Connecticut's HIE: A Look at the Nutmeg State's Approach to Sharing Patient Information

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Connecticut is in the midst of developing and implementing a pilot program for a state-wide health information exchange (HIE). Spurred by federal government policy, and a belief that the ease of sharing health information electronically will drive down healthcare costs and improve quality of care, Connecticut has spent significant time and resources to develop an HIE appropriate for the state, its residents, and its healthcare providers. This article provides background on the development of Connecticut's HIE and discusses current challenges and future plans.

Background

The impetus for a national network of health information exchanges came with the passage of the American Recovery and Reinvestment Act of 2009[1] (ARRA). Included in ARRA is the Health Information Technology for Economic and Clinical Health Act[2] (HITECH Act), which, among other things, provided states and other governmental jurisdictions an opportunity to access federal funds to plan, design, and implement health information exchanges.

The HITECH Act also designated the newly created Office of the National Coordinator for Health Information Technology (ONC) to serve as the principal federal agency responsible for implementing a nationwide health information technology infrastructure to enable the electronic use and disclosure of patient health information. To jumpstart development of this infrastructure, the ONC was charged with implementing three grant programs authorized by ARRA: (i) the Health Information Technology Extension Program, (ii) the State Health Information Exchange Cooperative Grants Program (Grants Program), and (iii) the Information Technology Professionals in Health Care Workforce Program.

While all three of these programs support the mission of state health information exchanges, the Grants Program is the one that helped launch the state exchanges, including Connecticut's. To implement the Grants Program, the ONC granted 56 awards totaling $548 million to help states and territories develop health information exchanges. In March 2010, the Connecticut Department of Public Health received $7.29 million from the ONC to support the development of a Connecticut exchange.

History in Connecticut

Connecticut began preparing for the establishment of a state-wide health information exchange in 2009 with the passage of Public Act 09-232 (2009 Act). The 2009 Act designated the Connecticut Department of Public Health (Department) as "the lead health information exchange organization for the state." As part of this role, the Department was tasked with submitting a "state-wide health information technology plan" to the state legislature and facilitating the implementation and periodic review of the plan. The Department also was charged with seeking private and federal funds (including those made available by ARRA) for the initial development of a state-wide health information exchange and developing standards and protocols for privacy in the sharing of electronic health information.

The 2009 Act also established the Health Information Technology and Exchange Advisory Committee (Advisory Committee). The Advisory Committee consisted of healthcare professionals, policy makers, and payor and consumer representatives and was tasked with examining and identifying ways to improve and promote health information exchange in the state. Specifically, the Advisory Committee was required to seek funding for the exchange and develop appropriate protocols and standards to facilitate the development of a state-wide exchange.

In 2010, the Connecticut legislature passed Public Act 10-117, which formally established the Health Information Technology Exchange of Connecticut (Exchange or HIE) as a quasi-public agency. The Exchange was the product of over a year of consultation and deliberation and is the entity tasked with implementing and managing Connecticut's health information exchange system.

Governance & Leadership

The following provides brief highlights of the governance and leadership of the exchange:

Board of Directors. The Exchange is governed by a 20-person Board of Directors. The Board's membership is a mix of the leaders of state agencies and appointments by the Governor and state general assembly. Provisions are made to ensure that consumers, hospitals, Federally-Qualified Health Centers (FQHCs), pharmacists, healthcare providers, and the business community are represented.[3]

Staffing. The Exchange is led by four officers: the Chairperson, the Vice-Chairperson/Treasurer, the Secretary, and the Chief Executive Officer. Other executive positions include a Chief Technology Officer, a HIT Coordinator, and an Administrative Project Officer. As of the date of this article, the Exchange is accepting applications for positions including a Program Development Officer and a Customer Support Manager.

Current Status and Activities

Connecticut's HIE is currently planning and preparing for the launch of a pilot program through which the HIE will evaluate its performance and troubleshoot as necessary prior to a full roll out. The HIE currently has not set a date for launching the pilot program. While the pilot program is being developed, the Exchange has been busy with other activities, including the following:

Educational Ventures. In conjunction with Capital Community College of Hartford, Connecticut, the Exchange has assisted in the development of a Health Information Technology Training Program. The training program offers accelerated and weekend courses in two tracks—HIT Consultants and HIT Engineers. The purpose of this program is to provide area businesses and healthcare providers an available and trained workforce to implement the HIE once it is live in Connecticut.

Policies and Procedures. As of the date of this article, the Exchange is developing a comprehensive set of policies and procedures to govern both its internal operations and the pilot program. Future policies may include ones addressing consent, participation, and security issues.

