

# **Governance Experience of Implementers of Health Information Exchange**

## **Inland Northwest Health Services**

### **Testimony to the Governance Workgroup of the HIT Policy Committee September 28, 2010**

#### ***Introduction:***

I am Jac Davies, Director of the Beacon Community of the Inland Northwest, speaking on behalf of Inland Northwest Health Services (INHS) in Spokane, Washington. INHS has been conducting regional health information exchange for more than a decade, serving hospitals, physician offices, clinics, laboratories and imaging centers in Washington state and Idaho. INHS is governed by a Board of Directors representing the two hospitals systems that formed our organization and also representing members of the community. In addition to the formal governance structure, INHS receives guidance from multiple community based advisory groups including the informatics committee of the Spokane County Medical Society and a regional Health Information Management workgroup.

Input from the Board of Directors and from the various advisory groups was used to develop and on an on-going basis to refine contractual documents that establish the roles and responsibilities of all organizations and individuals participating in health information exchange. If the participating organization is paying for the service, such as a hospital or physician office receiving EMR support in addition to health information exchange, the contractual documents cover the costs and scope of that service as well as responsibilities related to the HIE. If the participating organization or individual is only accessing information through the HIE, such as a physician in a rural community, the

contractual documents only cover the privacy and security requirements associated with the HIE.

### *Trust*

Trust in the exchange is established through the use of a common contractual framework. As noted above, this common framework covers privacy and security obligations including appropriate use of data. All participating organizations are aware of the contractual requirements and the knowledge that everyone must comply with the same requirements builds trust. When an organization raises concerns over a specific issue, the issue is discussed with the advisory groups and, if necessary, all contracts are updated to reflect whatever change was agreed upon.

We are fortunate to serve a region that has a strong history of collaboration between residents, including health care organizations. In health care the collaboration is based in large part on the realities of meeting the needs of patients who live in rural communities and who move between multiple providers. The regional HIE has leveraged that collaborative history as well as existing relationships to promote effective participation. There are active regional workgroups, advisory groups and coalitions on a variety of topics including health information technology, medical records, medical office management, health care research, and chronic disease. Rather than trying to build new HIE-specific groups we have relied on existing relationships and collaboratives. This has helped us maintain active participation across a variety of organizations and interests. Consumers have been engaged as part of the existing advisory groups and also through the creation of specific advisory groups on topics that have strong consumer interest such as personal health records.

HIE governance cannot be mandated from the federal level but instead should be driven by the particular business needs and relationships within each community. The ONC can help by providing templates and other sample documents that communities can adapt to meet their needs. Ideally there will also be a minimum set of functions and policies that each HIE should comply with in order to assure interoperability and the extension of the trust framework between HIE's. However, the exact governance structure should remain within the purview of each community.

### *Interoperability*

As with the other aspects of our HIE, interoperability is maintained through contractual relationships. Organizations that participate in the exchange of information agree through contracts on the mechanisms that will be used including data type, data format and messaging system. By complying with those requirements, interoperability is enabled and assured.

There are two potential roles for ONC in this arena. As noted above, ONC can and, through the NHIN process, is establishing a minimum set of functions and policies that any HIE seeking to exchange data outside of its boundaries should follow. Those functions and policies would define both the technical requirements for exchange data between HIEs and the trust framework for privacy and security, to assure any participating organizations that their health information will be treated appropriately. A second role for ONC or an ONC-approved body is to establish a certification process to identify HIEs that meet desired functional and policy requirements. This would not be a certification process for HIE products, but rather a certification process for any HIE organization that seeks to share data with other HIEs. Focusing on the HIE organization

rather than the technical solution will assure that the certification process captures policies and practices that are outside the realm of technology.

The current assumption is that HIEs will link to each other via the NHIN Connect gateway and, therefore, will meet the NHIN requirements. If that is the case, is a separate certification process necessary? We believe it is because at the community and regional level there are likely to be linkages between HIEs that do not go through the NHIN Connect gateway.

Health Information Exchange may be a function operated by a single corporation to link multiple facilities or it may be a community or state-based organization that provides HIE services. If a corporation has purchased an HIE product and is using it internally, does it need to comply with NHIN requirements and connect to the NHIN gateway? Absent regulation, is it possible to require businesses to use the NHIN gateway and associated policies?

A separate certification process would allow any organization using an HIE product and that seeks to share information outside of its own boundaries to quickly ascertain whether an external HIE meets some minimum requirements around functionality, policies and practices. The establishment of a certification process should not preclude individual communities or organizations from setting higher standards around the exchange of information, if they believe they have the need to do so. However, a common certification process would establish a minimum level for a trust framework that would apply to all participating HIEs.

### *Accountability, enforcement and oversight*

As with other aspects of the INHS process for HIE, accountability, enforcement and oversight are defined through the contractual framework with participating organizations. Each organization has the responsibility to make sure its employees are trained and are following the required policies and practices. In addition, INHS has a complex security system that allows us to determine if there is inappropriate access to the any health information, and to identify when such access occurred and the individuals involved. We also rely on participating organizations to monitor their employees and to rapidly notify us when employees leave or if there are any concerns regarding inappropriate use of health information. The rigor with which we enforce those policies and maintain the security framework has strengthened the overall sense of trust held by organizations participating in the HIE.

Rather than “establishing governance” ONC should establish a common framework for participation that would form the basis of the certification process described above. HIEs seeking to share information with other HIEs would be vetted as part of the certification process with a review to assure that all of their policies and practices met the minimum requirements. Appropriateness of the exchange of information should be monitored at the participating organization and the HIE level using a combination of policies and technology as described above.

Ideally consumers who seek access to their own information from the HIE would have an electronic personal health record which could receive data from the HIE in the same way that clinical endpoints will receive the data. If the consumer is uncomfortable with an on-line personal health record, the HIE should have a process for copying data from the HIE onto some device such as a CD or flash drive (provided that such devices are encrypted).

Consumer complaints should be investigated as a joint effort by the HIE and by the health care organizations that were part of the complaint. Resolutions to the consumer's complaint should be jointly reported back to the consumer so that the individual knows all affected organizations have responded.

The easiest and most effective discipline for "bad actors" is to cut them off from the HIE. If they are not complying with policies and practices for sharing data, they should not have access to that data. Given the various drivers and incentives that are developing for participation in an HIE, restrictions on access to shared data should encourage the bad actors to rapidly mend their ways.