

Health Information Communication and Data Exchange Taskforce of the State Alliance for e-Health

**Web Conference Call
January 29, 2008**

Agenda

AGENDA	
1:00 PM EST	WELCOME <ul style="list-style-type: none">• <i>Roll Call</i>• <i>December Conference Call Recap</i>
1:10	REVIEW WORK TO DATE ON STATE EMPLOYEE HEALTH PLANS <ul style="list-style-type: none">• <i>NGA staff will recap past discussions on state employee health plans.</i>
1:20	PRESENTATION OF STATE EMPLOYEE HEALTH PLANS PAPER <ul style="list-style-type: none">• <i>Shaun Alfreds, Eric Masters and Jay Himmelstein, UMASS Medical School Center for Health Policy and Research, will present an overview of findings from their interviews conducted with state employee health plan officials and staff members.</i>
1:45	DEVELOP RECOMMENDATIONS FOR STATE EMPLOYEE HEALTH PLANS <ul style="list-style-type: none">• <i>The taskforce will continue the discussion from its November meeting on developing recommendations for state employee health plans.</i>
3:30	REVIEW TASKFORCE WORK <ul style="list-style-type: none">• <i>The taskforce will determine if there are outstanding issues stemming from work to date.</i>
3:55	WRAP-UP AND ADJOURN <ul style="list-style-type: none">• <i>The floor will be open for public input.</i>

Principles

- **Leadership** – opportunities and challenges for publicly funded programs to drive the HIT agenda.
- **Financial and Contributory Responsibility** – appropriate roles and levers of publicly funded health programs to facilitate the development and sustainability of electronic HIE initiatives.
- **Consumer Involvement and Information Sharing** – the extent to which consumers are engaged by publicly funded programs in the decision-making process and development of electronic HIE efforts.
- **Interoperability** – relates to determining the level of technical connectivity between state health agencies with each other and with public/private electronic health information exchanges.
- **Structure of the HIT/HIE Initiative** – relates to determining the level of integration or alignment of publicly funded health programs with each other (e.g. Medicaid and public health) in terms of common policies and procedures for appropriately sharing health data. Assesses the cultural and technological barriers that impede public program participation in electronic HIE efforts.

UMass Work Product: Findings from the State Employee Health Plan Interviews

HICDE Taskforce Meeting – January 29, 2008

Shaun Alfreds, MBA, CPHIT

**University of Massachusetts Medical School – Center for Health
Policy and Research**

Agenda

- Goal and methods of the work product
- Findings from State Employee Health Plan interviews
 - Success factors
 - Key challenges
 - Recommendations to the HICDE Taskforce
- Recommendations from an expert panel on improving collaborations between state agencies
- Next steps

Goal and Methods of the Work Product

- Assist the taskforce in developing succinct actionable recommendations addressing HIT/eHIE for publicly funded programs
- Identified 8 HIT/eHIE initiatives involving state employee health benefit programs
- Interviewed key leadership in 7 states using a semi-structured interview protocol
- Incorporating findings into a final integrated white paper that reviews the key aspects of eHIE initiatives in publicly funded programs

State Employee Health Plans (SEHP) Interviewed

States interviewed:

- California
- Georgia
- Massachusetts
- Minnesota
- North Carolina
- Washington
- Wisconsin

Success Factors for SEHP Use of HIT and eHIE

- Executive-level leadership is an important factor for SEHP quality improvement initiatives involving HIT/eHIE.
 - Leadership from the Governor and the Legislature
- A multi-stakeholder collaborative ehealth governing body was highlighted as an important mechanism for convening and coordinating state-level eHIE.
 - Help mitigate competitive barriers between private vendors, providers, and purchasers;
 - Support community-wide strategies that promote provider adoption and use of HIT;
 - Promote intrastate agency partnerships; and,
 - Allow for the development of state-wide interoperable systems and collaborative quality improvement and transparency initiatives.
- Physician involvement in the development and leadership of HIT/eHIE initiatives was viewed as necessary for building trust in the provider community.
 - By positioning the programs as “physician driven”, the negative perceptions related to government and private interests dictating clinical care guidelines are diminished.

Success Factors for SEHP Use of HIT and eHIE, Cont.

