

**Ohio Health Information Technology Project Plan to  
Develop a Strategic Plan and Recommendations to  
Promote the Effective Adoption of HIT and HIE in Ohio  
January 19, 2006**

“What is beyond dispute is that this disaggregated information regime is an important reason the American health care system ranks a mere 37th in the world in quality and a sobering 48th in life expectancy.”

— Technology CEO Council Report, October 2005

The past two years have witnessed an increased attention and drive to promote more effective use of health information technology and the exchange of health information among providers. This drive has resulted in an increasing number of states engaging in statewide planning and implementation efforts to achieve this end. The Health Policy Institute of Ohio has worked to foster such an effort in Ohio and will convene a meeting around 60 senior level leaders from the employer, health plan, provider, government, technology, and consumer advocacy communities on February 24, 2006 to launch the Health Information Community of Ohio advisory group.

HICO will oversee the development of a strategic plan and recommendations to enhance the effective adoption of health information technology and health information exchange in Ohio. This position paper presents a proposed project rationale and plan to give form and structure for the dialogue at this event.

**BACKGROUND**

In October 2005, the Technology CEO Council issued a report calling for leadership to promote the effective adoption of health information technology in the U.S.<sup>1</sup> The Council argues that the US health care system suffers from an inadequate health information system which contributes to:

- Up to 98,000 hospital patient deaths from avoidable medical errors each year
- An estimated \$300 billion of wasteful spending on unneeded and redundant medical tests, with another \$150 billion lost to administrative waste
- Patients receiving recommended care only 54 percent of the time, according to a 2004 Rand study

The Council report cites a September 2005 Rand study that estimated savings of \$165 billion per year with adoption of a true national health information network by shortening hospital stays, encouraging appropriate tests and early treatment, and cutting administrative costs.

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<sup>1</sup> The Technology CEO Council is the information technology industry’s public policy advocacy organization comprised of chief executive officers from America’s leading information technology companies, founded in 1989. Its members are the CEOs from Intel, Hewlett-Packard, Unisys Corporation, NCR Corporation, IBM Corporation, Dell Inc, Applied Materials, Inc, EMC Corporation, and Motorola, Inc.

The CEO Technology Council calls for the adoption of a seven-point program to pursue pragmatic steps to address the problems caused, in part, by an inadequate health information system. These seven points are:

1. Employers must raise the bar for quality, efficiency, and safety by adopting principles that drive better health outcomes. Access to personal health information is an important component of such efforts.
2. Providers, payers, and regulators must adopt interoperable technology and common data standards.
3. The federal government must serve as an exemplar and change agent.
4. States must catalyze local change and establish the building blocks of a national system, convening dialogues to consider ways to improve health care through better information management including legislation that:
  - Medicare and Medicaid programs must drive quality medicine.
  - Public and private stakeholders must ensure patient privacy and data security.
  - Policy makers must provide adequate funding for health care IT leadership and change.

The Bush Administration had already initiated an effort to promote effective adoption of health information technology and exchange. On April 10, 2004 President Bush signed an Executive Order creating a commitment to hastening the adoption of HIT in the U.S. That Order established The Office of the National Coordinator for Health Information Technology, in the Department of Health and Human Services, headed by Dr. David Brailer. Dr. Brailer unveiled the administrations strategic HIT vision in July 2004.

Dr. Brailer and his staff are pursuing six distinct efforts to serve as the catalyst to facilitate this end. The efforts are:

1. A contract to push the 130 standards organizations in the U.S. to come up with a set of common, interoperable standards. This effort is akin to the creation of a standard gauge for railroads in the 19th century, a necessary development to foster effective economic development.
2. A contract to a certification body to create standards and a process for the certification of electronic health records in the ambulatory setting
3. A contract to try and harmonize privacy and security laws across all states
4. A contract to Harvard and George Washington Universities to look at adoption of HIT, searching for best practices
5. Four contracts with consortiums to launch small demonstration projects on how to promote effective health information exchange. These four consortiums will test different architectural frameworks for HIE, helping to identify best practices to incorporate in a national health information network

6. Work with the Centers for Medicaid and Medicare Services (CMS) to develop a exemption to the Stark anti-kickback rules to allow for hospitals to help finance the adoption of HIT in their offices. This exemption would apply only to the adoption of certified HIT systems which are interoperable.

