

eHealth Pod Pilot Program – Challenges

Pennsylvania's Department of Public Welfare's Office of Medical Assistance Programs (OMAP) developed the eHealth Pod Pilot Program to stimulate the use of health information technology by behavioral health and long-term care providers to electronically exchange health information. Providers were given technical assistance by Service Partners to improve coordination of care through the electronic transmission of Continuity of Care Documents (CCDs). The following presents the challenges encountered by the Service Partners, eHealth Pod providers and their exchange partners during the pilot.

The eHealth Pod providers all had varying levels of success during their participation in the pilot and yet experienced challenges as well. These challenges are broken out into three categories:

- I. **Challenges for Providers who were invited but did not Participate in the Pilot** – includes challenges for providers who declined to participate and providers who wished to participate but were unable to participate during the pilot timeframe.
- II. **Challenges for Providers Exchanging CCDs** – providers who attempted to generate CCDs experienced a set of challenges, for example getting staff members ready for exchange and adapting workflows for exchange
- III. **Challenges Beyond the Pilot** – the challenges of exchanging health information will continue after the pilot as providers work to maintain the exchange with their partners and without assistance from service providers.

I. Identifying Challenges for Providers Not Participating in the Pilot

Service Partners approached potential providers to participate in the eHealth Pod Pilot Program as part of the activities they conducted under the pilot. The Service Partners were familiar with providers from previous projects or through connections in the community. Several providers declined participation; however, other providers were interested but ultimately could not participate in the pilot.

Providers Declining Participation

Several providers immediately declined participation in the eHealth Pod Pilot Program. The primary reason cited was the presence of competing priorities. While many of the providers recognized the value of health information exchange, they identified other organizational needs that required attention first, such as transitions in leadership. Subsequently, many providers hesitated in participating in the program given that CCD exchange was not the most pressing need of the provider's organization.

In addition, providers also identified the lack of sufficient personnel, system, and infrastructure resources to accommodate CCD exchange. Many providers stated that they did not have the bandwidth to begin health information exchange in their organization. Several providers identified transitions in leadership or financial sustainability as major concerns for implementing CCD exchange. Other providers were not able to get organizational buy-in for participating in the pilot. This was a challenge faced by at least one hospital which had to get buy-in and approval from the CEO, COO, and CIO. Ultimately, this process proved too time consuming and difficult. Service Partners working with larger institutions, such as hospitals or group practices, found it more difficult to partner with them. In larger settings, Service Partners indicated difficulty in identifying the right stakeholder groups to approach

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within the organization to champion the pilot program. Additionally, some larger organizations experienced difficulty getting staff to buy-in and educated regarding initiatives related to the use of CCDs or mechanisms for health information exchange (HIE). For organizations, such as hospitals, filtering down communication on new programs from leadership to operational and administrative staff is an additional challenge to consider.

Providers Unable to Participate

Working with the Provider's Electronic Health Record (EHR) System and Vendors

Many providers expressing interest in the pilot also found that they had issues with their EHR software vendors that made participating in the pilot especially challenging. Selecting an appropriate EHR vendor is challenging for all providers but especially challenging for behavioral health and long-term care providers. Providers would select vendors based on the limited information available and often times, found these solutions were not appropriate for their patient population. Behavioral health and long-term care providers are generally not eligible to participate in the Meaningful Use EHR Incentive Program. Subsequently, there are fewer EHR systems certified that address behavioral health or long-term care practice needs. Therefore, the EHRs used by behavioral health and long-term care providers may be insufficiently prepared to produce and exchange a CCD, which is addressed under the meaningful use and certification requirements. For instance, one provider needed to replace their EHR since their existing system was unable to meet new certification requirements as well as address provider needs in supporting the delivery of care for their patients.

Additionally, Service Partners also found that providers were not using all of the functionality available in their EHR systems. Many providers were only using a minimal set of features in their EHR and therefore, not optimizing on their EHR functionality, including the creation of a CCD. Service Partners provided additional technical assistance to providers regarding the use of different functionality in their systems for increased care delivery and coordination purposes.

