exchange.

Question 2

JHT: That's great. Can you comment a little bit more? You mentioned how health information exchange can have enormous benefits for the populations that you are serving, primarily the Medicaid, uninsured, and the safety net, can you expand a little bit upon the benefits for those patients in particular?

BS: Sure. I think it is important to know a little more about our patients. Our patients are very diverse. Most of them are racial and ethnic minorities. Most come from low income households. Many have chronic illnesses. Many have behavioral health issues. They are people who have not gotten a lot from health care systems, frankly, but who have many needs and are a very diverse group. They are people often who for many years never had a medical home. They may have had no usual source of care. They would be interacting with multiple providers across the community and unfortunately, sometimes the care is not as coordinated as it should be. They have gone from emergency department to emergency department or to a doctor's office or they have been seen in a homeless health clinic. They really are the most vulnerable and sometimes there is sort of that patchwork of the clinical services and social services in their community. Because of that, their needs are very complex and tracking all of this information around their care is absolutely essential but also very hard. So if somebody has been seen in multiple sites and it's hard to link those records, if those records can't communicate to one another, then we see instances where folks come in to the hospital or the emergency department, or the clinic, and we don't know what happened to them before. So, we can't give them the right kind of care. Or, we wind up duplicating tests that they've had before. So, health information exchange is a huge challenge for our patients and for our hospitals, but also it could be hugely important in tying all of this together and rationalizing the sorts of care our patients are getting.

JHT: That's very helpful. So that's obviously very specific in terms of using information directly in patient care to encourage coordination and integration of care that may be received across a number of settings. Could you speak a little bit about other potential benefits that there may be for health information exchange, particularly for public hospitals as well as the health care system in general. Perhaps this may be things such as quality improvement or, you mention, disparities reduction. So, thinking a little bit more beyond patient care, what are some other benefits you see for health information exchange?

BS: Well, first of all there is the whole role of public health and population health here. So, I think all hospitals in America are now being challenged to look beyond just caring for a patient for a given episode to really improving the health and wellness of an entire community. That will require linkages between the health care system and the public health system. For some of our members, especially our public hospital members, that's already in place. So, for instance, if you have Contra Costa Regional Medical Center in the bay area of California, they are very much part of and linked to their county health department. So, their records around immunization, records around things that are happening around public health can be linked to the clinical records more easily in places like that. But, in other communities where linkages need to happen there are no natural connections. Starting to build that will be important for all hospitals in America, but, I would say, first and foremost, for our hospitals because they are dealing with the greatest gaps in care and the greatest gaps in health. Another critical role for health information exchange and technology is that it is helping us to fight disparities and close the gaps. Most of our patients are racial and ethnic minorities, most are low income. In many of our hospitals over 100 languages are spoken. We need to be able to understand who our patients are and health information and technology can help us do that by making it simple for us to ask and get data on a patient's language preferences, or their race and ethnicity. We can start to understand who our patients are and what the services are that they need. I had one hospital, for instance, who didn't realize that

they were registering hundreds of Spanish speaking patients per month until they started asking these questions and putting it into their health information system. In other cases, we know that there are hospitals across America who are working to improve quality but they find that the quality they are providing isn't the same for all of their patients. Health information and technology and exchange will allow us to know who our patients are, figure out the quality of care we are providing to each group and figure out a way to begin to close those gaps. That sort of role for disparity reduction could be really, really critical for electronic health records and the whole enterprise of health information if we wired in from the get go.

Question 3

JHT: That's great. So, these are some really wonderful concepts obviously, talking about fighting disparities and looking at public health and population health. Obviously, we are not to this place that you describe where all of these linkages are happening. I'm hoping you could comment on some of the barriers or challenges, especially for public hospitals, that are faced in trying to fully realize this potential of health information exchange.

BS: We see a number of barriers. Some of the barriers deal with standards. There are too many health information systems out there that don't talk to one another. We are looking to a day when we, as a nation, will really get to a point where information can flow seamlessly between systems, where we don't have silos, where we don't have these different ecosystems of health information that don't speak to one another. We're not going to get to a point where a patient can move between sites and know that they will get the best care at every site until we solve this problem. I would make that the number one issue for us around health information and exchange. As health systems, we have other challenges as well. Most of our hospitals lose money. The average Essential Hospital in America has a negative margin while most other hospitals in America have a positive margin. So, for us, resources are very thin. That plays out in a couple of ways. Putting these systems in takes money, it takes capital, and clearly, the federal programs that have been put into place, the stimulus programs and others have helped, but it's still a big lift for the hospitals that care for the most vulnerable who have razor thin or nonexistent margins. But, beyond the capital, there is also the question of just recruiting; retaining the kind of staff you need to actually put these systems into place and to keep operating them. Again, that is a struggle with finances and that is a struggle with dollars. In a competitive market where you are trying to attract those same people that a richer hospital across the city is attracting, it is harder to do that and will put even more pressure on our mission and being able to do the things that we need to do. The third thing I'd mention is something that probably doesn't get talked enough about. That is the whole issue of work flow and productivity. Our hospitals are some of the most complex hospitals in America. They're almost all teaching hospitals, they have big trauma centers, transplant programs, many of them today have now been designated as Ebola referral hospitals by their states. These are very complicated environments and are very large environments. Often with hundreds of thousands of patient encounters, even millions, every year. When you put in new technology into such a complex environment, where you have people from the hospital, the medical school, the public health agency, and all sorts of disciplines working under one roof, it's complicated. It's hard. Often it can lead to a drop in productivity. Things get slower as people get used to these new systems and try to figure out how to use them. We saw one hospital that needed about 20-25 hours of training per physician just to make sure that they knew how to enter data in the right way and could be accurate in their documentation. Some of our hospitals have thousands of physicians working under their roof and they are some of the largest training centers in America and in the world. So, you can imagine the expenses and just the productivity drops that come in a situation like this is another big challenge for us in moving ahead.