At the same time, the Secretary of HHS created an advisory group to help foster the effective adoption of HIT/HIE in both government and the private sector. This advisory group, the American Health Information Community (AHIC, also known as “The Community”) consists of nine high level representatives from government and eight high level representatives from the private sector. The purpose of this group is to identify breakthrough opportunities that hasten the adoption of HIT/HIE in the next one to two years. This group held its second meeting on November 30, 2005 and identified four areas on which to focus attention:

- Biosurveillance
- Consumer empowerment
- Health care quality management and reporting
- ePrescribing

### **STATE LEVEL ACTIVITIES**

State government plays several major roles in health care. These roles includes purchaser and administrator of health plans for Medicaid, state employees, and state retirees; regulator of insurance plans and providers; protector of public health through disease surveillance and prevention activities; and standard setter or enforcer. State government also often provides access to capital financing for infrastructure projects and for hospitals and other facilities to purchase and implement technology. States will increasingly find themselves involved with facilitating the exchange of data within and between local entities with the emergence of regional health information organizations.

The Technology CEO Council report identifies an important role that states play in enhancing the effective adoption of HIT and HIE. This report includes draft model legislation for states. Elements of that model legislation include:

- basing Medicaid reimbursement on value, with additional incentives for IT adoption;
- encouraging formation of regional health initiatives through loans, grants, and/or regional tax-exempt bonding authority;
- removing legal and regulatory impediments;
- making better use of health care data collected by state public health agencies; and
- enabling telemedicine through licensing reforms and Medicaid reimbursement.

An increasing number of states are seeking to develop state-level, multi-stakeholder, coordinated responses to foster adoption of health information technology and health information exchange.

Examples of these efforts include:

- Utah Health Information Network (UHIN), a non-profit organization that brought together providers and health plans in the early 1990s to promote more cost effective, standardized exchange of administrative data. UHIN has become a standard setting organization. It received one of the initial five statewide AHRQ HIT implementation grants in 2004 and is increasingly focusing attention on how to promote the exchange of clinical information.

- CalRHIO, founded and managed by Health Tech, a non-profit technology research organization with seed funding from the California Health Care Foundation. CalRHIO will promote policies, technology applications, and financial and business models designed to promote secure health data exchange
- The New York State Health Information Technology Policy Summit, sponsored by the United Hospital Fund, to engage key state level stakeholders in developing strategies and tools to advance broader adoption and use of HIT. In 2005, Governor Pataki allocated \$55 million of state funds to finance local health exchange demonstration projects, modeling New York's RFP on what the federal government has issued to ensure that the projects are compatible.
- Massachusetts eHealth Collaborative, with \$50 million in initial funding support from Blue Cross Blue Shield of Massachusetts to support broad adoptions of electronic medical records and interoperability across three demonstration projects.
- Arizona Health-e Connection, a 39 member board creation by State Executive Order, to develop a plan to build Arizona's HIT infrastructure over a six month period.
- Kentucky e-Health Network Board and Kentucky Health Care Infrastructure Authority, created by state legislation to provide leadership in the redesign of Kentucky's health care delivery system using HIT and to develop the Kentucky eHealth Network.
- Minnesota eHealth Initiative, a public-private collaboration established by legislation in 2004 designed to "... 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." By late 2005 the Steering Committee has:
  - delivered a report to Legislature (vision, roadmap, recommendations);
  - developed principles for MN Health information exchange (MH-HIE); collaborated on response to NHIN-RFI;
  - identified priorities for MN-HIE; and held statewide summit.
- Indiana Health Information Exchange, a new statewide organization formed through the collaboration of several organizations to extend and add to the HIT applications already developed by the Regenstrief Institute, starting with a common approach to clinical messaging.

## **OHIO-BASED ACTIVITIES**

Ohio has experienced several efforts to promote better adoption of HIT within large health care institutions, usually hospital systems and some physician practices. These efforts are creating the necessary capacity to make these providers operable in the latest world of HIT.

Ohio also several projects seeking to promote HIE at a community level. They are striving to create a capacity for interoperable exchange of information between different health care institutions and provider practices. In the last half of 2005, Ohio has experienced a growing intensity to create regional health information organizations in several areas of the state.

Prior to the efforts begun by HPIO, Ohio lacked a statewide effort to create dialogue around the effective adoption of eHealth, especially a dialogue that brings government, private payers, business, health providers, and consumers together. HPIO found a world where Ohio's HIT and HIE initiatives developed independently of each other, with limited, if any, support and learning from each other. People working on these projects focused on the tasks of their individual activities, failing to identify common strategic needs and pursuing public and private sector policy options that could enhance the success of the projects.

