

Update on the State HIE Program

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Little exchange occurring

- Almost three quarters of the time (73 percent) PCPs do not get discharge info within two days. Almost always sent by paper or fax (2009, Commonwealth)
- Only 19 percent of hospitals report they are sharing clinical information electronically with providers outside system (2010, AHA)

Cost of exchange high , time to develop is long

- Interfaces cost \$5K to \$20K due to lack of standardization, implementation variability, mapping costs
- Community deployment of query-based exchange often takes years to develop

Poised to grow rapidly, spurred by new payment approaches

- New payment models are the business case for exchange
- More than 70 percent of hospitals plan to invest in HIE services (2011, CapSite)
- Number of active “private” HIE entities tripled from 52 in 2009 to 161 in 2010 (2011, KLAS)

Many approaches and models

- In addition to RHIOs, many other approaches emerging, including local models advanced by newly emerging ACOs, exchange options offered by EHR vendors, and services provided by national exchange networks
- Seeing a full portfolio of exchange options, meeting different needs

Prior Assumption

- One state-run HIE network serving majority of exchange needs of the state
- Focus on developing query-based exchange

Current

- There will be multiple exchange networks and models in a state
- Key role of the state HIE program is to catalyze exchange in state by reducing costs of exchange, filling gaps and assuring common baseline of trust and interoperability, building on the market and focusing on stage one meaningful use

- **Focus** - Give providers viable options to meet MU exchange requirements
 - E-prescribing
 - Care summary exchange
 - Lab results exchange
 - Public health reporting
 - Patient engagement
- **Approach**
 - Make rapid progress
 - Build on existing assets and private sector investments
 - Every state different, cannot take a cookie cutter approach
 - Leverage full portfolio of national standards

We are here today...

Time Frame (n=1,442)