- SEHP involvement with HIT and eHIE was associated with broad health care quality and cost containment initiatives.
 - Clinical performance measurement.
 - Quality improvement programs (e.g., pay for performance).
 - Transparency initiatives (e.g. cost and quality websites).
 - Consumer wellness tools (e.g., personal health records (PHR)).
 - “Carrot only” approaches, where providers are not penalized but supported, has resulted in physician buy-in and support for the quality and performance initiatives.
- SEHPs, due to their large size, have significant purchasing power to support HIT and eHIE related projects.
 - Promote HIT/eHIE use by plans and providers.
 - Encourage vendor plans to report performance related data.
 - Promote interoperability and eHIE between plans.
 - Promote portability of consumer data across plans and providers.
- Joint purchasing strategies between the SEHP, other state agencies (including Medicaid), and outside stakeholders were identified as a successful mechanisms to drive state-wide HIT/HIE adoption and use.

Challenges Identified by SEHPs Regarding eHIE and HIT initiatives

- States are unsure of the national direction regarding HIT and eHIE.
- Quality measurement and reporting functionalities need to be embedded in HIT systems.
- Lack of Medicare participation in HIT/eHIE quality initiatives reduces impact.
- Educating employees (consumers) on the benefits (and realities) of HIT and eHIE.
 - Quality improvement requires consumer behavior change as well.
- Writing RFPs and contracts that address the health informatics needs of state agencies in the future.
- In many states there is a lack of high-speed internet connectivity for rural health care providers.
 - The varying connectivity between urban and rural settings presented challenges related to developing fair practices to hold vendors accountable for acquiring clinical performance data.

Challenges Identified by SEHPs Regarding eHIE and HIT initiatives, Cont.

- Addressing limited provider adoption of HIT/eHIE was an important role for all participating stakeholders, including the SEHPs.
 - There was consensus that SEHPs should not be subsidizing other state program investments in HIT and eHIE.
 - Direct purchasing of hardware and software for providers was not viewed as a fiscal responsibility of the SEHP.
 - Indirect incentives and market-based support for provider investments in HIT were viewed most likely to yield effective and efficient system adoption
- Many SEHP legacy systems are outdated and will require significant upgrades and/or replacement as they participate in eHIE.
 - Some interviewees suggested that state agencies are competing over limited funding streams, thereby impeding collaboration.
- Return on investment (ROI) and sustainability models are either limited or do not address the unique needs and requirements of state agencies.
- Limited funding opportunities present a challenge when considering scalability.

State-Level Recommendations for the HICDE Taskforce

- Governors should support the creation of a collaborative ehealth governing body to convene, facilitate, and direct state-wide eHIE efforts that include the needs of SEHP.
 - Focus efforts on specific collaborative, scalable projects that have a clear benefit to all stakeholders involved. Then, build buy-in for larger-scale initiatives.
- State ehealth governing bodies need to develop ROI studies that demonstrate the value and sustainability of eHIE.
- Governors should work with border states to align state data collection and sharing policies to support interstate data exchange.
- Executive leadership should make eHIE and HIT a priority across all levers of purchasing power for states.
 - Use the contracting process to align agency procurement of standardized systems
 - Remove barriers to interstate data exchange by promoting joint contracting
 - Improve bargaining/regulatory power with HIT vendors
 - Give payment preference to providers who have interoperable EHRs
 - Consider the promotion of “Centers of Excellence.”
 - Consider an EHR mandate.
- Governors and legislatures should support funding mechanisms to address the software, hardware, and connectivity issues common among rural health care practices.

Federal-Level Recommendations for the HICDE Taskforce

- The Department of Health and Human Services (DHHS), the Institute of Medicine, and/or the Surgeon General should review existing performance and quality metrics and promote a standard “minimum set” of quality metrics and evidenced based practice guidelines to be incorporated into nationally supported HIT/eHIE efforts.
- The Department of Health and Human Services should align quality improvement and purchasing strategies involving HIT and eHIE among all federal agencies.
 - There needs to be a clear statement and/or plan from the federal government as to the direction they wish to head in regard to HIT/eHIE. What technologies? What standards? Where is the funding coming from?
 - The Healthy People 2010 was an example of a successful, federally driven initiative that can be used as a model planning process for DHHS and the Office of the National Coordinator for HIT.
 - Medicare must be a full participant in eHIE to achieve a successful national health information infrastructure both from a data and a purchasing perspective.
 - Secretary Leavitt’s ‘Four Cornerstones’ are a good starting point for aligning purchasing priorities
- CMS, ONC, and other federal agencies should provide guidance to states for creating master patient indices that promote interoperability between states

States Participating in the Expert Panel Meeting

States:

- Indiana
- Minnesota
- Nebraska
- New York City
- Rhode Island
- Tennessee
- Vermont
- Washington
- Wisconsin

