



# **Health Information Community of Ohio Advisory Group Meeting**

**February 24, 2006**

**National Speaker Panel**

*"Discussion on How Other States Have  
Pursued a State-Level Conversation"*



# National Speaker Panel Format



- |   |           |                   |
|---|-----------|-------------------|
| • Introduction of Panelists                           | 2 minutes | Janet Marchibroda |
| • Introduction of NY State Initiatives                | 5 minutes | Rachel Block      |
| • Introduction of MN State Initiatives                | 5 minutes | Marty LaVenture   |
| • Introduction of TN State Initiatives                | 5 minutes | Vicki Estrin      |
| • Question #1 – “Value Proposition”                   | 2 minutes | Rachel Block      |
| Compare & Contrast                                    | 2 minutes | Marty LaVenture   |
| Compare & Contrast                                    | 2 minutes | Vicki Estrin      |
| Audience Engagement                                   | 4 minutes | ALL               |
| • Question #2 – “Stakeholder Buy-in”                  | 2 minutes | Marty LaVenture   |
| Compare & Contrast                                    | 2 minutes | Vicki Estrin      |
| Compare & Contrast                                    | 2 minutes | Rachel Block      |
| Audience Engagement                                   | 4 minutes | ALL               |
| • Question #3 – “Barriers and Challenges”             | 2 minutes | Vicki Estrin      |
| Compare & Contrast                                    | 2 minutes | Rachel Block      |
| Compare & Contrast                                    | 2 minutes | Marty LaVenture   |
| Audience Engagement                                   | 4 minutes | ALL               |
| • Question #4 – “Lessons Learned”                     | 2 minutes | Rachel Block      |
| Compare & Contrast                                    | 2 minutes | Marty LaVenture   |
| Compare & Contrast                                    | 2 minutes | Vicki Estrin      |
| Audience Engagement                                   | 4 minutes | ALL               |
| • Extra few minutes for overflow/additional questions |           |                   |

# Multi-Stakeholder Collaboration to Advance HIT Strategy – New York



***Long-term vision: Better information to support purchaser, clinician and consumer decisions***

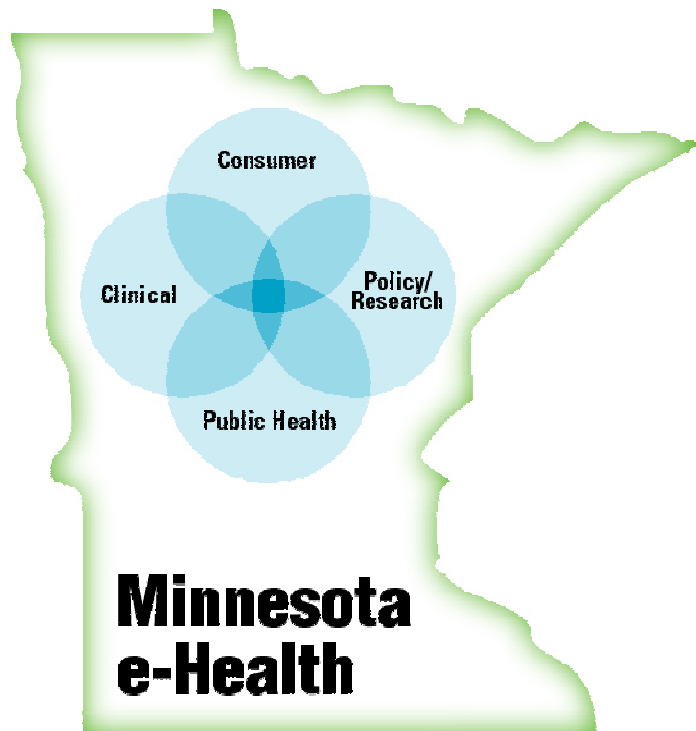
- HIT Implementation Priorities
  - Promote interoperability and clinical data exchange
  - Facilitate performance measurement
  - Improve prevention and chronic care management
- United Hospital Fund Activities
  - NYS HIT Policy Summit Initiative – partnership with eHealth Initiative Foundation (with assistance from Manatt Phelps and Phillips)
  - Goals for the initiative:
    - Help state and local leaders to formulate HIT policies designed to improve quality, safety and efficiency of health care
    - Establish the “value proposition” for HIT adoption and use
    - Identify and resolve key barriers at state and local levels (e.g., legal issues, coordination of incentives)
- Summit process laid the groundwork for multi-stakeholder policy discussion on HIT issues in New York
- HEAL-NY grants: collaborative projects focused on clinical data exchange, electronic prescribing and quality
- Health Care Facilities Commission
- F-SHRP waiver
- Demonstrations: disease management, pay for performance