HPIO, which came into existence in 2004, quickly appreciated the need for such an effort. In April 2004, HPIO received encouragement from within the employer community to submit a response to RFP for the first round of statewide HIE implementation federal contracts. HPIO attempted to develop a response, but learned that Ohio lacked certain core requirements for a winning proposal, such as an established multi-stakeholder group working on this issue and the ability of state government to authorize immediately submission of a proposal.

This initial work convinced HPIO of the importance of this area of work. The July 2004 national eHealth summit where Dr. Brailer unveiled the Bush Administration's plan for a national health information network reinforced HPIO's commitment to creating an Ohio eHealth community. It also revealed that Ohio had a large number of people with similar interest, many working on individual projects, but who did not know of the work of each other.

In October 2004, HPIO co-sponsored Ohio's first eHealth summit. This summit focused on individual's making short presentations on their respective eHealth projects. The event launched the beginnings of a statewide eHealth community. It also identified a common awareness among the participants on the need for more, directed work to assist in the development and implementation of HIT and HIE in Ohio.

Emerging from this summit, HPIO converted the group of people who helped plan the summit into a steering committee to explore how to build on the results of this summit. The group decided to develop a white paper on the status of eHealth in Ohio, seeking to better identify the range of eHealth projects taking place within Ohio and to understand perceived barriers and challenges to effective adoption of eHealth. HPIO contracted with the eHealth Initiative to develop this report and hosted Ohio's second summit on eHealth in October 2005.

The white paper and summit identified many economic and policy issues that affect the adoption of eHealth in Ohio, most which exist across the country. The economic issues identified included:

- Competition amongst industry stakeholders within same geographic regions preventing proactive collaboration
- Geographically diverse and fragmented, rural communities, who often experience higher costs to connect electronically with others

- Limited funding by payers to support for providers in covering the costs of moving to electronic health records
- Disagreement on who should bear the costs for implementing HIT in provider offices, especially in small practices
- Provider concern regarding what HIT investment makes economic sense and would have lasting value
- High initial acquisition and implementation costs;
- Slow and uncertain financial payoffs for health care providers;
- Disruptive effects on physician practices during implementation; and
- Payment systems that result in most HIT-enabled savings going to insurers, patients, and government payers like Medicare, while most adoption and care improvement costs are borne by providers.

Policy issues identified as potential limitations to the adoption of HIT or HIE included:

- Lack of national standards
- Fear that systems people would adopt will become obsolete in a short period of time
- Insufficient statewide electronic connectivity infrastructure
- Legal issues in several areas, such as
  - Confidentiality and Security
  - Electronic prescriptions
  - Record retention
  - Electronic signature
  - Telemedicine
  - Antitrust
  - Fraud and abuse
  - Malpractice Considerations

The participants in the summit, and those interviewed for the white paper, strongly supported the need for an a follow-up conference of a select group of senior level people representing different critical stakeholder groups, specifically providers, health plans, government, employers, and consumers. They favored that this meeting be convened by a neutral, nongovernmental entity to:

- Address issues that are common to all local and regional HIT and HIE initiatives
- Pursue the creation of ongoing statewide entity to promote HIT and HIE
- Develop a strategic plan and recommendations to promote the effective adoption of HIT/HIE

Accepting the recommendations from the October 2005 summit, the OHHIT steering committee agreed that HPIO should convene such an invitation only meeting in early 2006 and that HPIO should develop a project plan to present at this meeting for how to develop an Ohio eHealth roadmap and move implementation of that roadmap forward.

## **OHIO HEALTH INFORMATION TECHNOLOGY (OHHIT) PROJECT PLAN FOR 2006**

The project plan for 2006 begins with HPIO convening the Health Information Community of Ohio (HICO) advisory body. The HICO advisory body will provide refinement and affirmation

to the proposed project plan to develop a strategic plan and recommendations on how to effectively enhance the adoption of health information technology and health information exchange in Ohio, to advise on project opportunities that warrant immediate attention to pursue on a state-wide basis, such as the Health Information Security and Privacy (HISPC) contract opportunity for up to 40 states, and to give overall direction and feedback on the work from the working groups associated with this project.

A subset of HICO members will serve as steering committee members who will meet regularly to direct the project. The remaining HICO members will get together quarterly to review and discuss the work of the project.

HICO's membership will include senior level representation from employers, health providers, health plans, government, and consumers. The involvement of senior level representatives from these different sectors enhances the ability to generate the necessary commitment of time, energy, and resources to the project work. Provider representatives include participation from a wide range of providers including, at a minimum, large and small physician practices, large and small hospitals, long term care facilities, pharmacies, laboratories, and nurses.

