Health Information Technology Oversight Council

December 9, 2009

Stakeholder Conversation Brief

Multiple conversations were held during November and December regarding key questions related to the HITOC Strategic and Operational planning effort and the development of a statewide solution. Stakeholders included representatives from Legacy Health System, Oregon Association of Hospitals and Health Systems, Samaritan Health System, Providence Health System and Providence Health Plans, Umpqua One Chart, OHSU, CareOregon, Kaiser Permanente, Northwest Health Foundation, Oregon Business Council, Quality Corporation, Oregon Coalition of Health Care Purchasers, Mid-Columbia Medical Center and Greenfield Health.

The summary responses and themes fall under key themes including proposed governance models, potential incentives, overarching concerns, quality, prioritization and implementation.

The following ideas are taken from the conversations, some editing was done for readability only; every effort was made to maintain intended meaning.

General Comments:

Governance

The Network of Networks is a good model, but the federated model is also a good option. In the federated model, a statewide IT unit is primarily responsible for architecture, common infrastructure and services, and standards decisions, while each agency IT department has primary responsibility for application resource decisions. Agency IT managers report into the agency director as well as the central IT organization

Prefers the public utility model as it draws on the resources from a variety of entities. Sees too many limits in the private model as it does not vest enough shared-responsibility/trust into the public sector.

Governance is likely to be dictated by funding—it is almost impossible to separate the two.

The hierarchical picture suggests that a lot of state monies will be filtering down. None of local HIEs are non-profits. They have been created because a local business entity found them necessary. Is there a business model, something funded by local entities where you buy a seat at the table and use the government to buy a seat at the table for consumers, etc.? With financial buy-in people will have a real stake in the success of HIE endeavors.

Current proposed structure looks like a giant layer of bureaucracy.

Local HIEs: Portland HIE, Providence (statewide single HIE) wants to contribute and consume from other HIEs.

A central repository brings about many more issues rather than serving as a record locator or federation assistance.

Anyone from Portland should have access to the RIOS in Portland.

If re-drew, half was the regional HIE, other half was the aggregate of the public side. Most of the money will need to come from the local HIEs. Health plan will not fund all of the HIEs, but maybe do something in the middle.

The HIE needs to be statewide and have a greater value than local or regional market share.

A federated model may have advantages working across state boundaries, which will be important in the Metro region and Eastern Oregon.

Incentives

The Medicaid/Medicare payments are incentives that will encourage utilization efforts.

Potential incentives for provider adoption and utilization of these tools included paying physicians a transaction fee, involving physicians more in discussions and garnering information around what it would take for physicians to use HIT/EHR on a daily basis.

Ultimately the system needs to develop the capacity to not only give physicians a reason to use HIT, but also a reason to depend on it. Linking the capacities such as the medical home, laboratory, radiology, etc. and establishing links between the various capacities.

From a patient's perspective, if they develop the expectation that when using their record their physician will have input information/data from their last and/or all previous visits, this will incentivize providers to use EHR.

Recommendations for significantly engaging the business community included emphasizing the fact that health care is one of the principal uncontrollable costs to businesses right now (e.g. the cost of health coverage for employees, loss of productivity when employees are sick, etc.) Further, the Exchange and the public option were also identified as significant issues that will capture the attention of the business community. Finally, additional work to determine the value propositions for business community needs to take place.

The Umpqua OneChart system is IPA funded and providers have an incentive to participate, which has been a major factor in their success and the degree to which HIE has penetrated within their system.

Concerns/Input

Concerned about the business model/financial stability of a proposed plan.

A statewide solution for a state like ours is a no brainer.

Even when people have access to those databases and use them in their daily operations, their use is poor. A physician for example is not likely to look back at the complete record of their patient to ensure that there is nothing they aren't aware of. Usability may be good, but the actual usership is poor.

Compared to the RIOS experience of 2004/2005: This time there's money from the feds, technology has developed, privacy and security concerns still remain.

Don't forget rural Oregon.

Unless we really start to train providers to perform lookups as they walk into a room, the system will perpetually be underused.

To get adoption we must envision a world where providers are attracted to use telemedicine.

Does not believe that clinical prompts would actually change behavior.

HIPAA Issues: If the system doesn't know that a physician is a doctor for that patient, the system should indicate that a user is engaging in unauthorized use.

How will utilization of HIT will impact malpractice issues?

Non-health care workers have minimal faith as to the capabilities of the technology and its appropriateness in application.

Other areas similar to ours also have their doubts regarding the potential success of this entire HIE endeavor.

The business case for this is critical.

Concerned that the constant exchange of the vast amounts of data could give rise to additional problems. Other entities with a lot of community data would feel the same way. A solution to this concern would be a central data repository such as the NY model, to access data one time, or access and save the data. Building a standard interface to support information that is relevant to providers that can be easily identified, flagged and/or downloaded at the time of need. The more streamlined accessing the types of information providers want to use will promote the use of data acquired via HIE, as opposed to inhibiting the utilization of such data.

Providers will not be inclined to click onto a separate link to access data for each of the respective entities/health systems participating in the HIE.

Keep the existing support systems in place.

Reluctant to have state or any other entity act as a single repository holding all of the patients' data, maybe the repository would contain patient information that the entities actually share. Happier with a model to share information as opposed to storing all data within a single repository. Noted that some entities have lost patient data before.

How do you develop a financing model that meets these types of responsibilities?

Suggestions regarding other models and approaches?
The issue of regional exchange vs. state exchange—what will be enough? Is regional exchange or entity to entity exchange sufficient? It does not seem so in the grant.

Leverage the benefit of identity management through claims, etc. Most entities utilizing HIT have their own sort of identity management system and there should be a way to connect to a master identity system.