# Multi-Stakeholder Collaboration to Advance HIT Strategy – New York



- UHF Report to New York DOH – “Role of the State”
  - The state needs to articulate and broadly communicate its strategy to advance HIT adoption and use
  - Primary state responsibilities are allocating and monitoring use of state funds; can also play important policy role in facilitating HIT implementation
  - State should establish mechanism for stakeholder collaboration
    - convene planning committee to spell out functions, governance, etc

# Vision for the Minnesota e-Health Initiative



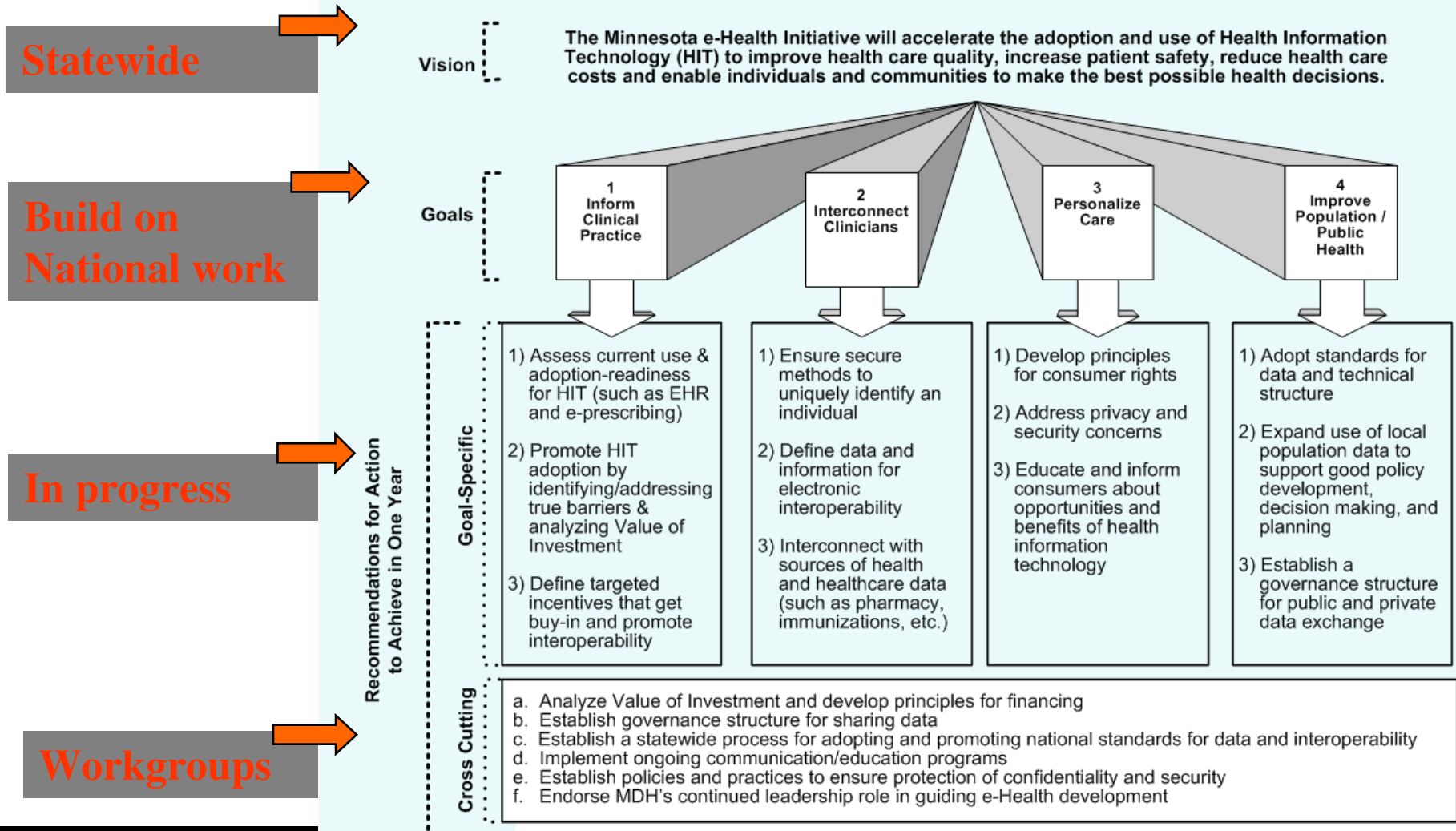
***"... accelerate the adoption and use of Health Information Technology to improve healthcare quality, increase patient safety, reduce healthcare costs and enable individuals and communities to make the best possible health decisions."***

