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RHIOs: Observations on Criteria for Success

October 14, 2005

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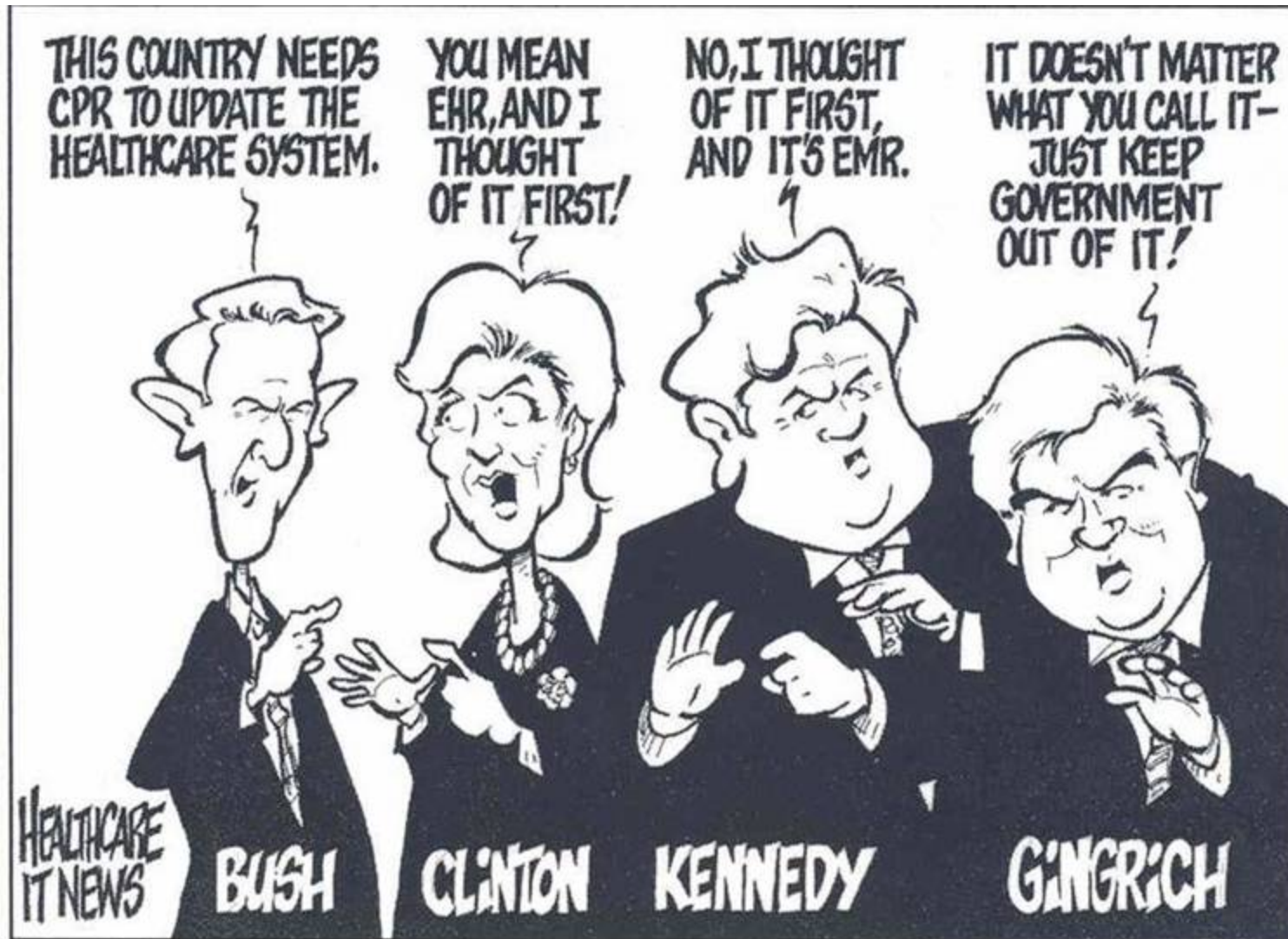
Today's Topics

- Creating context – why the interest in IT-enabled, connected healthcare?
- Pay-for-performance as a driver
- Regional Health Information Organizations (RHIO)
 - What are they?
 - What's happening around the country?
 - What are the challenges facing RHIOs?
- Observations on criteria for success

Making the Case.....

- Effect of recent hurricane disasters
 - Thousands displaced
 - Facilities destroyed
 - Records lost or destroyed
 - Public health concerns
- Government response
 - www.katrinahealth.org
 - Individual state responses
- “Bird Flu” pandemic
 - ER data reporting

Enter the Government



A New Generation of American Innovation

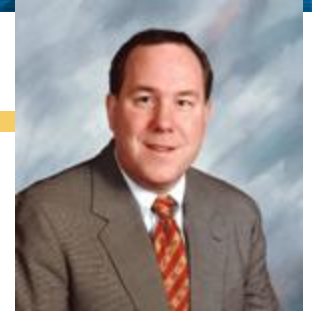
Transforming Health Care: The President's Health Information Technology Plan

“By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.”