JHT: That's really interesting, particularly the workflow and productivity. I agree that I think it is one of the issues that gets the least amount of attention but in some ways can be one of the most critical issues that providers face in particular when they are trying to move forward with these systems.

BS: It can. And I think it has been underestimated. I don't think we recognize the both human and financial costs around it and it doesn't just go all away at once. I know a lot of people who think "oh once you get past initial installation you won't have to worry about that again." But, the honest fact is that these systems require upgrades, it's a good thing, they need to be modified, and they need to be changed over time. These are not going to go away and this reality of our environment is here with us to stay.

Question 4

JHT: Absolutely. So, in thinking about these barriers you have identified in terms of standards, scarce resources, and work flow and productivity, what have you see as some of the most promising solutions or activities to address these challenges and those hospitals that have been able to overcome in part some of these barriers?

BS: I would say they have overcome it through will. They have overcome it because they know it is the right thing to do. Certainly, would we like to have more resources to do it? Sure. But I think that all of our members are committed and they know this is the future and that it is the right thing to do for our patients, especially the most vulnerable. When I see the promise of this and I see the benefits, I see things like the San Diego Beacon Program which is one of our member hospitals at UCSD. They have basically built a virtual safety net that links the hospitals, the community clinics, emergency medical services and others into one web that is built around an individual patient, not built around the hospital or the clinic. I think they are seeing some real results in terms of keeping people healthier and keeping them out of the hospital. We are seeing the same thing in Cleveland right now. If you look at the things that have happened at Metro Health in Cleveland, where they bolted together the public hospital, the private nonprofit hospitals, the community health centers of Kaiser Permanente, they have seen real results in less waste, fewer preventable admissions in the ER visits, and, actually closing disparities in things like high blood pressure control, hypertension control. That is another example. I think that we are at the beginning stages, despite the challenges, of seeing starting to see some real payoff here. And actually, I think that the big payoff may happen in the safety nets first with some of the most complex patients in some of the most unforgiving environments who will benefit most from the ability to move real, useful information from place to place along the continuum.

Question 5

JHT: So I'm thinking about the successes you've highlighted, are there any particular strategies that you would suggest, in particular for public hospitals and other providers as well, so they can continue to maximize the use and exchange of health information, both for patient care as we talked about earlier as well as sort of overall improvement of the delivery care system?

BS: I think that public and safety net hospitals have built really large, sometimes comprehensive systems of care. They have hospitals, they have clinics, they are often linked to the public health agency, but despite that, I think their challenge is to move beyond that, to build those bridges to people they haven't spoken to before. In the case of San Diego, that was the community clinics. In the case of Cleveland, that was linking across hospital systems; not just linking within the safety net but beyond the

safety net. I think that strategy is going to be absolutely critical. We've seen in this country a tough ten years economically. We've seen more people in need and more people vulnerable. We're going to see more people on Medicaid. So I think the challenges of the safety net and the issues around health information and exchange will go beyond the safety net. They will extend to all parts of the health system and everyone is going to have to have skin in this game. Building those bridges that go beyond our four walls, beyond honestly our hospital system to link in others are going to be absolutely critical to the future. I don't think that will always be easy. I think it may be politically difficult. I think it will be important. As part of that, we want to be able to measure quality and outcomes across those entire systems. So, simply measuring how I do around sepsis or how I do around readmissions is not going to be the whole picture or even a real picture of what is happening in a community. Instead, we will see strategies like in Cleveland where you really have community-wide performance measurement where you see a community-wide, honest self-examination of how we are doing for the people who rely upon us. Where the people don't view the improvement activity as something they do in their own practice or within their own hospital, but as what they do literally and figuratively as a community where they get together and spend the time to figure out these problems across these systems and silos. We are starting to see this in some places. But most of our communities in America are still far from that. That is going to be future strategy that really makes sense in this environment. One of the things I mentioned is how picking up providers who see low income patients really don't have continuity of care and maybe moving between different sites, perhaps, too often. We also know that one of the things driving the patients to these readmissions is the inability for the patients to get to the right medications or any medications in a timely way. One of the promises of health information exchange is the ability to do medication reconciliation electronically, to really allow people who have disruptions in care to have the right meds continuously. To not see changes or unplanned changes in what they are taking or gaps in what they are taking that could lead to them going downhill or needing to be readmitted. This is one of the many areas where health information exchange can make a difference especially for our patients.

JHT: This has been really helpful Bruce, thanks again for joining us today. We really appreciate your insights especially in terms of public hospitals and the opportunities and challenges that they face as they move forward with greater use of health exchange and information.

Further Resources:

- America's Essential Hospitals
 - <http://essentialhospitals.org/>
- CMS Meaningful Use Regulations
 - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html
- Kaiser Permanente Community Health Initiatives
 - <http://share.kaiserpermanente.org/article/community-health-initiatives-3/>
- Health Information & the Law Resources on Health Information Technology
 - <http://www.healthinfolaw.org/topics/58>