Less than 48 Hours

27%

2 to 4 Days

29%

5 to 14 Days

26%

15 to 30 Days

6%

More than 30 Days

1%

Rarely/Never Receive Adequate Support

6%

Not Sure/Decline to Answer

4%

Delivery Method (n=1,290)*

Fax

62%

Mail

30%

Email

8%

Remote Access

15%

Other

11%

Not Sure/ Decline to Answer

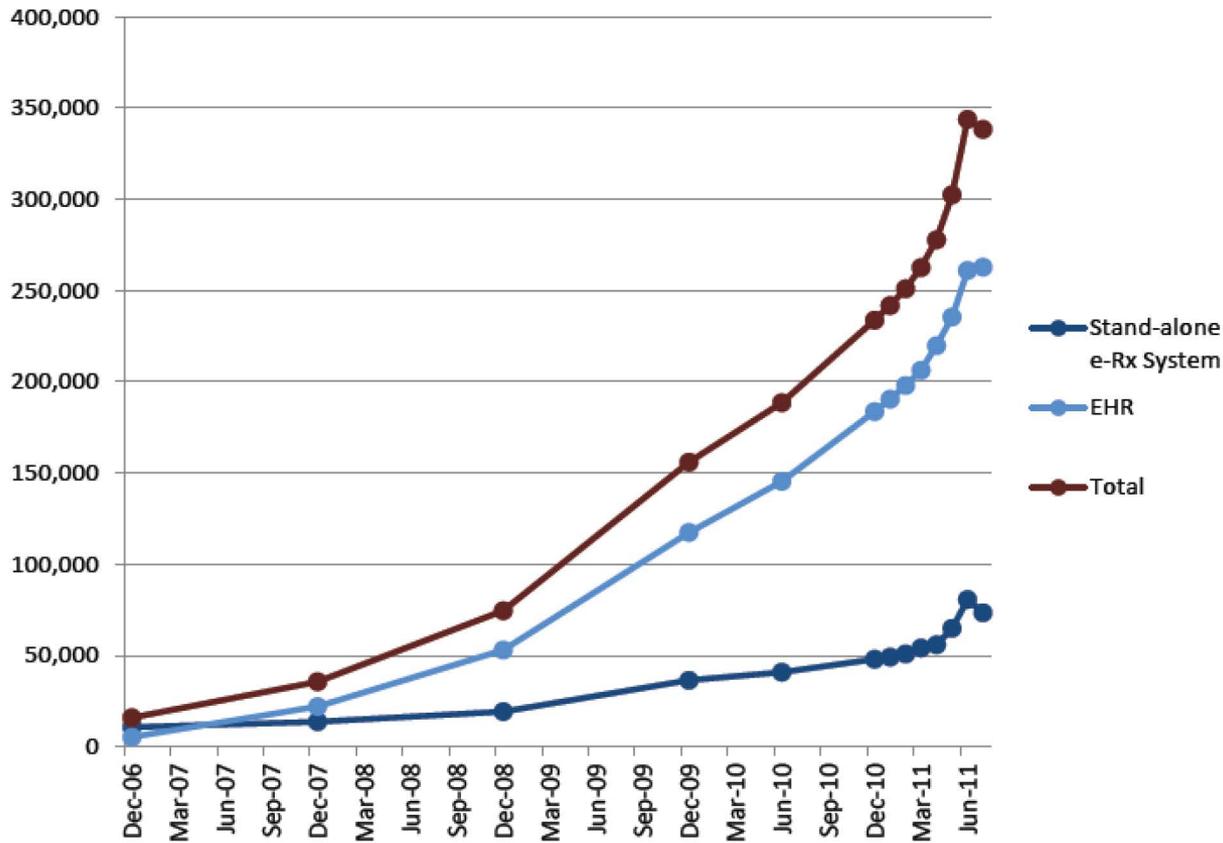
1%

19 percent of hospitals are exchanging clinical care records with ambulatory providers outside system (2010)

*Respondents could select multiple responses. Base excludes those who do not receive report. Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Will we soon see this curve? For care summary exchange? For lab exchange?

Number of e-Prescribers in US by Method of Prescribing

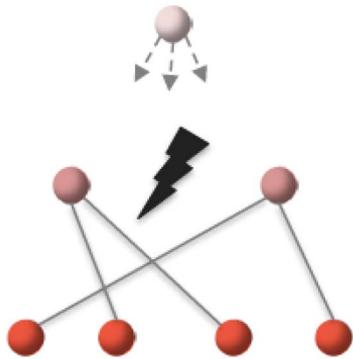


State HIE program opportunities to fill gaps, lower cost of exchange and assure trust

Opportunity	Description
White Space	Large areas of state don't have viable exchange options for providers
Duplication	Every exchange creates own eMPI, identity solution & directories
Information Silos	Unconnected exchange networks don't support info following patient across entire delivery system
Disparities	Low capacity data suppliers do not have resources or technical capacity to participate in exchange
Emerging Networks	Emerging networks need resources and technical support
Public Health Capacity	States' numerous reporting needs are resolved in one-off ways or aren't electronic
No Shared Trust/Interop Requirements	Lack of common technical and trust requirements makes negotiations and agreements difficult and slows public support and exchange progress

Opportunity	Strategies to Address	Number
White Space	Directed Exchange - Jumpstart low-cost directed exchange services to support meaningful use requirements	51
Duplication	Shared Services - Offer open, shared services like provider directories and identity services that can be reused	54
Information Silos	Connect the nodes - Infrastructure, standards, policies and services to connect existing exchange networks	25
Disparities	REC for HIE - Grants and technical support for CAHs, independent labs, rural pharmacies to participate in exchange	20
Emerging Networks	Support local networks – Connectivity grants and trust/standards requirements for emerging exchange entities	5
Public Health Capacity	Serve reporting needs of state - Support public health and quality reporting to state agencies	28
No Shared Trust/Interop Requirements	Accreditation and validation of exchange entities against consensus technical and policy requirements	17

Elevator

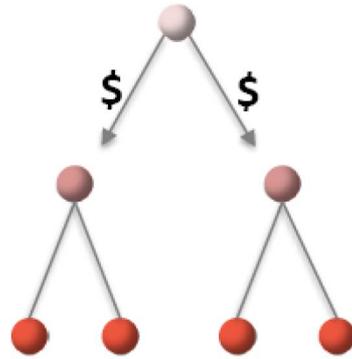


Rapid facilitation of directed exchange capabilities to support Stage 1 meaningful use

Preconditions:

- ✓ Little to no exchange activity
- ✓ Many providers and data trading partners that have limited HIT capabilities
- ✓ If HIE activity exists, no cross entity exchange

