Social Security Administration
Compassionate Allowance Outreach Hearing on Cancers
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I am John D. Halamka MD, CIO of Harvard Medical School, CIO of Beth Israel Deaconess, Chair of HITSP and a practicing Emergency Physician. I welcome the opportunity to present testimony to the committee today.

In the United States today, Health Information Exchanges and Regional Health Information organizations typically focus on the exchange of patient data for direct clinical care. Typical use cases include providing clinical histories to Emergency Departments, pushing laboratory/ radiology results from hospitals to physician offices, and supporting referral workflow between primary care clinicians/specialists.

However, secondary uses of data such as public health reporting, pharmacovigilance, biosurveillance and quality reporting can be equally important. The Social Security Administration disability evaluation process provides an great example of data exchange for secondary use that improves quality, saves money, and leads to increased patient satisfaction.

Today, the Social Security Administration pays over $500 million dollars per year to retrieve paper records and purchase consultative examinations when they are unable to obtain existing records in support of a disability application. Here's how it works:

1. A patient applies to the Social Security Administration for benefits related to a disability.

2. The patient signs an authorization to release medical records at a local SSA office or submits the form via mail.

3. The SSA forwards the authorization and a medical record request to hospitals via mail.

4. Health Information Management staff at each hospital copies paper records or prints electronic records, then sends those records to the SSA. It's a manual, costly process. Records are generally sent via mail, but some providers use fax or the SSA website to upload non-standard file formats, like Word, which the SSA converts to images for use in their current system. These images are just pictures, not data, and therefore are not searchable.

5. Staff at the SSA manually review the paper records to verify diagnoses, medications, lab results, and other observations which document disability.

6. The application is manually reviewed, then an administrative decision is made. The entire process takes about 6 months.

With interoperable data standards, the new process could be:

1. A patient applies to the Social Security Administration for benefits related to a disability

2. The application is entered into SSA's disability claims system

3. The patient authorization is digitized by a local SSA office and stored centrally

4. The case is transferred electronically to the State Disability Determination Service - who will determine whether the claimant is medically disabled according to SSA's rules.

5. At the same time as the electronic case is transferred, SSA's system automatically sends the digitized authorization to a hospital along with an electronic query to verify patient records are present - without any human intervention

6. The hospital verifies the authorization and sends an electronic clinical summary securely with the SSA

7. SSA receives the clinical summary, formats it in a document and automatically saves in the electronic disability folder - again, without any human intervention. At the same time, a rules engine reviews the data. Depending upon the data received, the system alerts the case adjudicator to take appropriate steps.

For example, the hospital includes an ICD 9 diagnosis code of 153.2, which is Malignant neoplasm of the descending colon, in the clinical summary. The summary also includes a secondary ICD 9 diagnosis code of 197.7, which is a secondary malignant neoplasm of the liver.

The rules engine automatically creates an alert to advise the adjudicator to consider the listing for Colon Cancer with distant metastasis. The adjudicator sees the alert when he/she opens the case for the first time.

8. The adjudicator finds the associated operative and pathology reports in the clinical summary and makes a decision on the case immediately. A process that used to take weeks will be accomplished in a matter of days.

Perhaps some day, with sophisticated enough clinical summaries and rules engines, a system could be developed to automatically make a decision on some disability claims based upon electronic health records.

Although the specific use case for exchange of data between hospitals and the SSA has not been in scope for HITSP, the interoperability specifications developed for biosurveillance, another secondary use of data, work very well. Specifically:

1. The PIX/PDQ transaction can be use to transfer patient demographic information and verify patient records are present

2. The Continuity of Care Document provides a clinical summary of problems, medications, allergies, and laboratories

3. The XDR standard provides secure transport of the CCD from hospital to the SSA

Of course, patient privacy must always be protected with any data exchange. Technical security standards enforce privacy policy and the social security administration workflow is predicated on patient authorization, acceptance of the signed authorization by the hospital and transmission of records to SSA only after patient identity has been verified.

The fact that HITSP interoperability specifications have been recognized by Secretary Leavitt means that standards for labs, medications, clinical summaries, transport, and security are available to meet the interoperability requirements of clinicians, patients, hospitals, labs, pharmacies, and government agencies. 2008 is the tipping point for interoperability now that standards are available, government and hospital stakeholders are aligned, and the business case for data exchange is clear.

BIDMC is currently working on a pilot with SSA to implement the HITSP standards and the workflow described above. A successful pilot could lead to wide adoption of data sharing in support of the disability process and integration of these workflows into the Nationwide Health Information Network. Best of all, the enhanced service to patients will likely result in lower overall costs, making implementation fundable from the savings of eliminating paper record transfer.