### **Rationale for the OHHIT project**

- There is a clear, inevitable movement to universal adoption of health information technology and health information exchange in this country
- Multiple national reports include a call to action for states to focus attention on HIT and HIE.
- Ohio lags behind many other states in developing a coordinated, statewide response to federal efforts to create the national health information network
- Ohio needs to position itself better to successfully respond to federal funding opportunities around the adoption of HIT and HIE and then coordinate or manage such projects, such as the Health Information Privacy and Security Contract
- Ohio should elevate its position as a state leader in HIT and HIE at the provider, health information company, purchaser of health benefits and government arenas
- Lack of effective adoption of HIT and HIE contributes to the inefficient and ineffective delivery of health services, less than optimal health outcomes, and higher than needed administrative expenses for financing and delivery health services
- Ohioans whose health care services, privacy and security of information, or work conditions and those Ohio organizations that deliver care, pay for the delivery of care, purchase health care benefits, or regulate the delivery of care should be involved in developing Ohio's response to the inevitable movement to greater adoption of health information technology and health information exchange
- Improved use of HIT and HIE across all systems of health care is a critical component needed to alleviate cost pressures on Ohio's Medicaid program and for other public and private purchasers of health benefits, including the public retirement systems

### **Project Vision**

To simplify the administration of health care and promote high quality, cost effective, consumer-centered care by enhancing the effective adoption of Health Information Technology and secure, reliable Health Information Exchange in Ohio.

## Structure of the Project

The Health Policy Institute of Ohio (HPIO) will serve as the neutral convener of the OHHIT project. This project will focus its attention on two primary activities in the coming year:

- 1) Develop a strategic vision, plan, and recommendations on how to enhance the effective adoption of HIT and HIE in Ohio by October 2006.
- 2) Manage the activities required under the Health Information Privacy and Security Contract (see attachment that describes this activity)

The structure of the OHHIT project will employ the following groups, many of which coincide with groups required for the Health Information Privacy and Security contract, though these groups will focus on some tasks that go beyond those required for the HISPC activity:

- **Health Information Community of Ohio Advisory Group** – A group of around 60 individuals consisting of representatives of the multiple groups with an interest in the delivery of cost effective, high quality care, including consumers, government, health plans, providers, and employers. The Advisory Group will meet quarterly and provide general oversight, direction, and reaction to the work undertaken in the OHHIT project.
- **Stakeholder groups** – groups of individuals defined by their relationship to health information (public and private payers, consumers, physicians, hospitals, long-term care facilities, dentists, mental health care providers, etc.). The hope is to have representatives within each group come together to form advisory groups for that respective stakeholder community, such as physicians or consumers.
- **Steering Committee (SC)** – a group of no more than 20 individuals representing different groups within the stakeholder community who provide direct leadership for the project. For the HISPC activity, it must include a representative from each major stakeholder group, 1 or 2 members of the legal working group, 1 or 2 representatives from state government (including an individual directly representing the governor), and the state subcontractor. The Governor or his appointed authority must make all appointments to the Steering Committee to be in compliance with the HISPC activity.
- **State Variations Working Group (VWG)**
  - assesses variations in organization-level business policies and practices, categorizing them as barriers, best practices, or neutral with respect to interoperability.
  - identifies other barriers to adoption of health information technology and exchange
- **State Legal Working Group (LWG)**
  - assesses applicable privacy and security policies underlying regulations, court cases, etc. and identifies legal sources of barriers to interoperable electronic health records.
  - reviews barriers identified by in the business policy assessment work, mapping those barriers to applicable state privacy and security laws. assesses legal issues related to other adoption barriers to HIT and HIE