Capacity-builder

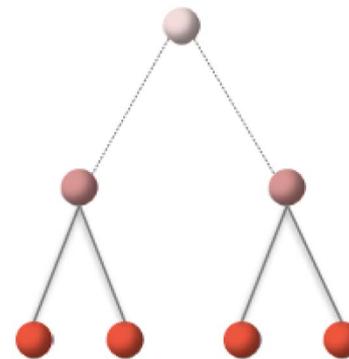


Bolstering of sub-state exchanges through financial and technical support, tied to performance goals

Preconditions:

- ✓ Sub-state nodes exist, but capacity needs to be built to meet Stage 1 MU
- ✓ Nodes are not connected
- ✓ No existing statewide exchange entity

Orchestrator

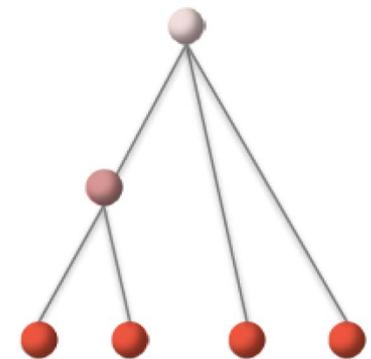


Thin-layer state-level network to connect existing sub-state exchanges

Preconditions:

- ✓ Operational sub-state nodes
- ✓ Nodes are not connected
- ✓ No existing statewide exchange entity
- ✓ Diverse local HIE approaches