--President George W. Bush, State of the Union Address, January 20, 2004

- **President Bush has outlined a plan to ensure that most Americans have electronic health records within the next 10 years.** The President believes that better health information technology is essential to his vision of a health care system that puts the needs and the values of the patient first and gives patients information they need to make clinical and economic decisions – in consultation with dedicated health care professionals.
- **The President's Health Information Technology Plan will address longstanding problems of preventable errors, uneven quality, and rising costs in the Nation's health care system.**

April 26, 2004



News Release

FOR IMMEDIATE RELEASE
Thursday, May 6, 2004

Contact: HHS Press Office
(202) 690-6343

Secretary Thompson, Seeking Fastest Possible Results, Names First Health Information Technology Coordinator

HHS Also Announces Milestones in Developing Health IT

Saying that "health information technology has the potential to greatly improve health care even as it yields huge savings," HHS Secretary Tommy G. Thompson today announced the appointment of David J. Brailer, M.D., Ph.D., to serve as National Health Information Technology Coordinator. This is a new position at HHS, created by President Bush last week to coordinate the nation's health information technology efforts.



News Release

Wednesday, July 21, 2004

Thompson Launches "Decade of Health Information Technology"

Strategic Report Outlines Steps to Implement Widespread Adoption of Electronic Health Records and New Nationwide Interoperable Health Information Network

HHS Secretary Tommy G. Thompson today released the first outline of a 10-year plan to transform the delivery of health care by building a new health information infrastructure, including electronic health records and a new network to link health records nationwide. At the same time, he announced a number of new action steps to help advance health information technology immediately

"America needs to move much faster to adopt information technology in our health care system," Secretary Thompson said as he released the action report ordered by President Bush. "Electronic health information will provide a quantum leap in patient power, doctor power, and effective health care. We can't wait any longer."

The plan, prepared by the new National Coordinator for Health Information Technology, David J. Brailer, M.D., Ph.D., lays out the broad steps needed to achieve always-current, always-available electronic health records (EHR) for Americans. EHR systems would also enable physicians and other health professionals to electronically tap into a wealth of treatment information as they care for patients. The report was released in Washington, D.C., at a Secretarial Summit on Health Information Technology bringing together the nation's technology and health leaders.

The New York Times

OP-ED CONTRIBUTOR

Operating in a Vacuum

By **NEWT GINGRICH** and **PATRICK KENNEDY**

Published: May 3, 2004

WASHINGTON — Health care policy is a partisan minefield, with Democrats and Republicans differing on everything from Medicare changes to malpractice reform to strategies for covering the uninsured. Yet, while the two of us have been on opposite sides of most of those battles, we both believe that America's health care delivery system must be transformed. To begin that transformation, we should heed President Bush's call last week for widespread adoption of electronic health records. As the president noted, "The 21st-century health care system is using a 19th-century paperwork system."

The archaic information systems of our hospitals and clinics directly affect the quality of care we receive. When you go to a new doctor, the office most likely has little information about you, no ability to track how other providers are treating you, and no systematic way to keep up with scientific breakthroughs that might help you.

So, Why the Focus on HIT?

- High, rapidly rising costs
- No link between higher costs and improved quality
 - Poor service quality
 - Highly variable clinical quality
 - Very little information on clinical quality and outcomes
- Patient safety issues
- Incredibly complex and costly administrative processes
- Access issues – 45 million uninsured in the USA and others that are under-insured

IT can be a key part of the solution.
Cost, quality / safety and access issues are not new to healthcare!

What is needed to address these issues?

- Good information about what works and what doesn't (outcomes)
- Good information about errors and “near misses”
- More standardized care plans and processes
- Good access to relevant clinical information during patient care
- Good access to relevant medical content
- Ability to share – while appropriately securing – information
- Good information about the quality of providers
- Simplified financial / patient management processes
- ...

Information & knowledge supported and enabled by IT is a key part of the solution.

What is driving change in the USA?

- Budget pressures on businesses and all levels of government
 - Rising deficits
 - Global competition for businesses
 - Business Roundtable / Leapfrog Group
 - National Federation of Independent Businesses (NFIB)
- Increasing cost-shifting to consumers combined with increasing consumerism by aging baby boomers
- Technology advances in other industries and for consumers are raising expectations for clinicians

What is inhibiting change in the USA?

- Fragmented cottage industry on the provider side
- Strong lobbies and entrenched special interest groups
- Conflicting or negative financial incentives
- Historical IT systems
 - Expensive
 - Departmentally focused and don't "play well with others"
 - Insufficiently robust functionality, poor performance and complexity of core systems
- Lack of "value from IT-related investments" acumen
 - Executive understanding and support
 - Willingness to change processes to align with and take full advantage of technology
 - Organizational change management capabilities
 - Understanding of the business / clinical needs by the IT professionals

Healthcare IT Could Provide Substantial Savings

Potential Annual Cost Savings from Nationwide Adoption of IT:

Category of IT Adopted	Potential Cost Savings
Ambulatory electronic health records	\$78 billion (10 years)
Ambulatory computerized provider order entry	\$44 billion

Source: Center for Information Technology Leadership (www.citl.org)

Framework for Strategic Action

- Four goals, 12 strategies (<http://www.hhs.gov/healthit/>)
 - Inform clinical practice
 - Interconnect clinicians
 - Personalize care
 - Improve population health
- Consolidates and coordinates many initiatives currently underway
- Makes the case for “why now” to adopt HIT
 - Avoid medical errors
 - Improve use of resources
 - Accelerate diffusion of knowledge
 - Reduce variability of care
 - Advance consumer role
 - Strengthen privacy and data protection
 - Promote public health and preparedness



FOR IMMEDIATE RELEASE
Wednesday, May 11, 2005

Contact: HHS Press Office
(202) 690-6343

HHS Secretary and Leading U.S. Companies Say Health Information Technology Should Be Urgent Priority

Public-Private Collaboration Necessary to Achieve the President's Vision for Widespread Health IT Adoption

HHS Secretary Mike Leavitt issued a new report today citing investment in information technology (IT) as an essential, high priority for the American health care system and the U.S. economy.