Recommendations for Facilitating Collaborations Among State Agencies

- Develop strategic principles that the information system will process in a modern way to meet current standards and definitions for interoperability, privacy, and create a framework for coordinating those efforts across agencies
- Designate one person or office whose role is dedicated solely to all issues related to ehealth and provide resources for them to:
 - Align accountability, responsibility, policy, legal issues, and resources for eHIE and HIT across all state agencies
 - Provide vision and strategic leadership
 - Clarify the roles of various state agencies
 - Bring subject matter expertise to the table
 - Develop the action plans and roadmaps
 - Provide guidance to RHIO and other public/private eHIE initiatives
- Cross agency HIT and eHIE efforts must bridge social and clinical services and use purchasing and regulatory power to assure that all IT systems incorporate these functionalities
 - Necessary for administrative and program monitoring
 - Specific social and clinical functionalities need to be incorporated into EHR and other HIT systems supported and purchased by state agencies
- Workforce development and resources are needed for all state agencies to appropriately integrate informatics

Thank You!

For Further Information:

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Taskforce State Employee Health Plans Recommendation Concepts

1. Personal Health Record

A tool to help employees and family members become educated consumers and provide personalized health management (Implemented in Georgia, Washington and New Jersey).

Specifications:

Employees should be educated about the benefits, content, and functions of the PHR.

States should offer PHRs that are portable, to the extent feasible, allowing employees to maintain or move the PHR and/or the data it contains even after employment or coverage ends or changes.

Employees should control who is allowed to access their PHRs.

Employees should choose, without condition, whether to grant access to personal health information within their PHRs for any "secondary uses." An audit trail that shows who has accessed the PHR should be easily available to employees.

State public programs should implement evolving national standards for portable personal/family health history.

2. Electronic Prescribing

A tool to improve quality of care, reduce costs and improve customer satisfaction (Implemented in Hawaii, Maine, Minnesota, Kentucky, and Oregon).

State employee health benefits programs should support requirements for e-prescribing from participating providers. States should aim for full implementation by the end of 2010. Following this date, states should continue to focus on improving medical practice through IT.

Consider this tool to improve quality of care, reduce costs and improve customer satisfaction.

Taskforce Recommendation Concepts (cont.)

3. Purchasing Power	<p>What do states need to do to leverage their purchasing power? Define which publicly funded programs can be leveraged then align public programs (and private sector employers, where and if appropriate) through contracting and/or legislation.</p>
4. Secondary Use	<p>States should aggregate information across their public programs for the purpose of predictive modeling, population health and analysis.</p>
5. Patient Privacy	<p>States have to clearly lay out guidelines regarding use and safeguarding of information on employees contained in health IT systems. Specifications: Strong level of security, a robust authentication process for access, and an audit trail that shows who has accessed information and when.</p>

Taskforce Recommendation Concepts(cont.)

6. Pay for Performance	States should consider programs such as pay-for-performance. In addition, information systems have to begin to be designed with the capability for collecting data on quality.
7. Patient-Centered Medical Home Patient Centered Medical Home is defined as a physician-directed team that coordinates and facilitates care for the patient.	States should consider programs such as the patient-centered medical home to improve population health outcomes, especially for chronic disease.
8. Master Patient Index	Each state should designate an authority to create a master patient index for statewide health information exchange. The master patient index should 1.) Adhere to standards and 2.) Include data from all public programs. The body maintaining the MPI should address 1.) Governance and 2.) Data sharing agreements.

Concepts that appear in other recommendations

- Personal Health Records
- Purchasing Power
- Pay for Performance

Personal Health Records

Could Medicaid Recommendation 6.1, adopted by the State Alliance on 10/3/2007, be aligned with a State employee health plans recommendation, and reading as follows?

M Recommendation 6.1: State Medicaid agencies and **State Employee Health Plans** should ensure portable, private and secure access to personal health information to their enrollees through HIT systems such as personal health records. The State Alliance should encourage states to provide human and financial resources to develop cultural and linguistic competency required to engage diverse Medicaid/SCHIP enrollees.