- develops a set of recommended policies that are consistent with laws of Ohio
- works with the Solutions and Implementation Plan Working Groups.
- **State Solutions Working Group (SWG)**
  - reviews barriers identified in the assessment of variation of state laws and business policies and formulate preliminary solutions to the barriers. Drafts report for deliverable number 3 in the HISPC activity.
  - reviews other barriers identified and formulates recommendations on how to address these barriers
  - is responsible for advising on the development of standards, new technical options, and strategies to promote HIE.
- **State Implementation Plan Working Group (IPWG)**
  - explores governance issues related to creation of an ongoing state level organization
  - assesses sustainable financing options for any ongoing statewide organization
  - reviews the interim analysis of solutions (Deliverable #3) and proposes preliminary implementation plans (Deliverable #4) for the HISPC activity
  - reviews analysis of solutions to other barriers and proposes preliminary implementation plans
- **Clinical and Administrative** – Responsible for determining clinical and administrative priorities and strategies for effective use of HIT. Also, provides clinical or administrative direction on existing projects.
- **Ad Hoc Working Groups (AWG)** – subgroups which require input from multiple stakeholder groups and are formed to conduct work needed by other working groups. These groups may meet only once or twice to handle their work tasks. Potential ad hoc group will form around specific issues to develop the current status of these efforts in Ohio, the preferable status for such efforts, the barriers and opportunities around such an issues, and recommended options to effectively pursue the use of health information technology and exchange in these areas:
  - E-prescribing
  - Cost effective administrative data exchange, especially billing and eligibility data
  - Public health surveillance
  - Continuity of care record
  - Long term care and post acute care services
  - Personal health record
  - Medicaid

In the process of creating an OHIO HIT/HIE strategic plan and recommendation HICO and its workgroups will engage in the following work between February and October 2006:

- Review, discuss and validate findings and feedback received from Ohio stakeholders regarding the opportunities and barriers related to the use of HIT.
- Identify public and private policies that could enhance the effective adoption of eHealth.

- Determine what type of state level ongoing organizational activity is needed to continue to focus needed attention on HIT/HIE.
- Promote effective coordination between local regional health efforts and the state level efforts.
- Identify options for financing HIT/HIE efforts
- Identify ways to integrate HIT/HIE activities with Third Frontier efforts.
- Develop principles for Ohio Health information exchange (OH-HIE)
- Collaborate on responses to federal grant opportunities;
- Identify priorities for OH-HIE, developing ad hoc groups to explore promising options. Possible priorities could include clinical messaging, cost-effective exchange of administrative data; post acute care/long term care; e-prescribing
- Affirm value propositions for the adoption of HIT/HIE in different settings and for different stakeholders

### **Proposed Project Timeline for Development of the Strategic Plan and Recommendations**

<b>Item</b>	<b>Date</b>
First meeting of the Health Information Community of Ohio	February 24 2006
Finalize external financing support for the OHHIT project	March
Finalize membership for all workgroups	March
Kick off meeting for all workgroups	March 27
Workgroup meetings	April/May
Second meeting of HICO	May 19
Workgroup revisions based on HICO meeting	May/June
Statewide summit to release interim strategic plan report	July 10
Workgroup revisions based on statewide summit	July/August
Third HICO meeting	September 8
Finish Strategic Plan and Recommendations	September 25
Second statewide summit	October 6

### **Required Project Timeline for HISPC work:**

<b>Item</b>	<b>Date</b>
Proposal Due	March 1, 2006
Subcontracts signed by selected states	April 28, 2006
Kick Off Meetings	April 28 - May 15, 2006
Deliverable 1: Work Plan Due	May 26, 2006
Training Sessions	June 2006
Deliverable 2: Interim Assessment of Variation Report due	August 25, 2006
Deliverable 3: Interim Analysis of Solutions Report due	October 16, 2006
Deliverable 4: Interim Implementation Plan Report Due	November 16, 2006
State and Regional Workshops	October 20 – November 22
National Meeting	February 2007
Deliverable 5: Final Assessment and Analysis Report due	February 15, 2007
Deliverable 6: Final State Implementation Plan Report due	February 15, 2007

## **Project Requirements**

- External funding of between \$500,000 and \$600,000 to handle all project functions, including the hiring of three full time staff (either on contract or as employees of HPIO) to coordinate the day-to-day work. HPIO does not have the funds to run this project without external financial support. The HISPC project will provide between \$150,000 and \$350,000 to this work. Ohio's application for the HISPC RFP is asking for the full \$350,000 contract award.
- Buy-in and commitment from stakeholder groups to actively have representatives participating in the various working groups and within their own stakeholder community
- A committed and engaged Steering Committee and Health Information Community of Ohio Advisory Group
- Effective project management by HPIO

## **Conclusion**

Plans are underway at the federal level to promote a national health information system. This system will require state level financial and operational support. It will also require careful assessment of state level barriers to implementation and identification of policy options to enhance effective implementation. Ohio must act now and assume a leadership role in this important transformation of health care. Prompt action will enhance Ohio's ability to access national funding support and ensure that any newly-developed system meets the needs of Ohio's government, providers, employers, and citizens. This project proposal offers a vision and approach for Ohio to create an Ohio action plan around this opportunity.