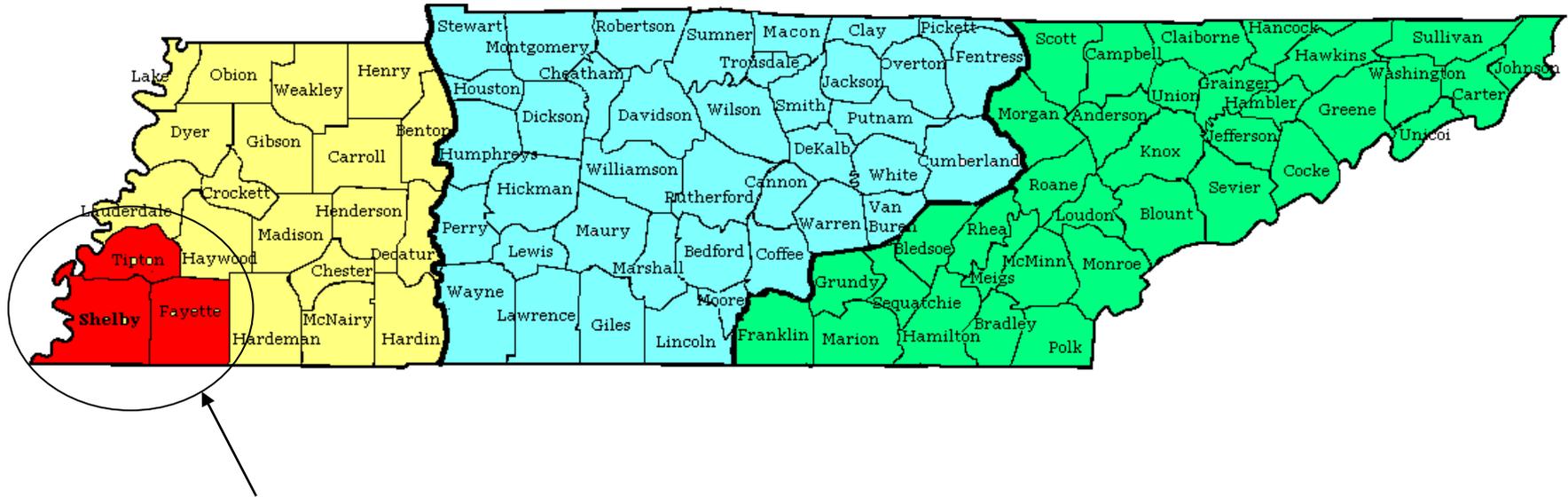




***Creating an Environment of
Consensus – The challenges
of implementing a
governance structure to run
an HIE***



Where are we talking about?



All parties recognize that health care is regional and that a significant number of individuals seeking care in Tennessee are residents of one of the 8 bordering states

Note – There are other regional initiatives and state-wide HIT initiatives funded by HHS, AHRQ and HRSA in the state

Summary of Project

Funding Sources

September 21, 2004, Tennessee received a 5 year contract/grant from Agency for Healthcare Research and Quality (AHRQ) - total award is \$4.8 million

State of Tennessee provided additional funds in the amount of \$7.2 million for the same 5 year period

MidSouth eHealth Alliance will receive additional funding from the state to fund operations (e.g. Executive Director and local support staff)

Vanderbilt's Role

“Donated” the use of its technology for the project

Serves the functions of Project Management Office and Health Information Service Provider

Responsible for compliance with the AHRQ contract

Also supports as requested other HIT activities across the state at a planning level

Initial Participating Organizations

- Baptist Memorial Health Care Corporation – 4 facilities
- Methodist - Le Bonheur Children's Hospital
- Methodist University Hospital
- The Regional Medical Center (The MED)
- Saint Francis Hospital & St. Francis Bartlett
- St. Jude Children's Research Hospital
- Shelby County/Health Loop Clinics (11 primary care clinics)
- UT Medical Group (200+ clinicians)
- Christ Community – (3 clinics and 1 mobile unit)
- Memphis Managed Care-TLC (MCO)