Recommendation -

<p>Benefits for state employee health plans: Help employees and family members become educated consumers and provide personalized health management (Implemented in Georgia, Washington and New Jersey).</p>	<p>Possible Specifications:</p> <ol style="list-style-type: none">1. Employees should be educated about the benefits, content, and functions of the PHR.2. States should offer PHRs that are portable, to the extent feasible, allowing employees to maintain or move the PHR and/or the data it contains even after employment or coverage ends or changes.3. Employees should control who is allowed to access their PHRs.4. Employees should choose, without condition, whether to grant access to personal health information within their PHRs for any "secondary uses." An audit trail that shows who has accessed the PHR should be easily available to employees.5. State public programs should implement evolving national standards for portable personal/family health history.
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Purchasing Power

Purchasing Power: Could Medicaid Recommendation 6.0 be aligned with a State employee health plans recommendation, reading as follows?

- M Recommendation 6.0: State Medicaid agencies **and State Employee Health Plans** implementing electronic health record systems, should implement a standards-based personal health record function that is portable and includes appropriate privacy and other consumer protections. When available, state Medicaid programs should require use of certified electronic health records and networks with standards-based information exchange capabilities. (10/3/2007)

Recommendation -

Background:

- What do states need to do to leverage their purchasing power?
- Define which publicly funded programs can be leveraged then align public programs (and private sector employers, where and if appropriate) through contracting and/or legislation.

Pay for Performance

Pay-for Performance: Could Medicaid Recommendation 7.0 be re-framed to address the view of State employee health plans, which is similar to those expressed by Medicaid agencies?

- M Recommendation 7.0: State Medicaid agencies should implement incentive programs and, or reimbursement policies such as pay for participation, rate adjustment, case management, and quality pay for performance that will encourage provider adoption and use of HIT systems and participation in electronic HIE.

Recommendation –

Background:

- States should consider programs such as pay-for-performance.
- In addition, information systems have to begin to be designed with the capability for collecting data on quality.

Additional concepts discussed by the Taskforce

- Electronic prescribing
- Secondary use
- Patient Privacy
- Patient-centered medical home
- Master Patient Index

Electronic prescribing

<p>Benefits for state employee health plans: Improve quality of care, reduce costs and improve customer satisfaction (Implemented in Hawaii, Maine, Minnesota, Kentucky, and Oregon).</p>	<p>Working Language: State employee health benefits programs should support requirements for e-prescribing from participating providers. States should aim for full implementation by the end of 2010. Following this date, states should continue to focus on improving medical practice through IT. Consider this tool to improve quality of care, reduce costs and improve customer satisfaction.</p>
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Recommendation -

Secondary use

Recommendation –

Background:

States should aggregate information across their public programs for the purpose of predictive modeling, population health and analysis.

Patient Privacy

Recommendation –

Background:

States have to clearly lay out guidelines regarding use and safeguarding of information on employees contained in health IT systems.

Specifications:

Strong level of security, a robust authentication process for access, and an audit trail that shows who has accessed information and when.

Patient-centered medical home

Recommendation –

Background:

Patient Centered Medical Home is defined as a physician-directed team that coordinates and facilitates care for the patient.

States should consider programs such as the patient-centered medical home to improve population health outcomes, especially for chronic disease.

Master Patient Index

Recommendation –

Background:

Each state should designate an authority to create a master patient index for statewide health information exchange. The master patient index should 1.) Adhere to standards and 2.) Include data from all public programs. The body maintaining the MPI should address 1.) Governance and 2.) Data sharing agreements.

Other recommendation concepts that could be aligned with State Employee Health Plans

- Financing
- Standards
- Health IT Workforce
- Consumer engagement

Taskforce Considerations, State Employee Health Plans (cont.)

4. **Financing: Could Public Health Recommendation 2.0 align with a State Employee health plans recommendation, reading as follows?**

- PH Recommendation 2.0: Governors and state legislators should align to establish flexible financing mechanisms (e.g. pooling funds across relevant state agencies, bridge funding between federally-funded programs) across public agencies and within state jurisdictional boundaries to develop and support electronic HIE and ensure that state data partners (e.g. Medicaid, public health, **State Employee Benefit Plans**) can operationally and financially sustain electronic health information exchange for the purposes of it being a necessary public benefit and utility to improve public health and healthcare value to all state residents. *(TF adopted 12/14/2007, not yet adopted by the State Alliance)*

5. **Standards: Could Public Health Recommendation 8.0, Medicaid Recommendation 6.0 and findings related to state employee health plans be aligned?**

- PH Recommendation 8.0: The State Alliance should support the requirement that public health systems adhere to HITSP standards as recognized by the Secretary of HHS that supports standards-based clinical documentation, messaging and laboratory reporting. *(TF adopted 12/14/2007, not yet adopted by the State Alliance)*
- M Recommendation 6.0: State Medicaid agencies implementing electronic health record systems in the Medicaid program, should implement a standards-based personal health record function that is portable and includes appropriate privacy and other consumer protections. When available, state Medicaid programs should require use of certified electronic health records and networks with standards-based information exchange capabilities. *(10/3/2007)*

Taskforce Considerations, State Employee Health Plans (cont.)