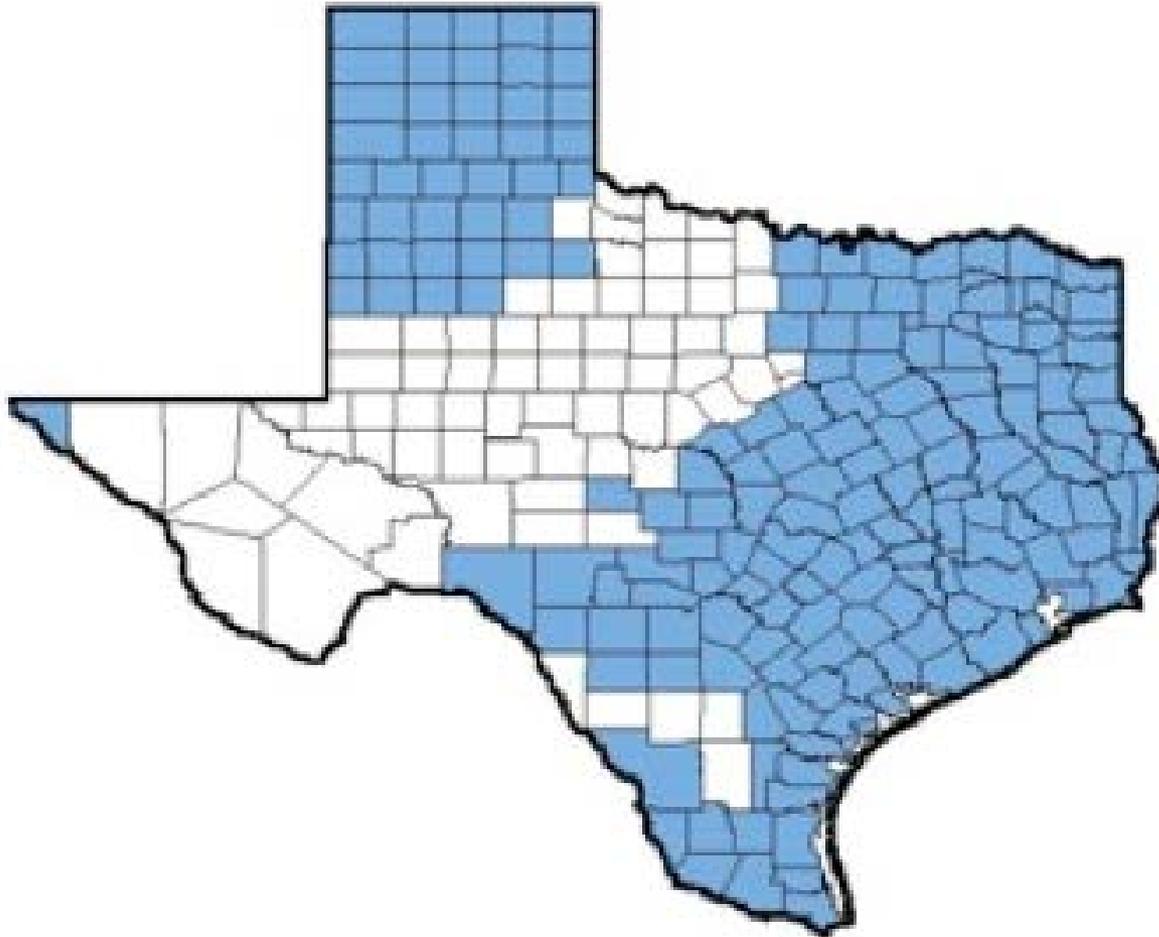
Public Utility



Statewide HIE activities providing a wide spectrum of HIE services directly to end-users and to sub-state exchanges where they exist

Preconditions:

- ✓ Operational state-level entity
- ✓ Strong stakeholder buy-in
- ✓ State government authority/financial support
- ✓ Existing staff capacity



- Provider outreach focused on how service can help providers coordinate care and meet meaningful use requirements:
 - Sharing a care summary when patient referred
 - Immunization reporting
 - LTPAC transitions
- Offered a time-limited free sign-up period to create a sense of urgency among eligible providers and hospitals
- A month after launch, more than 500 providers have signed up for service

- One of the key factors for a large scale adoption of a provider directory is for it to be flexible and provide accurate and up-to-date information
- Every provider added to the provider directory is checked against 13 discrete elements leading to an accuracy rate of 98% with elimination of duplicates
- The provider directory is easily configured and integrated into other existing systems such as the WHIO (Wisconsin Health Information Organization), WCHQ (Wisconsin Collaborative for Healthcare Quality), and the WCMEW (Wisconsin Council on Medical Education and Workforce)
- Currently the provider directory only has capabilities that allow end-users to search for physicians and clinics, but future plans will allow for the HISP to synchronize Direct certificates and addresses to fields within the provider directory

- Indiana has five operational HIEs: HealthBridge, HealthLINC, IHIE, MHIN, and The Med-Web
- The state HIE program is funding these exchange organizations to begin sharing information across exchange entities, with the goal that patient information can securely follow patients wherever and whenever they seek care in the state
- The state's HIEs are working together to agree on a shared set of privacy and security requirements and implement the NwHIN Exchange service stack
- While the state's SDE is facilitating the work between HIEs and holding them accountable for deliverables and consensus, the resulting connected nodes will each maintain independent architectures and governance processes

- Many hospital labs in OHIO currently do not exchange electronic laboratory data in a structured format
- Ohio Health Information Partnership's (OHIP) is focusing on enabling this capability for 69 hospital labs located in the underserved area
- OHIP will support "lab over Direct" and provide a data management service to enable LOINC coding
- OHIP, the Ohio Department of Health and the CDC-funded Laboratory Interoperability Cooperative are working collaboratively with the Ohio Hospital Association (OHA) in these efforts

- The Cal eConnect HIE Expansion Grant Program funds community based initiatives that support providers in meeting MU requirements and are consistent with national and statewide policies, standards and services. Five grants totaling \$3 million have been made to date:
 - EKCITA (Central Valley) will support providers to receive structured lab results from labs, share patient care summaries and connect to immunization registries
 - Los Angeles Network for Enhanced Services (LANES) is partnering with the Regional Extension Center to connect REC supported EHRs to HIE services with focus on underserved providers
 - Redwood MedNet will support EHR connectivity to labs (results and orders), hospital sharing of discharge summaries with PCMH, provider sharing of care summaries with referring providers and patients (PCHR)