"Information technology is a pivotal part of transforming our health care system," Secretary Leavitt said. "We are at a critical juncture. Working in close collaboration, the federal government and private sector can drive changes that will lead to fewer medical errors, lower costs, less hassle and better care."

The report, "Health Information Technology Leadership Panel: Final Report," was released at the Business Roundtable's Chief Executive Officer (CEO) Health Care Summit where Secretary Leavitt and Treasury Secretary John Snow discussed the burden of rising health care costs on the U.S. economy and global competitiveness and the role of health IT in managing these costs.

Health Information Leadership Panel

- Three key imperatives
 - Widespread adoption of interoperable health IT should be a top priority for the U.S. health care system.
 - The federal government should use its leverage as the nation's largest health care payer and provider to drive adoption of health IT.
 - Private sector purchasers and health care organizations can and should collaborate alongside the federal government to drive adoption of health IT.
- Six conclusions
 - Potential benefits of health IT far outweigh manageable costs.
 - Health IT needs a clear, broadly motivating vision and practical adoption strategy.
 - The federal government should provide leadership, and industry will engage and follow.
 - Lessons of adoption and success of IT in other industries should inform and enhance adoption of health IT.
 - Stakeholder incentives must be aligned to foster health IT adoption.
 - Among its multiple stakeholders, the consumer – including individual beneficiaries, patients, family members and the public-at-large – is key to adoption of health IT and realizing its benefits.

NHIN – A Work in Progress

- RFI let by the ONCHIT in November, 2004; 512 responses received by the January, 2005 deadline
- Key themes from the responses are:
 - Standards
 - Governance
 - Privacy
 - Regionalization
 - Financing
 - Architecture
 - Regulation
- Summary of responses released June 3, 2005



Office of the National Coordinator for Health Information Technology (ONCHIT)

American Health Information Community (the Community)

On June 6, 2005, Health and Human Services (HHS) Secretary Mike Leavitt announced the formation of a national collaboration, the Community, that will advance efforts to reach President Bush's call for most Americans to have electronic health records within ten years.

The Community will help nationwide transition to electronic health records – including common standards and interoperability – in a smooth, market-led way. The Community, which will be formed under the auspices of the Federal Advisory Committee Act, will provide input and recommendations to HHS on how to make health records digital and interoperable, and assure that the privacy and security of those records are protected.

The Community will be chartered for two years, with the option to renew and duration of no more than five years. The Department intends for the Community to be succeeded within five years by a private-sector health information community initiative that, among other things, would set additional needed standards, certify new health information technology, and provide long-term governance for health care transformation.

Four RFPs Let June 7, 2005

● **Standards Harmonization Process**

- Develop, create prototypes for, and evaluate a process to unify and harmonize industry-wide health IT standards development, maintenance and refinements over time.
- Awarded to ANSI, 10/07/05 - \$3.3 million

● **Conformance Certification Process**

- Develop, create prototypes for, and evaluate a conformance certification process for health IT, including the infrastructure or network components through which health IT systems interoperate.
- Awarded to Certification Commission for HIT, 10/07/05 - \$2.7 million

● **Privacy & Security Assessment**

- Assess and develop plans to address variations in organization-level business policies and state laws that affect privacy and security practices, including those related to HIPAA, which may pose challenges to interoperable health information exchange.
- Awarded to Health Information Security & Privacy Collaboration, 10/07/05, \$11.5 million

● **NHIN Demonstrations**

- Develop, and create prototypes for, and evaluate a nationwide health information network (NHIN) architecture for widespread health information exchange that can be used to test specialized network functions, security protections and monitoring, and demonstrate feasibility of scalable models.