6. **Health IT/Informatics Workforce: Could Medicaid Recommendation 5.0, Public Health Recommendation 1.0 and findings related to State Employee Health Plans be aligned?**

- M Recommendation 5.0: To successfully implement HIT and eHIE initiatives and to adopt MITA, state Medicaid agencies will require new technology, project management, policy, legal, consumer protection and programmatic competency development. Therefore, states should fund greater development of technical assistance resources for state Medicaid/SCHIP and information technology agencies to build workforce competency for eHIE. *(10/3/2007)*
- PH Recommendation 1.0: Governors must provide resources (e.g., funding made available in state budgets) to public health agencies under state jurisdiction to support their ability to secure staff experienced and educated in public health informatics and train their existing workforce to develop leadership and maintain competency in this area. As staff expertise is being developed states should consider multi-state collaboration (e.g., networking and sharing expertise) to increase workforce capacity. *(TF adopted 12/14/2007, not yet adopted by the State Alliance)*

7. **Consumer engagement: Could Public Health Recommendation 3.0 align with a State Employee health plans recommendation?**

- PH Recommendation 3.0: The State Alliance should recommend that state public health departments expand their mission to engage consumers and promote the benefits of health information technology and health information exchange. Public Health should avail itself the opportunity that EHRs provide and connect with providers and assist them in pushing consumer-specific information and health education. Public health should enable direct consumer access to personal health information databases that they operate (e.g., immunization registries, newborn screening, lead testing programs). As a participant in e-Health activities, public health also should provide resources to build health literacy and ensure cultural and linguistic appropriateness. *(TF adopted 1/9/2008, not yet adopted by the State Alliance)*

Recommendations that could convey cross-agency perspective

- **This already appears in the taskforce's recommendations on a single health IT authority, issuing an executive order or legislation and developing a roadmap.**
- **It also could be conveyed in the recommendations on health IT/informatics workforce, systems functionalities and health IT adoption.**

Taskforce Considerations, Cross-agency

8. Health IT/Informatics Workforce, continued: Public Health Recommendation 1.1 also aligns with Medicaid Recommendation 5.0.

- PH Recommendation 1.1: Governors must provide resources and seek outside expertise to support the development of executive leadership and programmatic management in the areas of public health informatics, change management, project management, HIT provider and consumer communication, outreach and involvement, vendor management, and systems thinking competencies. *(TF adopted 12/14/2007, not yet adopted by the State Alliance)*
- M Recommendation 5.0: To successfully implement HIT and eHIE initiatives and to adopt MITA, state Medicaid agencies will require new technology, project management, policy, legal, consumer protection and programmatic competency development. Therefore, states should fund greater development of technical assistance resources for state Medicaid/SCHIP and information technology agencies to build workforce competency for eHIE. *(10/3/2007)*

9. System Functionalities: Could Public Health Recommendation 7.0 incorporate the priorities of other agencies, such as quality measurement and reporting functionality needs of state employee health plans?

- PH Recommendation 7.0: All electronic health records systems supported by state funding must have public health functionalities to support objectives for bi-directional exchange of data across clinical care and public health. Upon purchasing or upgrading publicly purchased health information systems, states should establish a specific plan for continuing maintenance and staffing. *(TF adopted 1/9/2008, not yet adopted by the State Alliance)*

Taskforce Considerations, Cross-agency (cont.)

10. Health IT Adoption: Could Medicaid Recommendation 6.1, Public Health Recommendation 6.0 and the considerations around health IT adoption amongst state employee health plans be aligned?

- M Recommendation 6.0: State Medicaid agencies implementing electronic health record systems in the Medicaid program, should implement a standards-based personal health record function that is portable and includes appropriate privacy and other consumer protections. When available, state Medicaid programs should require use of certified electronic health records and networks with standards-based information exchange capabilities. *(10/3/2007)*
- PH Recommendation 6.0: Governors should ensure that in the planning and collaboration around health information exchange that every child must have a patient-centered electronic health record that is transferable to other providers and accessible to individuals by 2014. At a minimum, the record should include guardianship information, newborn screening, family history, growth, immunization, birth history, problem lists, medications, and allergy data. *(TF adopted 12/14/2007, not yet adopted by the State Alliance)*