Service Partners also found limitations with the EHRs, which the provider's vendor was unable to address. Many providers reported the lack of updates, lack of existing functionality, and the continuously changing technical requirements as barriers to sending and receiving CCDs. Providers attempted to work with their vendors to make the necessary modifications to enable CCD exchange, however, the barriers were often too difficult to overcome. In addition, when providers worked to develop CCD exchange functionality to their EHRs, the additional costs were prohibitive to adoption.

Lack of Incentive to Exchange CCDs

The lack of policy and guidance for behavioral health and long-term care providers was often a contributing factor to a provider's decision to not participate in the pilot program. As previously discussed, behavioral health and long-term care providers are not generally eligible for the EHR incentives so they do not necessarily need to adopt and meaningfully use certified EHRs. Additionally, even when providers attempt to adopt, implement, or upgrade certified EHRs, there was a lack of guidance available to assist them with this process.

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II. Challenges for Providers that Exchanged CCDs

Ensuring Staff Readiness for Exchange

Identifying the gaps in staff readiness for CCD exchange was a key challenge for participating eHealth Pod providers. Prior to the start of the pilot, Service Partners found many providers and staff did not fully understand the implications of HIE or the different methods of CCD exchange, such as secure messaging like DIRECT. Service Partners delivered provider-specific technical assistance to alleviate provider and staff concerns and to address questions regarding the process for exchanging CCDs. In addition, Service Partners conducted comprehensive readiness assessment to prepare eHealth Pod Providers for exchange, which included ensuring due diligence for technical, workflow, and staff requirements for HIE. There is often a lack of organizational bandwidth to accommodate requirements creating additional burdens on an already stretched organization.

Creating, Sending, and Receiving CCDs

One of the major challenges eHealth Pod providers faced was preparing their EHR systems to electronically exchange health information, including CCDs. Many participating providers worked closely with their EHR software vendors to establish the infrastructure necessary to send and receive CCDs. Some providers found they needed to upgrade their EHR to ensure their EHR system had the capacity to exchange CCDs. Behavioral health and long-term care providers are generally not eligible to participate in the Meaningful Use EHR Incentive Program putting less pressure on vendors to certify products geared for these settings. Therefore, behavioral health and long-term care providers may need to have additional discussions with their vendor in order to confirm system readiness for CCD exchange.

Additionally, even though certified EHRs have the ability to create CCDs, many of the participating providers in the pilot program found their EHRs created CCDs in an unusable format. For example, several EHRs were creating CCDs without style sheets, making it difficult to read. Therefore, as part of this pilot program, providers worked with their Service Partners and their vendors to identify and attach an appropriate style sheets to their CCD.

The systems used by pilot participants did not enable automatic electronic consumption of the CCD into the EHRs. The eHealth Pod Providers found their EHRs were not able to integrate the CCDs directly into their EHR. Instead, several providers created workarounds, such as sending the CCD as a PDF through DIRECT manually uploading or attaching the PDF to the EHR, so that providers were able to access patient information. These providers needed to modify and create new workflow processes to accommodate for the lack of automatic consumption of the CCD. For instance, one modification providers made was to identify a responsible party for checking DIRECT mail and collecting the CCDs sent from the exchange partner to the provider so the CCDs could be included in the EHR.

Identifying Methods of Exchange

In their final guidance of Stage 2 Meaningful Use, CMS outlined that use of DIRECT protocols would permit providers to meet requirements associated with transport of health information between a sender and receiver. Due to this new requirement, many of the eHealth Pod providers elected to use

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DIRECT as the platform for transporting CCDs with their exchange partners. While participating providers were not required to use DIRECT messaging, OMAP worked with Health Information Service Providers (HISPs) to offer DIRECT licenses to providers and organizations at no charge for the duration of this project. However, the lack of knowledge regarding DIRECT was a barrier for providers. Service Partners provided additional education and outreach to their providers regarding DIRECT services, including DIRECT's limitations to interoperability.