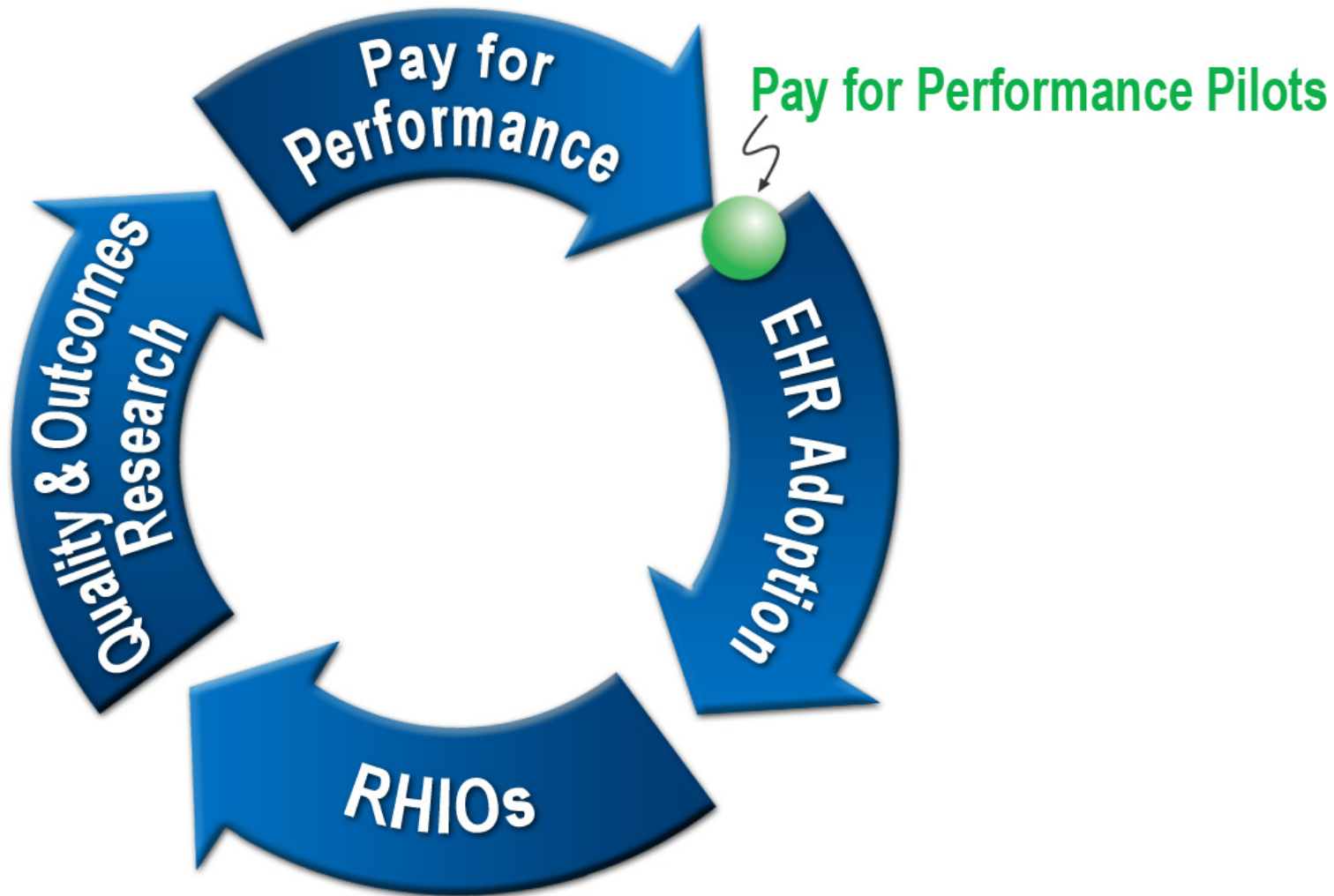
Wired for Health Care Quality Act

- S. 1418 combined the Frist-Clinton and Enzi-Kennedy bills
- Was passed by the Health, Education, Labor and Pensions (HELP) committee
- Promotes adoption of interoperability standards and connected, IT-enabled healthcare delivery to improve quality and reduce costs
- \$275 million in grants over 2 years; bonus payments for achieving quality targets
- Codifies ONCHIT & AHIC
- \$5 million in grants to medical schools for demonstration projects on integrating IT into medical education
- Stark and anti-kickback safe havens – REMOVED FROM BILL

Federal Government Recap

- Bipartisan agreement that HIT is part of the “fix” for healthcare
- Seeking to facilitate collaboration to achieve an IT-enabled, connected healthcare delivery system by 2014 – does not want to mandate
- Probably isn't going to pay (much) for HIT – but Medicare likely to provide (some) reimbursement incentives for use and clinical reporting

Pay-for-Performance: Driving HIT Adoption, Influencing RHIOs



Drivers for EHR Adoption

	<u>Admissions</u>	<u>Days</u>	<u>Procedures</u>	<u>Quality</u>	<u>Financial info</u>	<u>Clinical info</u>
Reimbursement Type						
FFS	+	+	+	0	Low	0
Per diem	+	+	-	0	Low	0
DRGs / case rates	+	-	-	0	High	Medium
Capitation	-	-	-	0	High	Low
P4P	+	+/-	+/-	+	High	High