*Source: Committee Report to the Legislature, January 2005*

# Minnesota e-Health Initiative Roadmap for Strategic Action



Source: Committee Report to the Legislature, January 2005



# Minnesota e-Health Steering Committee Progress – Proposed Actions: 2004-2006



## Progress To date

- Delivered report to Legislature (vision, roadmap, recommendations)
- Developed principles for MN Health information exchange (MH-HIE) (Goal 2: Interconnect)
- Collaborated on response to NHIN-RFI
- Identified priorities for MN-HIE
- Held statewide summit

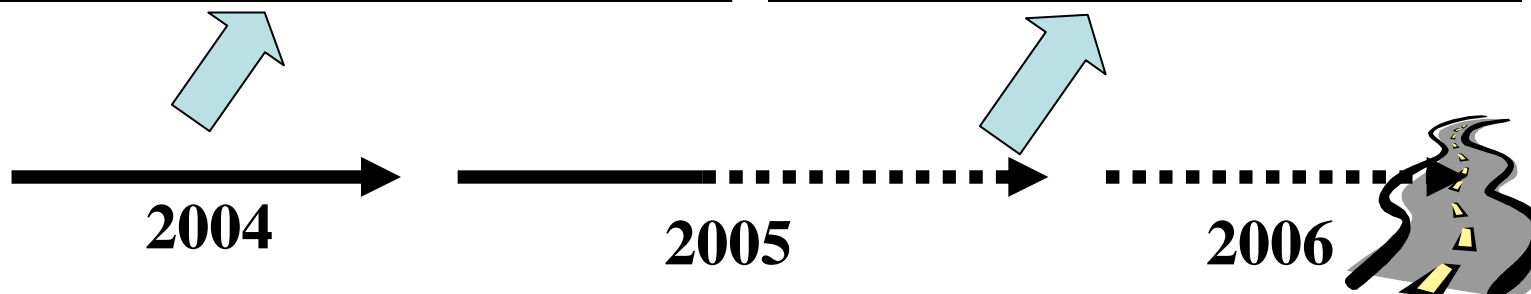
## Next Action Steps

### **MN Health Information Exchange**

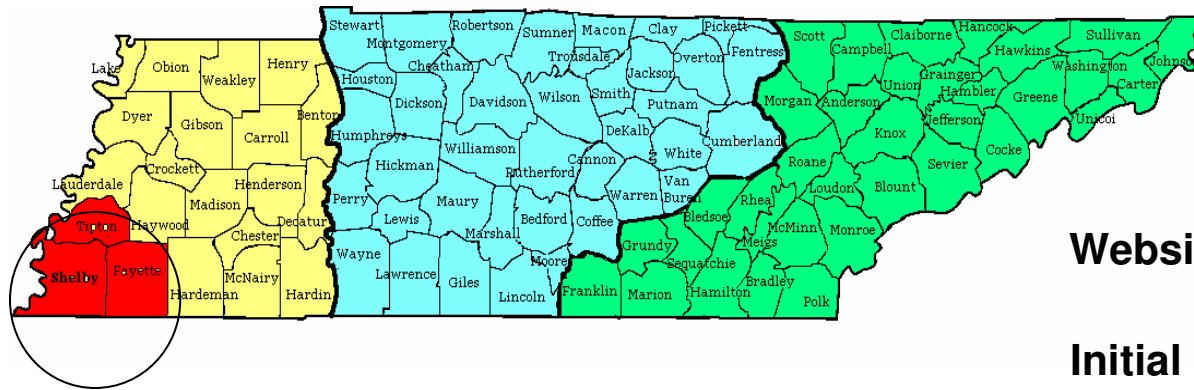
- Seek further input/commitment
- Establish Board
- Business planning for exchange: e.g. Laboratory, Pharmacy, Disease Surveillance, Immunization Information

### **Advisory Committee**

- Assure broad HIT assessment
- Advance the roadmap: Goal 1: Goal 3: and Goal 4:



# Summary of Project - Tennessee



Website: [www.Volunteer-eHealth.org](http://www.Volunteer-eHealth.org)

## Initial Participating Organizations

- Baptist Memorial Health Care Corporation – 3 facilities
- Methodist - Le Bonheur Children's Hospital
- Methodist University Hospital
- The Regional Medical Center (The MED)
- Saint Francis Hospital & St. Francis Bartlett
- St. Jude Children's Research Hospital
- Shelby County/Health Loop Clinics (11 primary care clinics)
- UT Medical Group (200+ clinicians)
- Memphis Managed Care-TLC (MCO)

## Funding Sources

September 21, 2004, Tennessee received a 5 year contract/grant from Agency for Healthcare Research and Quality (AHRQ) - total award is \$4.8 million

State of Tennessee provided additional funds in the amount of \$7.2 million for the same 5 year period

MidSouth eHealth Alliance will receive additional funding from the state to fund operations (e.g. Executive Director and local support staff)

# Summary of Project - Tennessee



- Process Overview
  - Planned from August 2004 – January 2005
  - Created an infrastructure to support a planning process and the AHRQ project
    - CEO/local leadership team
    - Work Groups: Clinical, Financial, Technical, and Privacy/Security
    - Work Groups met a minimum of once a month in this phase
    - Governor's office was involved in all steps of the planning phase
  - January 2005 community "claimed" ownership, formed a board, kept the work groups, adopted a name (MidSouth eHealth Alliance, etc. Board celebrated one year anniversary this month and elected a new set of officers
  - Work groups meet regularly about every other month face to face and more often if needed or by conference calls in between face to face meetings
- Vanderbilt "donated" the use of its technology for the project and serves the functions of Project Management Office (PMO) and Health Information Service Provider (HISP). Vanderbilt is also charged by the state to comply with the conditions of the AHRQ contract and to support other HIT activities across the state at a planning level
- Current State of the Project
  - Board celebrated one year anniversary in February
    - Formally incorporated in August 2005
    - Submitted application for 501 c3 status in January
  - On October 1, 2005 demonstrated the ability to exchange 25% of the core data elements in compliance with the AHRQ contract
  - Have 9 production data feeds and 3 test data feeds
    - Data is housed at Vanderbilt and pushed via VPN connection. Most is real time 3 feeds are batched every 24 hours
  - Working through a Regional Data Exchange agreement
  - Defining and developing policy and procedure primarily focused on Privacy and Security issues but also some operational
  - Working towards initial use in one test Emergency Department for May 2006
    - Will bring on 4 additional Emergency Departments over the summer of 2006
    - Will bring on the remaining Emergency Departments (8) through the end of 2006 and first quarter 2007

# Question 1 - Value Proposition



<b>Minnesota</b>	<b>New York</b>	<b>Tennessee</b>
<ul style="list-style-type: none"> <li>• Empower citizens as health care consumers</li> <li>• Ensure all relevant medical information on an individual is securely available to their current physician or to an emergency room</li> <li>• Reduce costly inefficiencies within and across health care settings</li> <li>• Use health care and public health data to better protect communities against health risks or threats.</li> <li>• Improve the safety and quality of health care</li> </ul>	<ul style="list-style-type: none"> <li>• CITL article in Health Affairs (January 2005) describes national model</li> <li>• UHF grant to CITL for NYS analysis</li> <li>• Net benefit for NYS = \$12 billion over 10 years, \$4 billion per year with fully standardized interoperability</li> <li>• Facilitate performance measurement</li> <li>• Improve prevention and chronic care management</li> </ul>	<ul style="list-style-type: none"> <li>• Need to understand the "big picture"                             <ul style="list-style-type: none"> <li>– There will be losers and winners initially – someone's repeat test is someone else's lost revenue</li> <li>– Balanced Scorecard approach works well to better understand the value</li> </ul> </li> <li>• SW Tennessee focused on Emergency Departments to begin to define the value proposition                             <ul style="list-style-type: none"> <li>– Focused on repeat tests, reduction in Observation days and ED efficiencies with estimated savings of \$24.2 million with a potential of \$48.1 million over a five year period of time</li> <li>– Estimated cost per facility per year to participate \$30,000 in "sweat equity"</li> </ul> </li> </ul>