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Where and How We Started

- Our state and specifically Governor Phil Bredesen considered HIT as one way to help with our TennCare (TN Medicaid) crisis
 - February 2004 Governor Phil Bredesen in his State of TennCare address to the legislature discussed the urgent need to reform TennCare. As one example of reform he introduced the idea of Health Information Technology (HIT) applied in the Memphis region
 - June 2004 the state and Vanderbilt apply for an Agency for Healthcare Research and Quality (AHRQ) State Regional Demonstration (SRD) contract
 - July 2004 the Governor announced the Volunteer eHealth Initiative as a 6 month planning initiative to determine the value of HIT for the state
 - August 2004 an planning initiative that is 80% focused on SW Tennessee (Shelby, Fayette, and Tipton Counties) and 20% on the rest of the state. Planning effort was funded by the state.
 - Tennessee was one of five states to receive a 5 year contract/grant from ARHQ on September 21, 2004. Planning effort was refocused to approximately 95% Memphis and 5% rest of the state



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Initial Challenges

- **Community History – pre August 2004**
 - Memphis is a highly competitive health care market
 - History of excellence within systems but no community based sharing
 - One failed attempt at CHMIS – Community Health Management Information System lead by a local business coalition and funded by a Robert Wood Johnson grant
 - History of data sharing within hospital systems only
- **August 2004 – what the participants were saying**
 - Why are we here? The governor said “planning” not implementation.
 - What is Vanderbilt doing here? Don’t they know the difference between Nashville and Memphis?
 - What or who is AHRQ?
 - We will only meet on “neutral ground” – meetings cannot be held at individual organizations



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Why organizations participated initially

- The governor personally requested their participation
 - Someone from the governor's office participated in every CEO/Leadership meeting and many of the work group meetings.
- No one was excluded from participating – all meetings were open
 - We included community leaders, business leaders, other related organizations focused on the health of the community
- Know one wanted to be left out – just in case
 - We had broad participation as a result
 - Worked in our favor towards establishing relationships
- Real work was getting done
 - Work groups meet at least once a month
- Funding from the state and AHRQ plus access to technology through Vanderbilt
- Planning was demonstrating what everyone already knew:
 - Memphis sees a majority of the State's TennCare patients plus heavy MS and AR Medicaid and high levels of charity patients
 - Very active emergency rooms – with a number of patients visiting multiple emergency departments for care
 - The health of the community was not one provider's issue or problem – it was a part of all providers' missions to improve



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Turning point for the project

- November 2004 Vanderbilt Center for Better Health conducted a DesignShop in Memphis to facilitate the planning effort
 - No one was excluded from participating
 - Day 1 was focused on the vision and working with organizations to understand how all connected to the vision
- Created on Day 2 an ad hoc work group called Governance
 - Anyone who wanted to participate was welcome – we did not restrict this to the CEO/Leadership Work Group
 - Governor put on the table the ability to stop now and give the money back
 - About 15 people came to the break out session that last about six hours
 - Wrestled with the issues and presented to the larger group (about 70 people) a list of considerations and recommendations
 - First recommendation to the larger group – Memphis needed to take ownership of the project. The larger group agreed.
 - Governance principles were created and circulated

General Governance Considerations for a Regional Data Exchange

- Start with a leadership group of organizations who desire to participate in the regional data exchange
 - Facilitate dialogue regarding the governance structure – what do they want from the regional data exchange?
- Assuming a 501(c)3 corporation is the preferred way to organize:
 - Form a governing board to oversee operations. Someone or a sub-committee proposes a slate for the larger group to agree or disagree with
 - Keep membership to 9 – 12 members for effective decision making
 - Determine how will votes be allocated
- Who will be responsible for the governance set-up and operations?
- Because board is limited in size and probably will not capture all of the needs and issues for all stakeholders, an advisory board is recommended to represent the employers, payers and healthcare community and report to the governing board. Over time expect the board to include stakeholders that were previously represented on the advisory board
- A sustainable model for the regional data exchange is needed – what is the board's timeline for accomplishing this?
- Bylaws are necessary to address how the boards are appointed, managed and linked
 - If 501c(3) is desired, work with attorney to draft these
 - If no 501c(3), decide best way to get these done through a sub-committee
- Identify guiding principles and structure to describe how the board will work together
 - How often to meet? Standard date and time (e.g. 2nd Monday of the month)
 - Meeting locations?
 - Who will coordinate agendas and document meeting minutes?
 - What constitutes a quorum and how will decisions be made (i.e. consensus, majority vote, combination, etc.)?
 - Can members send surrogates? Can surrogates vote?

