Remove Barriers to Interoperability

OVERVIEW
Achieving widespread interoperability of electronic health records is a well-recognized national priority that is in the best interests of patients, providers and the entire health care system. Removing barriers to interoperability – including preventing the practice of “information blocking” – is critically important to ensuring that every patient with cancer receives the highest quality health care services and support. Health information technology systems must be able to efficiently communicate, exchange data and permit health care professionals to make effective use of the full scope of available electronic health information.

BACKGROUND
Widespread interoperability is critically important to current and future efforts to deliver high-quality, high-value oncology services to individuals with cancer. The treatment of cancer is complex, often requiring coordination of care and the exchange of detailed clinical information among multiple health care providers using different health information systems. The average Medicare beneficiary sees seven providers annually, and depending on the diagnosis, cancer patients are likely to interact with even more, creating an urgent need for interoperable health records. Real interoperability includes the ability to identify, extract, and use health care data within and between systems, certainly not the situation that exists in many practices today.

Many practices have invested tens of thousands of dollars in electronic health records (EHRs) in order to comply with Meaningful Use (MU). This investment is ongoing, as upgrades to security or updates to ensure continued compliance with MU are required. It has been reported that US health systems invested over $10 billion in EHRs between 2008 and 2013 – and are projected to spend another $10-15 billion by the end of 2016.¹ While it was initially believed these EHRs would be interoperable, many cannot communicate with other systems inside or outside of their network, causing physicians and patients to resort to faxing or hand delivering records that are sometimes critical to the patient’s treatment. The scanning or uploading of static documents to the EHR further compounds the lack of true interoperability, and often results in unnecessary duplication of effort. Fixing this problem should not require further costs to physicians who have already invested significant resources in good faith – especially as the act of complying with MU itself has been implicated in some of the lack of innovation in EHR products.

The magnitude of the lack of interoperability becomes clearer upon examination of the numbers involved: more than 591,000 eligible professionals, hospitals, and critical access hospitals were actively registered in the Medicare/Medicaid EHR Incentive programs as of July 2016; as of that same date, over 506,000 health care providers received payment for participation in the Incentive Program; and over $23.7 billion in incentive

payments were made between May 2011 and July 2016 (for the Medicare program alone). The sheer scale of involvement by health care providers, and the amount of money already invested, adds to demands that we see a return on investment as reflected by the ability of EHRs to be meaningfully interoperable in such a way that they add to, rather than detract from, the efficiency of patient care.

Lack of interoperability is also impeding big data efforts in oncology. ASCO has launched the CancerLinQ initiative with the goal of distilling massive volumes of clinical data from large groups of cancer patients into meaningful information that can improve clinical decision making. Achieving widespread interoperability is a threshold requirement to take full advantage of these new capabilities.

Some ASCO members are now reporting barriers to interoperability arising from several forms of so-called “information blocking.” Information blocking is the practice of knowingly and unreasonably interfering with the exchange or use of electronic health information, and can include:

- Attempts to include per transaction fees within contracts for each import or export of information to a different platform for electronic health information.
- Refusal to establish connections to permit information exchange with systems developed by competitors.
- Establishing technological limits to the amount of historical health information that can be exported to a recipient on a different company’s electronic health record platform.
- Developing proprietary standards for communicating clinical information documents that are inconsistent with established industry standards such as DICOM and HL7.
- Requiring that a health care provider contractually agree to give the electronic health record company an exclusive license to use the health care provider’s data, thus effectively prohibiting the health care provider from making clinical data available for use by others, including quality improvement companies.

REQUEST

We urge Congress to pass legislation, such as the 21st Century Cures legislation (H.R. 6) or the Improving Health Information Technology Act (S. 2511), to improve interoperability and prohibit intentional information blocking.

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