# Question 2 – Securing “Buy-In”



<b>Minnesota</b>	<b>New York</b>	<b>Tennessee</b>
<ul style="list-style-type: none"> <li>• Be inclusive of private and public healthcare and public health settings, including LTC</li> <li>• Build on a “culture of collaboration”</li> <li>• Create broad statewide vision</li> <li>• Focus action on visible steps</li> <li>• Guide by broad public – private advisory Committee</li> <li>• Use a neutral convening body</li> </ul>	<ul style="list-style-type: none"> <li>• In 2005, DOH asks UHF to prepare report with recommendations</li> <li>• Qual-IT newsletter provides topical updates and analysis</li> <li>• State HIT working group focused on communication and policy coordination</li> <li>• UHF and eHI now developing web-based resource center and information sharing tools</li> <li>• Smaller regional efforts viewed as more feasible, easier to identify and engage the relevant stakeholders</li> <li>• Every community should have basic infrastructure for data exchange</li> <li>• Stakeholder group could establish a new policy governance model</li> </ul>	<ul style="list-style-type: none"> <li>• It helps to have a “heavy hitter” convene the stakeholders (in Tennessee it was the Governor)</li> <li>• Build in the time for dialogue so that true consensus can be achieved. We continue to remain inclusive – we want to hear everyone’s voice.</li> <li>• Convene on neutral territory until people begin “getting along”</li> <li>• In Memphis, local “ownership” was important and going through the work to file for incorporation and not-for-profit status was important.</li> <li>• Healthcare is local and projects will be driven locally – that needs to be a core principle; however, the state has a role in convening and setting the guiding principles for all players across the state.</li> </ul>

# Question 3 – Barriers and Challenges



<b>Minnesota</b>	<b>New York</b>	<b>Tennessee</b>
<ul style="list-style-type: none"> <li>• Data (e-mail) overload / knowledge deficit</li> <li>• Assuring rural / underserved needs are met</li> <li>• Addressing population health issues</li> <li>• Use opportunities for federal/private funding</li> <li>• Model for sustainable funding for projects</li> <li>• Utilizing expertise state wide</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing Communication and Collaboration</li> <li>• Priorities for HIT Implementation</li> <li>• Costs, Benefits and the HIT Value Proposition</li> <li>• The state should have one voice, we need a blueprint to move forward together</li> <li>• Laissez-faire approach will take too long</li> </ul>	<ul style="list-style-type: none"> <li>• The players in Memphis have a long standing tradition of not getting along or playing well together.</li> <li>• “Who are you (Vanderbilt) to tell us what to do?”</li> <li>• The technology is hard but the policies and procedures especially around security and privacy are even harder.</li> <li>• Funding for operations and legal expenses</li> <li>• Coordinating with other HIT initiatives around the state</li> </ul>

# Question 4 – Key Lessons Learned



<b>Minnesota</b>	<b>New York</b>	<b>Tennessee</b>
<ul style="list-style-type: none"> <li>• Be consumer-focused</li> <li>• Establish communities of practice</li> <li>• Use endorsing Legislation</li> <li>• Gov/t role: neutral convening body, facilitation, assist in measurement, assessment and communications</li> <li>• You don't need "all" the answers today</li> <li>• Leading from the "backseat" is OK</li> <li>• Plan Broadly, Implement Incrementally</li> <li>• Include Public Health from the beginning</li> </ul>	<ul style="list-style-type: none"> <li>• Multi-year plan for broad statewide adoption</li> <li>• Technical and operational coordination across disparate regional initiatives through standards and data exchange</li> <li>• Strategic coordination across the full spectrum of health care interests – hospitals, payers, physicians, consumers</li> <li>• Medicaid should provide leadership and foster policy alignment to promote HIT adoption and use</li> </ul>	<ul style="list-style-type: none"> <li>• Be willing to start small and grow big</li> <li>• Start where the energy is</li> <li>• Vendor management strategy</li> <li>• Collaboration and trust are not built overnight- achieved when the parties are willing to work together and take ownership in the process                             <ul style="list-style-type: none"> <li>– Don't discount the naysayer – listen</li> <li>– Don't short cut the process by eliminating the planning but be willing to jump into implementation too</li> <li>– It is very easy to talk about what the technology can and should do but actually making it work is a different story</li> </ul> </li> <li>• Do not underestimate the security, privacy and legal issues!                             <ul style="list-style-type: none"> <li>– Budget for legal fees</li> </ul> </li> <li>• There may not be an answer to the question</li> </ul>