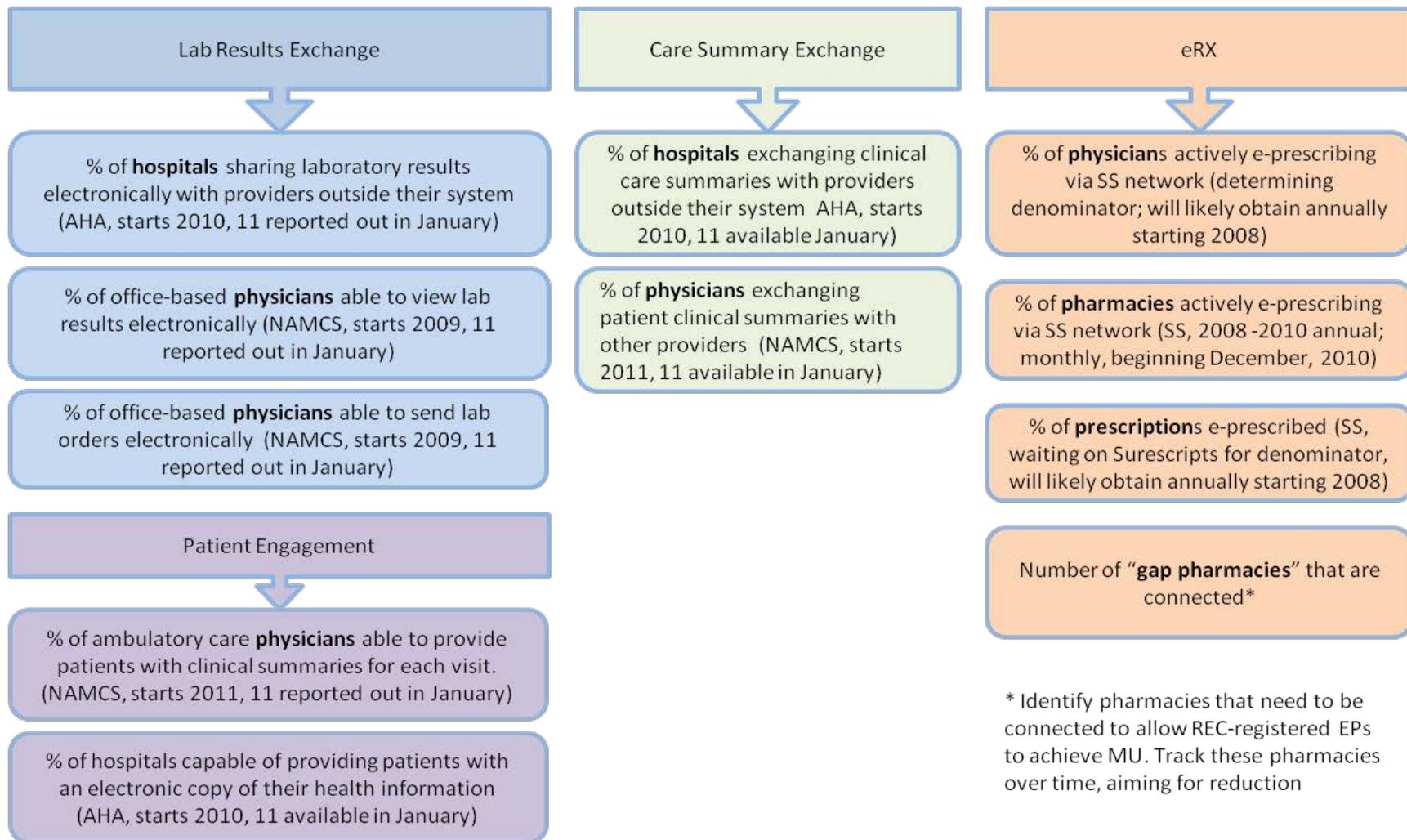
- Providers can use the Kentucky Health Information Exchange (KHIE) to submit data to the KY Immunization Registry. To date, nine providers have tested immunization messages via KHIE to facilitate their MU attestation to Medicare
- The state will use KHIE to transmit electronic results from newborn screening to providers across the state. This functionality will go live the first quarter of 2012
- Approximately 55,000 babies are born every year in Kentucky and all of them have 48 metabolic screening tests performed in the Kentucky State Laboratory. The results are currently paper-based and are either mailed or faxed to providers

Rhode Island

Accreditation and validation of exchange entities against consensus technical and policy requirements

Putting the I in HealthIT 
www.HealthIT.gov

- The Rhode Island Quality Institute created a “HISP Vendor Marketplace” and RI trust community to support rapid scaling of directed exchange to support providers sharing care summaries for referrals and other uses
- *HISP Marketplace*: Chose 4 vendors to be listed in the Marketplace www.docEHRtalk.org and available at a discount to Rhode Island providers. Selected based on meeting technical, process, and organizational best practice criteria
- *RI Trust Community*: Validates and authenticates users and issues digital certificates



- Provider adoption and workflow for key exchange tasks
- Alignment with care transformation and payment reform efforts
- Scaling directed exchange
- Broader adoption of query-based exchange
- Sustainability
- Business practices