



AHIMA Public Policy Statement: Interoperability

AHIMA's Position:

AHIMA supports the use of policy to promote a technically, functionally, and semantically interoperable healthcare system. Health information (HI) professionals have extensive knowledge and expertise to contribute to developing policies around interoperability in healthcare. To make the strides needed to strengthen interoperability within healthcare, public policy must:

- 1. Improve standardization of health data to support interoperability.** Standardization of health data promotes information sharing and improved interoperability wherever healthcare data is shared. All types of health information should be included in standardization efforts, including newer types of data being collected, such as social determinants of health (SDOH), patient-reported, and remote patient-monitored data. Policy must also encourage both appropriate terminology and content standards, including normalization processes to encourage semantic interoperability. This can enable data to be shared across systems – as it was originally intended – with the correct and intended meaning.
- 2. Support technologies that advance the bidirectional sharing of patients' health data.** Policy must encourage adoption and implementation of effective two-way electronic data sharing for optimal patient care. Adoption and use of open application programming interfaces (APIs) and modern technical standards, such as fast healthcare interoperability resources (FHIR), will help to facilitate timely access to health information between providers, patients and/or their caregivers, and payers. This includes the adoption of appropriate privacy and information security policies, which must also be considered in advancing the bidirectional sharing of data to ensure the privacy, confidentiality, and security of a patient's health information. Positive feedback referral is needed to enhance care coordination and outcomes.
- 3. Promote incentives for electronic health information sharing across all healthcare settings.** The rate of adoption and use of interoperable health IT among long-term, post-acute care (LTPAC) and behavioral health providers continues to lag behind acute and ambulatory care providers. In the fourth quarter of 2019, 21 percent of inpatient post-acute providers responded that they had some technological capabilities of EHRs that were operational. Long-term care administrators also reported that 86 percent of their facilities were not exchanging health information electronically with referring hospitals, physicians, or home health providers.¹ As a result, data exchange between transitions of care remains a challenge. Positive incentives should be considered to support all care settings, allowing them to transition to interoperable electronic health records (EHRs) and technologies.

¹ Available at: <https://blackbookmarketresearch.newswire.com/news/post-acute-providers-predict-probable-insolvencies-under-value-based-21033595>.

4. **Promote and/or incentivize data sharing between external reporting systems, including between clinical and public health systems, registries, and health information exchanges (HIEs).** Interoperability must be a goal for all stakeholders within the health ecosystem. From tracking the spread of disease to identifying population-level interventions, our public health and registry systems are necessary to promote the health and well-being of individual patients. Data sharing between clinical and public health systems must be timely, secure, de-identified when appropriate, and must not share more information than necessary for the achievement of the stated health goal.
5. **Prioritize privacy and security.** Sharing of data across organizations requires consideration of privacy and security issues, including consent management, data segmentation, and the authorization and authentication of data recipients prior to exchange.

Background

Interoperability is the ability to capture, communicate and exchange data accurately, effectively, securely, and consistently with different information technology systems, software applications, and networks in various settings, and exchange data, such that the clinical or operational purpose and meaning of the data are preserved or unaltered.² For nearly two decades, interoperability within healthcare sphere has been a priority of the federal government. The Office of the National Coordinator for Health Information Technology (ONC) was established in 2004 by Executive Order, and was codified in legislation in 2009, with the enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act, as part of the passage of the American Recovery and Reinvestment Act. The HITECH Act provided broad, permanent authorities for ONC to promote the facilitation of the secure use of and exchange of interoperable health information. It also invested \$17 billion in economic incentives to providers and hospitals for the adoption and use of EHRs.

Congress continued its work around health information technology and interoperability with the passage of the 21st Century Cures Act (Cures Act) in 2016. The Cures Act defined interoperability as health information technology that “(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; (B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and (C) does not constitute information blocking as defined in section 3022(a).”³ The Cures Act included provisions to promote this definition of interoperability and prohibit information blocking by health information networks, health information exchanges (HIEs), providers, and health IT developers.