Need to ask ourselves:

- What do we want to build?
- What are our technology options?
- How are we going to pay for it?
- How do we want to govern it?
- What are the legal and privacy issues, etc.

From a funding perspective it makes sense to pay a licensure fee and an HIE fee. One fee for doctors ($100), PA/NP ($50) and one for nurses ($25). Maybe the health systems pick up the cost for an HIE licensure fee.

Does not support transaction fees, but rather a uniform fee.

HIE patient identification functions: MPI vs. an algorithmic federated patient identification model. In terms of a patient identifier, the federated model seems to have more appeal to providers and patients. Most importantly, whatever we do it must be coordinated and in sync. There may be a phase-in period, but we don't want to add additional administrative expenses

Link into one single-repository that would serve as a greater common good to the state.

Due to the immense level of interfacing capability development amongst IT products (in the past two years), it may be possible for a product's portal that is open for business exchange to automatically begin exchanging with other products in the hub. Envision a giant central hub to aggregate these.

An algorithmic approach will be the best way to succeed.

eMPI: biggest problem was not establishing the number but losing the number. ID numbers were either split or two people shared the same number.

Humans will have to identify if the records are duplicates and merge or unmerge records.

Consider those without government issued IDs such as undocumented people living in this country, those coming out of incarceration have no government issued ID for a period of time, which interferes with getting access to care during that period.

How much information do you need to make available to identify each patient?

Have different number at each facility but one overarching number across all.

Can you build the "number" from unique identifiers composed of 5 main demographic categories or assign a random number? Assigning a random number would be easiest.

The idea of exchanging the information without anyone owning the information will be the most challenging.

How can the State support or drive HIE operations in areas of the state not currently covere regional HIE efforts?

Help reach out to rural Oregon, create nodes where there are no existing HIE's, connect nodes, set standards that create benefit for all of Oregon. Consider legislative language that requires entities to engage.

Seed capital grants for the creation of new organizations.

AHRQ put a lot of money towards this and very few attempts were successful.

Seed funding for low or no interest loans could help with adoption and help expand existing HIEs to rural regions.

IPAs seem to be the best bet.

Maybe once something is established the incentives could be effective, but otherwise just place monies towards the expansion. Need to grow where there is already capacity and interest.

Incent existing HIE organizations to broaden their service area.

Who is responsible? How do we reach out? What is the value proposition to connect them? For example if people in those communities never leave those communities.

Sharing patients at various borders: in Portland we share patients with Southern Washington, in Ontario they share Idaho patients and in Medford they share patients with California.

The value is where the patients are and where the patterns are. So, it doesn't make sense to get the patient data from someone in a rural area to someone in Portland that is unlikely they

will need to access that patient's data. Rather that person in the rural community may see a separate provider or health org. in an adjacent community and that is where the data connection and data share needs to be made. Maybe then it makes sense to have the patients' data feed up into a state repository.

OReHC should provide operational HIE service functions because people in rural communities all over the state are using services statewide and this is happening everywhere, within health systems, even here.

Majority of the use will be local with the exception of OHSU; all other systems are fairly statewide. Everyone reaches out to the Coast and the Gorge, and various others connect to certain areas throughout the state.

Priorities for HITOC implementation

Focus on the minimum and most significant amount of things in the short time frame that we have. Launch from there then introduce additional capabilities incrementally.

Use the incremental approach as far as introducing and incorporating various capabilities such as POLST or immunization databases for example.

They would further like to see an improvement in public health overall. Leverage the benefits of the data to drive change mechanisms to produce a much more noticeable change in public health, in order to evaluate the process for the prevention of disease, etc. Instead of thinking of individual patient populations, we need to begin to think about the greater purview of our population (states, communities, etc.).

Medications and problems lists are a very strong tool for their practice.

Data from the EPM system is likely to be much more up to date due to emergent services gathering lists.

"Meaningful Use" States will have the ultimate responsibility to report on Medicaid reimbursements, but not Medicare.

If the impetus is to help providers receive the reimbursements to Medicaid and Medicare they we need to also focus our attention around this area.

More interested in a provider-to-provider exchange at the time of need. For example: one provider requests certain criteria per the other physicians chart that information is sent to the requesting physician and feeds into their patient's chart. This is one of the most frustrating and relatively simple functions that remain missing within the existing designs/operations.

What will be the cheapest to build and have the highest potential for functionality?

Quality

Quality reporting is big picture for the logical integration of the data—clinical and administrative/claims data.

Envisions that the quality metrics piece will take up to 2-3 years. Other states such as Wisconsin and Cincinnati, Ohio, have been unable to do the quality metrics. They end up just shipping their data file for others to compute. Then value was added to the data with an associated fee as part of the transaction.

Once they trust "the middle" they want "it" to do the work. Possibly an incremental model to accrue trust of the system.

A lot of medical groups are using online tools to access claims data—biggest in Oregon is Adventist.

Could the central repository serve as an effective quality-reporting tool?

Blumenthal recently came to speak with them and stated that he had three areas of focus: interoperability, quality and e-prescribe.

The State Medicaid conference paid great attention to quality reporting and measurements, CHIPRA for example:

i. Ultimate goal: Deliver the best care to our patients, meet the regulatory requirements, and ease the use for our clinicians.
ii. **HIE makes it feasible for doing measurement off of real (clinical) data as opposed to claims data.
iii. Better data, larger numbers…
iv. Measures unequally burden primary care because that is where they land. Measures are fine as long as we are paying primary care appropriately with respect to these requirements.
v. Real way to determine quality is to perform a chart review. Because in the chart is embedded how they really practice.
vi. There's chart review and there's patient mix and everything else that needs to be considered.
vii. Macro Markers: generic utilization, ER admission, hospital admissions, total costs, etc. (relatively simple stuff).