However, despite having DIRECT licenses, participating providers found it challenging to identify potential partners who would be prepared to exchange CCDs using the DIRECT transport mechanism. Currently, there is no comprehensive listing of providers with DIRECT that is available to the public. Many participating providers found it challenging to identify other providers who were prepared to exchange CCDs using DIRECT.

Adapting Workflows for Exchange

Another challenge for participating providers was obtaining patient consent prior to the exchange of health information. Due to new HIPAA guidelines, which now include provisions of HITECH, providers need to be more cognizant about their data exchange policies. In addition, getting consent, particularly from behavioral health providers, is especially challenging due to the importance of protecting behavioral health and mental health treatment information. Service Partners educated providers on the challenges of not being able to segregate this information and its implications on receiving consent from patients. As a result, many providers adopted various workflow solutions to ensure that universal authorizations and data consent agreements were in place for both providers that send information. This often created additional workflow challenges since providers needed to keep track of which providers had universal authorizations and data consent agreements in place.

Additionally, providers encountered further workflow challenges during the exchange of CCDs. First, the lack of message automation with the DIRECT accounts used required providers to assign the added responsibility of monitoring DIRECT and making sure the patient's health information was stored in an accessible place. Second, since many of the providers were unable to electronically consume and integrate the health information directly into the EHR without mapping the document, some data required manual input into the system. Finally, providers needed to implement a process to identify patients eligible for participating in the exchange of data and to alert staff to new patient information.

III. Challenges Beyond the Pilot

Sustaining the Health Information Exchange Effort

The greatest concern for providers as they plan for exchanging health information beyond the pilot program is the ability to financially and programmatically sustain HIE related processes. Providers will also face new challenges without support from the technically proficient Service Partners who helped them successfully exchange CCDs. Behavioral health and long-term care organizations may not have sufficient resources, personnel, or finances to continually invest in innovative HIE practices. Providers are often pushed to make difficult financial decisions based on needs and resources of the organization. Particularly, smaller practices may lack the education and expertise to start and sustain the level of

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effort needed for electronic health information exchange. Many providers in the pilot stated that if they had not been approached by Service Partners with offers to provide technical assistance and training, they would not have considered exchanging CCDs as a top organizational priority.

In addition, although providers were able to modify their workflow and administrative processes to accommodate for exchange, the inclusion of other processes may be a significant undertaking. As they expand their exchange efforts to incorporate other organizations, participating providers will need to re-examine their processes to accommodate the increased exchange volume. In particular, exchanging with primary care physicians or specialists, such as allergists, results in an increased number of exchanges per patient. As participating providers begin to exchange with other types of providers, they may need to make additional modifications to their exchange process, which may result in examination of resource availability.

Expanding Health Information Exchange

As providers begin to exchange and integrate CCDs into their patient care management process, they will look to expand the volume of exchanges by partnering with additional providers or organizations with overlapping patient populations. Increasing the number of exchanges poses additional workflow concerns and causes organizations to reassess their technological infrastructure. For instance, while point to point manual exchange is a low-cost, short-term alternative, providers may want to consider a long-term technological solution to support more automated exchange. Several providers identified plans to use a portal or an HIE in the future to ensure the automatic consumption of exchanged data.

Accommodating Policy and Government Requirements

Providers must frequently adopt various policy and government requirements, which can exert pressure on the organization's workflow and programmatic vision. Many providers participating in the pilot remarked that, while federal mandates regarding health information technology are well-intentioned, they often do not reflect the complex and unique challenges facing behavioral health and long-term care providers. As participating providers build off and expand the HIE infrastructure developed as part of this pilot, providers must balance the policy and government requirements and the specific needs of the behavioral health and long-term care patient population.

Additionally, there is often a knowledge gap that providers must overcome in order to fully understand policy requirements. One of the benefits of the pilot program was the support and education provided through the Service Partners. However, many providers participating in the pilot indicated the need for additional education, particularly for technically complex issues, such as the adoption of health information exchange practices. Continuous education and communication is necessary to keep providers informed of innovative practices, lessons learned, and potential challenges to new policy changes.

Additional Information about the eHealth Pod Pilot is available at:
www.pamahealthit.org