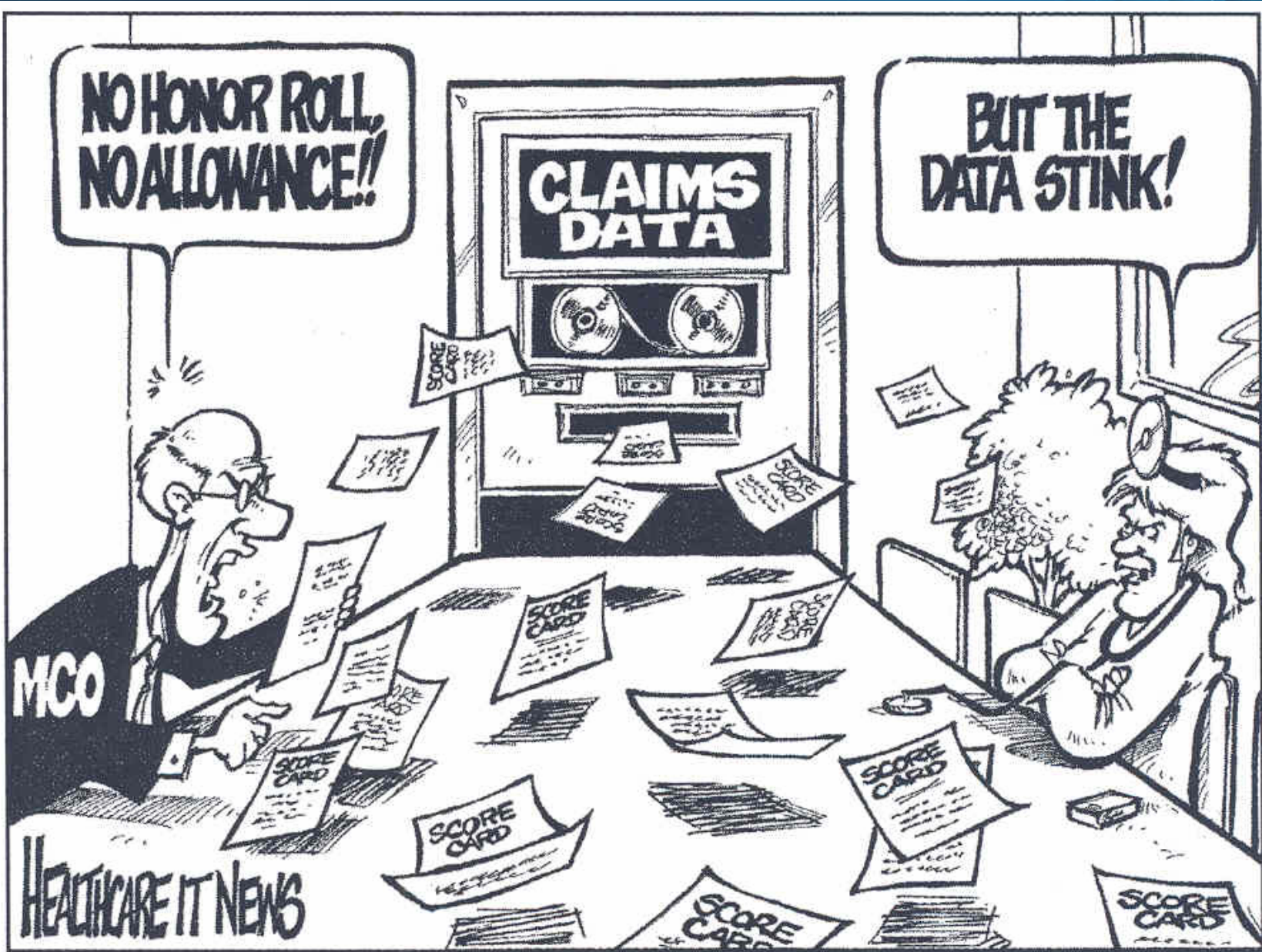
**NO HONOR ROLL,
NO ALLOWANCE!!**

**CLAIMS
DATA**

**BUT THE
DATA STINK!**

MCO

HEALTHCARE IT NEWS





MEDICARE NEWS

FOR IMMEDIATE RELEASE Contact: CMS Media Affairs
January 31, 2005 (202) 690-6145

MEDICARE BEGINS PERFORMANCE-BASED PAYMENTS FOR PHYSICIAN GROUPS

New Demonstration Program Tests Financial Incentives for Improved Quality and Coordination in Large Group Practices

The Centers for Medicare and Medicaid Services (CMS) today announced new initiatives to pay health care providers for the quality of the care they provide to seniors and people with a disability, reflecting an Administration commitment to reward innovative approaches to get better patient outcomes at lower costs.

“Better care should be rewarded, and thanks to growing support from health care providers and other stakeholders, we have better approaches to doing so than ever before,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. “It is time that we pay for the quality of the health care provided to our beneficiaries, not simply the amount. We are working to apply this in every setting in which Medicare and Medicaid pays for care.”

Further information on the demonstration is available at <http://www.cms.hhs.gov/researchers/demos/pgp.asp>

The New York Times

ON THE WEB

FLEXING MEDICARE'S MUSCLES

A Bonus for Health, Payable to the Doctor

By [GINA KOLATA](#) and [REED ABELSON](#)

Published: April 15, 2005

A quiet revolution is taking place in Medicare, one that could set a new standard for the way medicine is practiced in this country.

For the first time in its history, Medicare is starting to embrace an approach that has changed industries as diverse as carmakers and fast-food restaurants - giving employees financial incentives to meet goals for quality.

By the end of this year, more than 600,000 Medicare recipients will be in test programs that pay doctors and hospitals bonuses for achieving better results, like increasing the number of diabetic patients whose blood sugar is under control.

Some see this experiment as the last best hope for a medical system in crisis, facing soaring costs and questions about what all that money is buying.

“Pay For Performance” With Real Clinical Measures



- Initial focus—improving care for diabetic patients (will be expanded to other conditions in future)
- Based on actuarial estimates of long-term costs for patient care (achievable savings of \$350 per patient per year)
- Piloting in Louisville, Cincinnati, Boston, Albany NY (national rollout anticipated)
- Initial approach—physician/patient “opt-in” with only upside incentives
 - \$100 per physician per patient per year—diabetic care benchmarks
 - \$50 per patient per year
 - \$55 per physician per year—installing clinical HIT reporting tools

Medicare Value Purchasing Act of 2005

- Introduced by Sen. Grassley (R-IA, chairs Senate Finance Committee) and Sen. Baucus (D-MT, ranking member Senate Finance Committee) on 6/30
- Supports a public-private collaboration to identify quality of care measures
- 1% Medicare premium in year 1 for reporting quality measures
- Premium scales up to 2% in years 2 – 5 for achieving quality targets
 - Starts in 2007 for hospitals and 2008 for physicians, exceptions may be granted

Regional Health Information Organization

- An independent entity that provides and supports IT-enabled capabilities to facilitate multiple healthcare entities within a geographic area in sharing, communicating, and exchanging information
- Healthcare entities are physicians, institutional providers, government & private payers, labs, PBMs, government agencies, employers, and patients
- Information can be clinical, administrative, and/or demographic
- Often – but not always – sponsored or organized by one or more government, or government-sponsored organizations
- Also can be sponsored by provider/payer/physician consortiums

Regional Health Information Organization

- RHIO objectives:
 - Support and improve healthcare quality and outcomes
 - Streamline processes for care
 - Streamline administrative processes
- Information is shared in order to:
 - Avoid duplicate tests and treatments
 - Reduce errors in medications and treatments
 - Reduce administrative and direct costs of care & payment
 - Facilitate disease management programs
 - Enable medical research
 - Improve community health status
 - Support improved bio-surveillance

Current Assumptions About RHIOs

- RHIOs will be in the experimental stage for a while longer; no model or formula for success - yet
- EHRs will not be in every provider location, at least for the foreseeable future
- No complete set of interoperability standards exists at the start of RHIOs

Why are RHIOs Important?