To support the implementation and future sustainability of the regional information exchange, the Memphis Executives identified considerations for a RHIO governance structure

Governance Considerations

- A 501(c)3 corporation is preferred for the Memphis RHIO
- A full-time Memphis Executive Director is recommended for the RHIO to be successful; the position is responsible for the RHIO governance set-up and operations
- A governing board is necessary for overseeing operations
- An advisory board is recommended to represent the Memphis healthcare community and report to the governing board
- A sustainable model for the RHIO is needed; this work could be targeted for year two
- Initial board representation is recommended to be based on:
 - Applying the 80/20 rule and selecting physicians and payors that represent a larger population base
 - Ensuring participation from day one through the end of the AHRQ contract term
 - Including representation from those entities that will be critical to keeping the momentum and being successful
 - Limiting the initial focus of the RHIO to Emergency Departments; as this focus changes over the years, the types of physicians represented could possibly change
- Bylaws are necessary to address how the boards are appointed, managed and linked
- Meetings will be held once a month – with other work done in sub-committees appointed by the board.
- Members may send surrogates to board meetings but surrogates may NOT vote.

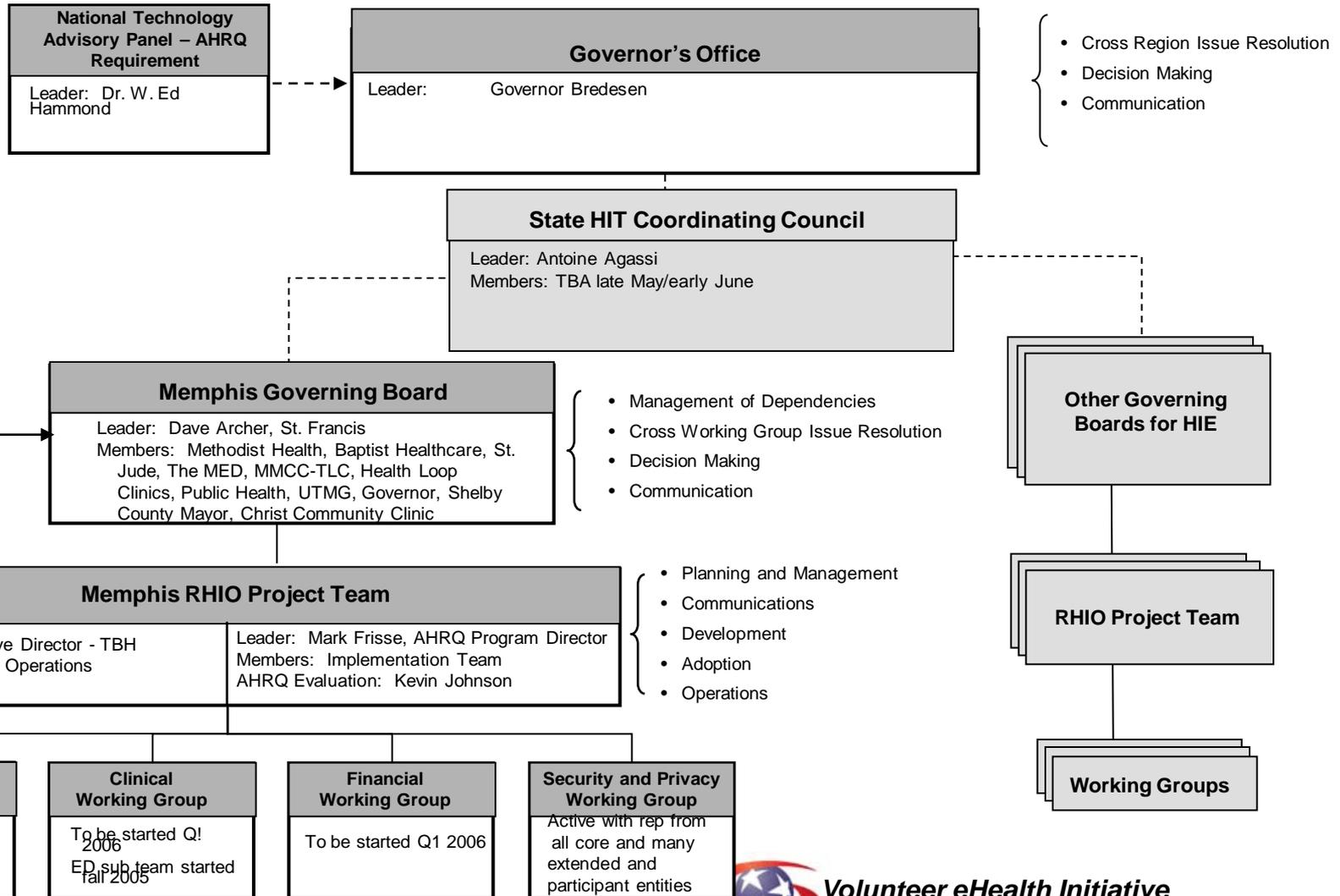


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The proposed governance structure provides a working model to establish the Memphis RHIO and a blueprint for other regions