Challenges

As mentioned above, Connecticut's HIE currently is in the process of planning and implementing a pilot program. Doing so has been slower than originally expected, as the HIE has been confronted with numerous challenges, including competing priorities and market forces.[4]

Direct vs. Comprehensive Solution. When establishing an HIE, a fundamental question is whether the HIE will pursue a "direct" or "comprehensive" solution. While definitions vary, a "direct" solution typically means that the HIE will work directly with providers to register them with and connect them to the HIE. This "one doc at a time" approach typically involves outreach to and participation from individual healthcare providers and small group practices.

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By contrast, a "comprehensive" solution typically refers to a strategy that involves a broad roll-out of the HIE, incorporating large institutional providers and various existing information exchange systems or platforms. This solution envisions a fully functional HIE established upfront, rather than one built "one doc at a time." However, a downside to this approach is that a comprehensive solution requires significantly more time to establish than a direct solution HIE.

The Connecticut HIE originally opted for a comprehensive solution. By selecting a comprehensive solution, the HIE intended to take advantage of the efforts of Connecticut's large institutional providers to develop their own information sharing arrangements. The HIE also believed that large institutional providers would be the most appropriate initial participant pool for the HIE. Accordingly, the HIE began to design a comprehensive solution pilot program and lined up a vendor to develop and implement the pilot program.

Despite this initial strategy, the roll-out of a comprehensive pilot program was later deemed to conflict with guidance from the ONC. The ONC informed Connecticut that it preferred the HIE begin with the "direct" approach discussed above. While ONC's preference for the direct approach may stem from a desire to have the HIE up and running in a shorter time frame than would be possible with the comprehensive solution first proposed by Connecticut, the change is likely to have the opposite effect and delay, rather than accelerate, the launch of the HIE pilot as discussed further below.

Provider Interest. One challenge Connecticut's HIE is facing is aligning provider interest with the objectives of the pilot program. As mentioned above, the comprehensive solution was originally proposed to target Connecticut's large, institutional providers. These providers have made significant progress in developing information sharing infrastructure independently of the HIE and many expressed interest in participating in the pilot program.

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Despite this initial enthusiasm, the HIE's switch to a direct approach has dampened the interest of these large, institutional providers. Many such providers view the direct approach as too cumbersome and slow, and fear that their own initiatives may be delayed or hampered by waiting for the HIE's "one doc at a time" roll-out. These providers thus are taking a wait and see approach while continuing to work on their own information exchange programs.

Despite the direct approach's focus on small and individual providers, the HIE has found that small providers, on the whole, are less interested and/or willing to participate in the pilot program and are, in general, farther behind on the adoption of electronic health records and the sharing of patient information electronically. This lack of interest in participating in the pilot program may result in further delays to the HIE's launch.

ACOs/RHIOs. Delays in the launch of the pilot program also has raised concerns that the large, institutional providers the HIE envisioned as initial participants will instead begin establishing their own exchanges, particularly regional health information exchanges (RHIOs) or intra-system exchanges.

These concerns are heightened with the growth of accountable care organizations (ACOs). Under the Medicare Shared Savings Program (MSSP), ACOs are groups of physicians, hospitals, and other healthcare providers who come together voluntarily to give coordinated care to the Medicare patients they serve. Participating ACOs that satisfy certain requirements related to reporting, quality, and other metrics may be eligible for enhanced reimbursement under the MSSP. To properly coordinate and track these efforts, ACOs typically seek the efficient and cost-effective sharing of patient information between ACO participants often through existing or specially established information networks or protocols.

In effect, Connecticut's HIE is concerned that the rapid movement towards electronic sharing of health information by healthcare providers involved in ACOs, which typically includes some of the state's largest healthcare providers, will leap frog the HIE while it implements its direct solution.

Consent. On a practical level, another challenge facing the HIE is the issue of how smaller participating providers obtain proper patient consents. While larger institutional providers may have the experience and resources to collect and maintain such consents, many of the small and independent providers targeted by the direct solution have expressed apprehension in doing so.

For example, smaller providers often simply lack the staff to ensure that patients have signed the consent, to answer questions patients may have about it, and to file and record the consent, along with any subsequent changes or revocations to it. Similarly, physicians report having little time to sit and discuss consent forms with patients.

Conclusion

Connecticut's experience with bringing a health information exchange on line is instructive as to the challenges other states may face when implementing any type of broad information exchange system. To confront these challenges, Connecticut has put together an experienced and strong team of leaders who have worked with a variety of industry players to make the HIE a reality. When launched, Connecticut's HIE has the potential to significantly improve the provision of healthcare in the state.

About the Author

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Endnotes

1 Pub. L. No. 111-5 (2009).
2 *Id.* at Title XIII.
3 Conn. Gen. Stat. § 19a-750(c)(1).
4 This section of the article is based upon interviews with HIE officials.