- RHIOs are viewed as integral to national efforts to use IT as a tool to improve the efficiency and effectiveness of health care delivery
- RHIOs are also the building blocks of an improved national network of syndromic surveillance
- RHIOs will also be the vehicle we use to aggregate de-identified clinical data to support quality improvement research
- RHIOs may ultimately be the point of distribution of best practice protocols to providers at the point of care

Why Might RHIOs Work?

- Many of us recall CHINs of the early 90's
 - Nearly all failed
 - No agreement on who would pay
 - No compelling reason for cooperation among competing organizations
 - No agreement on who would “own the data” especially in a centralized database architecture
 - High cost of building the technical infrastructure
- What's different now?
 - Federal government involvement
 - Growing pressures to contain healthcare costs and improve healthcare quality
 - Improved technology
 - Consumer expectations and use of the Internet
 - New opportunities to develop sustainable funding

Current RHIO Activity

- Over 200 RHIO efforts underway nationwide
- Typically formed by providers, business coalitions, physicians, health plans, or government-related entities
- 42 states have at least one RHIO organized or planned
- 24 states have introduced and/or passed legislation supporting RHIOs or other e-health initiatives
- Congress is considering bills in both Houses – and 1 Senate bill is moving quickly



HHS Awards \$139 Million To Drive Adoption of Health Information Technology

HHS Press Release Date: October 13, 2004

The U.S. Department of Health and Human Services today announced \$139 million in grants and contracts to promote the use of health information technology (HIT). Awarded through HHS' Agency for Healthcare Research and Quality (AHRQ), this multi-year program builds on President Bush's initiative to use HIT to improve the Nation's health care system.

These awards will provide insight into how best to use health information technologies to improve patient safety by reducing medication errors; increasing the use of shared health information between providers, laboratories, pharmacies and patients; helping to insure safer patient transitions between health care settings, including hospitals, doctors' offices, and nursing homes; and reducing duplicative and unnecessary testing.

For specific information on each award, go to www.ahrq.gov/research/hitfact.htm.

2004 AHRQ Grants to Local Organizations

- Louisiana: \$1.7 million over 3 years
 - Cardiovascular Care Disparities: Safety-Net HIT Strategy
 - Distance Management of High-Risk Obstetrical Patients
 - HIT Service Integration
 - Louisiana Rural Health IT Partnership
- Mississippi: \$1.42 million over 3 years
 - Creating Online NICU Networks to Educate, Consult & Team
 - Detecting Med Errors in Rural Hospitals Using Technology



Funding Awards Announced for Historic First Public Private-Sector Collaboration on Community Electronic Health Information Exchange

Over Two Million Dollars Being Distributed to Improve Connectivity, Reduce Medical Errors and Create More Efficient Healthcare for Patients in Their Own Communities

WASHINGTON, D.C., July 21 — The Foundation for eHealth Initiative (eHI) today announced the selection of nine communities nationwide that are being awarded funding -- collectively totaling over \$2 million -- through the Connecting Communities for Better Health (CCBH) program to pursue local projects in electronic health information exchange. Announcement of the CCBH awards were made as part of the NHII 2004 Cornerstones for Electronic Healthcare Conference during the Secretarial Summit on Health Information Technology (HIT) hosted by HHS Secretary Tommy G. Thompson and at which Thompson and National Health Information Technology Coordinator David Brailer, MD, PhD unveiled the nation's first strategic framework report on a ten-year initiative to develop electronic health records and other uses of health information technology and advance HIT adoption.

Nine CCBH Awardees

- Connecting Colorado - [Denver, CO]
- Indiana Health Information Exchange (Central Indiana Healthcare Collaboration) - [Indianapolis, IN]
- MA-SHARE MedsInfo e-Prescribing Initiative – [Waltham, MA]
- MD/DC Collaborative for Healthcare Information Technology - [Baltimore-Washington Metropolitan Area]
- Santa Barbara County Care Data Exchange – [Santa Barbara, CA]
- Taconic Health Information Network and Community - [Fishkill, NY]
- Tri-Cities TN-VA Care Data Exchange - [Kingsport, TN]
- Whatcom County e-Prescribing Project - [Bellingham, WA]
- Wisconsin Health Information Exchange (National Institute for Medical Informatics – Midwest) - [Milwaukee, WI]

What's Working

- Oversight provided by broad-based collaborative group representing the local healthcare market (e.g., providers, payers, hospital association, medical society, QIOs, DOH)
- Collaborative group independent of a specific government agency or a single private entity
- Focus is on community benefits, approach is patient-centric
- Benefits are driving technology decisions, not the other way around
- Business model based on subscriptions
- Start up funding needed, sources are varied
- Getting started!