² Available at: <https://bok.ahima.org/doc?oid=301914#.YS0bl45Kg2w>.

³ Available at: <https://www.healthit.gov/topic/interoperability>.

Key Points

Improving interoperability within and across health systems could yield considerable benefits, including:

- Enhanced patient safety and outcomes by ensuring that providers have accurate and complete patient medical records with less manual effort;
- Increased cost-effectiveness to individual systems and the healthcare ecosystem as a whole in the long-run;
- Reduced costs to healthcare organizations, providers, and patients, stemming from increased productivity and decreased duplicate tests;
- Improved longitudinal records of all patient health information, including patient health conditions and medical services;
- Increased privacy and security of patient health information;
- Increased ability for innovators to enter into the healthcare space because of clear standards and improved interoperability;
- Advancing the quadruple aim of healthcare to enhance patient experience, improve population health, reduce costs, and improve the work life of healthcare providers, and;
- Improved health data use in public health surveillance systems, registries, and HIEs, resulting in improved ability to track population-level and public health issues.

To realize the benefits of improved interoperability, certain barriers must be addressed, including:

- **Lack of a national strategy on patient identification.** The inclusion of Section 510 in the Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) section of the federal budget has stifled work around patient identification between the private sector and HHS for more than two decades. Today, lack of widespread operational principles, as well as limitations in processes and technologies, result in inaccurate patient identification.⁴ This patient misidentification can include duplicate records and overlaid records, resulting in interoperability challenges between EHR systems.
- **Lack consistent technical and content standards between clinical data capture systems.** Various EHR systems may not be implemented in ways that easily integrate third-party patient health information or health data. Lack of standardization and data quality are barriers to a more fully interoperable system.

⁴ECRI Institute PSO Deep Dive: Patient Identification: Executive Summary. Available at: https://www.ecri.org/Resources/Whitepapers_and_reports/PSO%20Deep%20Dives/Deep%20Dive_PT_I_D_2016_exec%20summary.pdf.

- **Cost of health IT implementation and adoption of new technologies.** Implementing new EHRs, standards and complying with new or changing regulations can impact the timeliness of ensuring that health IT systems are operating in a way that fully supports interoperability. Further, the continued reliance on fax machines is a barrier to more efficient and secure data transfer.
- **Privacy and security challenges.** Workforce training on administration of privacy and security measures, including consent management and appropriate authorization and authentication practices, can be lacking, causing barriers to safe and secure interoperability.

Current Situation:

Recent steps towards improved interoperability came with the implementation of the 21st Century Cures Act Information Blocking rule, which took effect in April of 2021. This rule ensures that providers are required to make a core set of clinical data available to those requesting access to such data in a timely fashion. The Cures Act also improved interoperability between providers and registries, by requiring EHRs to be technically capable of transmitting to, receiving, and accepting data from registries as a condition of certification in accordance with standards recognized by ONC.

At the same time, as part of the Cures Act, the federal government has instituted policies and adopted technical standards that support third-party access to provider information systems through open APIs. Similar policies have been adopted as part of the CMS Patient Access and Interoperability rule, which encourages the use of APIs to facilitate data sharing between providers and plans. Additionally, the creation of the Trusted Exchange Framework and Common Agreement (TEFCA) is in progress, with the goal of establishing a floor of universal interoperability across the country. ONC and the Sequoia Project have worked with industry stakeholders to create an approach to enable nationwide health information exchange across different health information networks, and are aiming for the Trusted Exchange Framework, the Common Agreement Version 1, and the qualified Health Information Network (QHIN) Technical Framework (QTF) Version 1 to be available for participation in the first quarter of 2022.

The COVID-19 pandemic has highlighted the need to improve interoperability within the healthcare and public health systems. Patient identification, ensuring accurate longitudinal records of patients' health, and exchanging data between clinical and public health systems have shown the need for a fully interoperable health system.

As policymakers seek to improve nationwide interoperability within and across health systems, AHIMA and its members are prepared to lend their knowledge and expertise to the conversation.