Common Challenges

- Need for interoperability standards
- Money, money, money
 - Start-up funds
 - Sustainable funding model
 - Payers will not pick up the full tab
- Blueprint for a technology architecture
 - Distributed versus centralized data structure
 - Low technology user interface
- Politics
 - Finding, or creating, a neutral entity to sponsor RHIO – i.e., a “Switzerland”
- Competitive differences
 - Lack of trust among parties
 - Fear of lost advantage
 - Pride of ownership
- Consumer involvement

Findings - Governance

- Most are creating a corporate structure
- Some, but not many, are defined by state statute
- Independent
- Some are pursuing 501(c)(3) status
- LLC incorporation used in some cases
- Boards are broadly representative of the local healthcare market
- Typically have working committees to establish policies (e.g., mission, governance, financing, technology, privacy & security, legal, communication & marketing)

Findings - Financing

- Grants are frequent source of funding for
 - Planning
 - Start-up
 - Technical infrastructure
- Primary grant sources are government and private foundations
- Business models
 - Subscription fees for participants is predominant model
 - Some pay-per-use models
 - Incentives are planned for future
- Careful analysis of who pays for and who benefits from the network may drive the allocation of “who pays what”
- Some are of the opinion that if the benefits don't drive the participants to “ante-up” no amount of government funding will ensure success

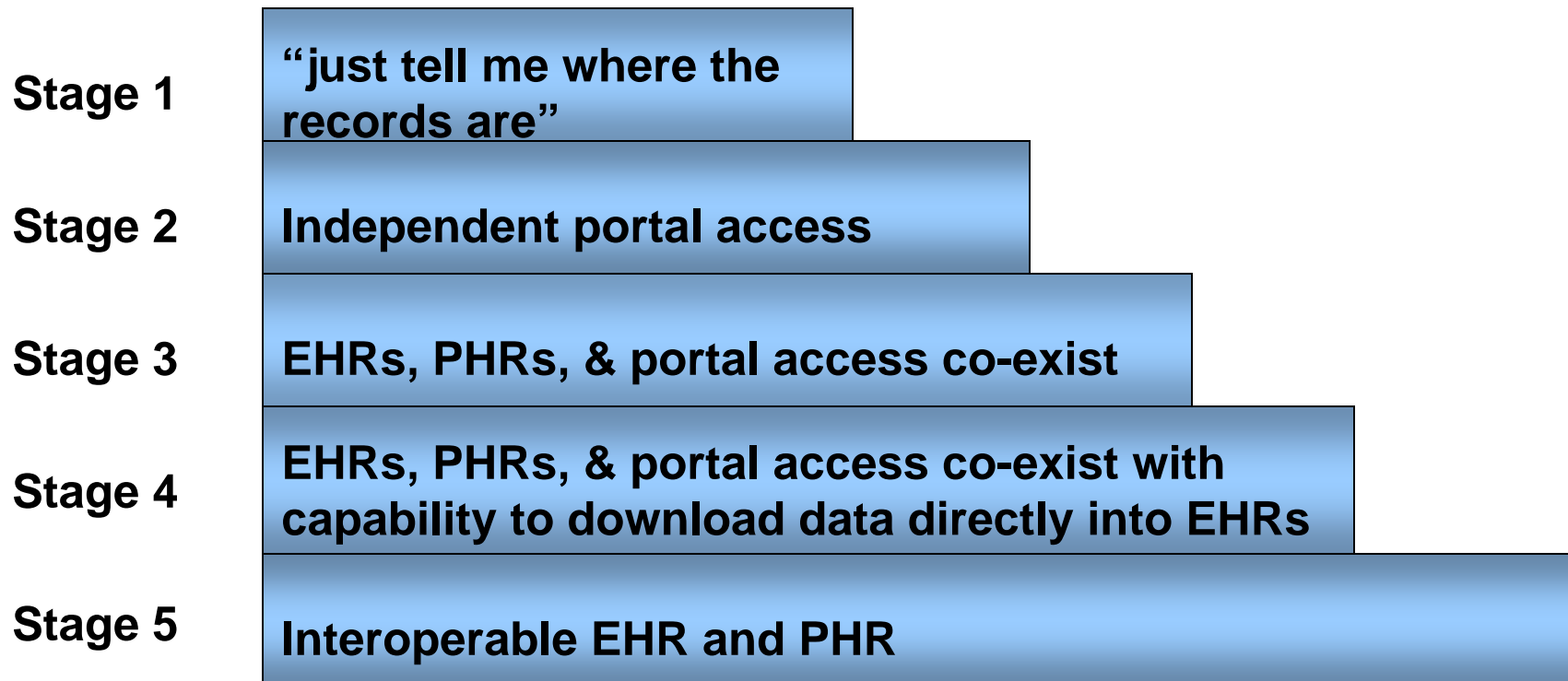
Findings – Privacy & Security

- HIPAA privacy and security concerns
- Harmonizing HIPPA and more stringent individual state regulations
- Other privacy considerations
 - Financial services transactions
 - Children's Online Privacy Protection Act (COPPA)
 - ACLU lawsuits
- Consent forms, privacy notices & opt-out (or opt-in)
- Education in the community especially around consents
- Technical architecture development
 - Sign-on and passwords
 - Secure infrastructure
 - Encryption techniques
- Internet security protocols need to be strengthened

Findings - Technology

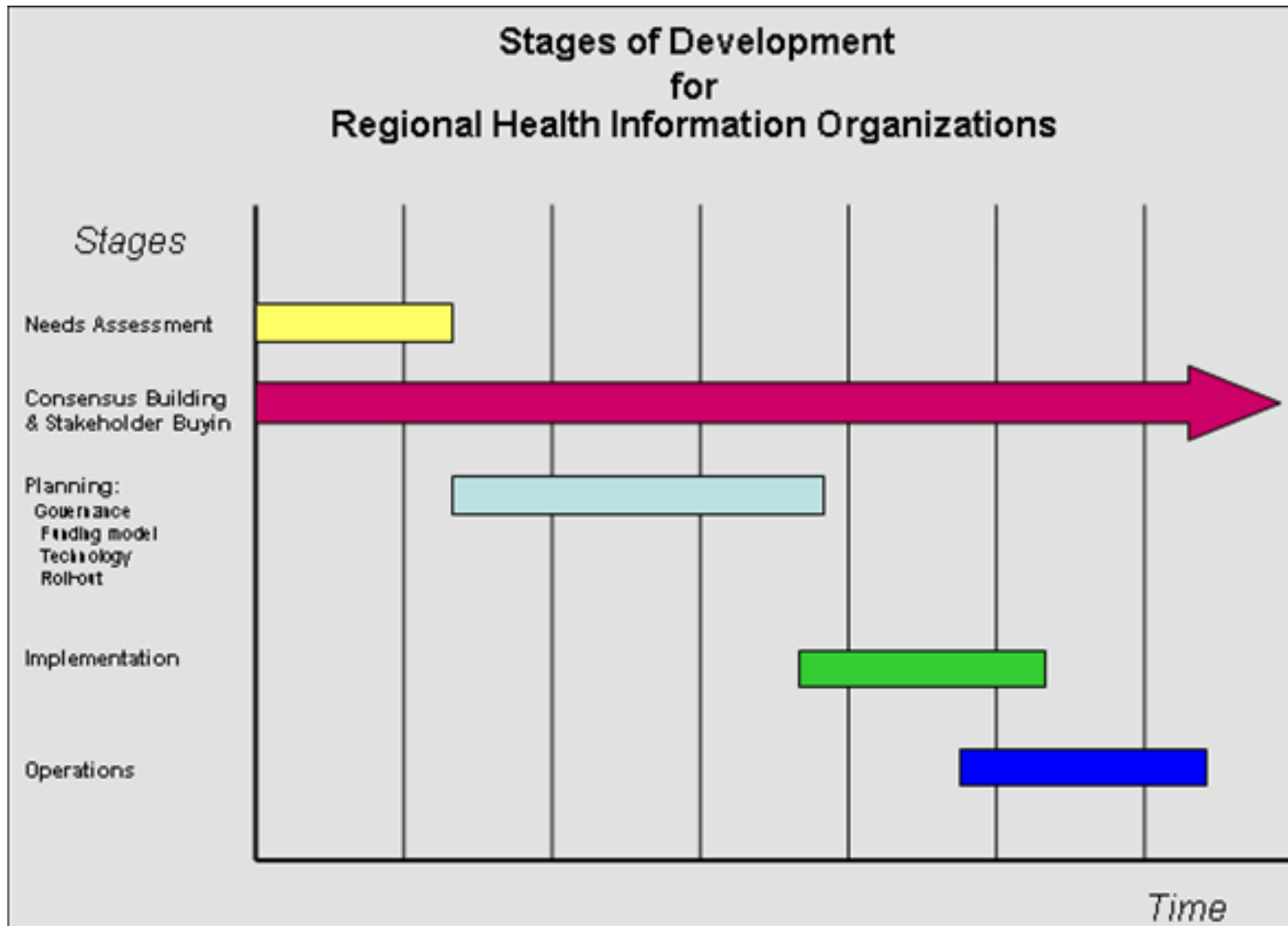
- Two broad technical models
 - Central data repository
 - Distributed, peer-to-peer data sharing (i.e., “Napster”-like)
- Most will utilize a “portal-type” access method
- Unique patient identification is critical and perilous
 - A national identifier – voluntary or mandatory – is unlikely any time soon
 - Probabilistic matching requires that “someone” resolve the uncertain matches
- Interoperability standards – both transactional and semantic – are required to keep costs down and content meaningful

Evolution of Data Sharing Functionality



All functionality states could potentially simultaneously co-exist within a RHIO

RHIO Development Stages



Suggested RHIO Roadmap

Governance and Strategy

Reason for Being
Vision
Mission
Guiding Principles
By-Laws
Goals
Objectives
Success Criteria

Business and Systems Design

Business Modeling
Systems Modeling
Business Plan
Financial Plan
Systems Plan
Macro Design

Requirements Definition and Solution Design

Policy and Procedure Definition
Design Goal Prioritization
Use Case Development
Requirements Definition
Micro Design
Technology Selection

Solution Implementation

Build
Unit Test
Systems Test
User Test
Roll Out
Repeat for new stakeholders and functionality

On-going Operations and Technical Support

Strategic Operations
Business Operations
Administrative Operations
User Technical Support
Network Operations

Critical Success Factors for a RHIO

- Broad stakeholder participation & buy-in
- Ownership & governance
- Privacy & security
- Funding – startup and ongoing
- Implementation plan
- Patient identification

- *Prioritizing efforts – focus on successfully implementing one benefit at a time*

If these things aren't done properly, the best technology in the world isn't going to make the RHIO successful.

Maximizing IT Value



advisory services

implementation services

Thank You!

Dewey E. Freeman

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