Structure



January 31, 2005 – Planning effort is over

- Plan for implementation of an HIE was approved by all the work groups including the CEO/Leadership Work Group
 - Delivered to the state on January 28, 2005
- State agreed that Memphis should own the process and the project
- The state presented a slate of officers and a structure (based upon the “Considerations” to the CEO/Leadership Work Group
 - Work Group came back with some slight modifications and officers were elected
- Memorandum of Understanding and Business Associate Agreements were signed to start the project and allow Vanderbilt to start working with the data
- First board meeting was February 23, 2005

Now that we have “it” what do we do with “it”?

- Bob Gordon, EVP/CAO for Baptist Memorial Healthcare Corporation and Board Chairman, at the first meeting proposed the following principles and they were adopted
 - Must have the right people at the table with authority to commit
 - Must have the right motivation – the purpose of this RHIO is to improve patient care
 - Must be non-proprietary – truly a collaborative agenda
 - Everything done in the open and above board. No hidden agendas
 - Must provide value to those who participate
 - This (HIE/RHIO) will be happen. We can *lead, follow, or get out of the way*
 - Data is shared but never relinquished. Ownership of the data stays with the one who brings it to the table
 - The rules of who has access to the data is set by the owners of the data and managed by the RHIO
 - Technology is merely a means to the end
 - Technology is an evolving enabler not the ultimate objective

Now that we have “it” what do we do with “it”?

- Board adopted the name MidSouth eHealth Alliance and created a logo
- Board and community focused on “start up issues”
 - Identify and hire counsel
 - Incorporation
 - Application for not-for-profit status
 - Develop policies and procedure
 - Funding
 - Resources
 - Etc.
- Work groups were refocused from planning to detail design and implementation
- Work groups wrestled with the tough issues, educated the board and the board worked through them as well.

Where we are today...

- **State of Tennessee**
 - Convening a statewide HIT coordinating council to address issues such as privacy, legal, interoperability and standards, and sustainable business models
 - Council will be appointed through an executive order
 - Council will begin meeting in second quarter of 2006
- **MidSouth eHealth Alliance**
 - Board celebrated one year anniversary in February
 - Formally incorporated in August 2005
 - Granted not-for-profit status (501 (c) (3)) by the IRS on March 8, 2006
 - Once funding is secured from the state, will recruit for an Executive Director
- **Had first initial use in one test Emergency Department at the Regional Medical Center (The MED) on May 23rd**
 - ED is principal focus for early efforts because it presents a financial return to participating hospitals. It is also a state-wide priority
 - ED will be used to pilot technology approaches but is not a “final product” for the data exchange
 - Have 11 production data feeds and 2 test data feeds
 - *Data is housed at Vanderbilt and pushed via VPN connection. Most is real time; 4 feeds are batched every 24 hours*
 - *Will bring on 4 additional Emergency Departments over the summer and fall of 2006*
 - *Will bring on the remaining Emergency Departments (8) through the end of 2006 and first quarter 2007*



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Where we are today...

- Work groups are active and focused on implementation for initial use and beyond
 - Privacy and Security
 - *Drafted and facilitated signature of a Regional Data Exchange agreement. (Started this process in November 2005)*
 - *Defined and developed policy and procedures for initial use*
 - *Now reviewing and revising with an eye towards broader application of use (beyond the ED)*
 - Technical
 - *Increasing the number of production data feeds as well as the amount of data being sent*
 - *QA of production data*
 - Financial
 - *Focused on Sustainability Business Model*
 - *Linking efforts with the Evaluation Team*
 - Clinical
 - *Giving feedback on web browser interface to reflect the needs of a regional data exchange effort in the Memphis community*
 - *Identifying the next area of focus after the Emergency Department*



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Lessons Learned...

- **Communicate, communicate and just when you are sick of it, communicate again**
 - Always assume you were not heard or understood the first 3 times you communicated the message
 - This stuff is new and requires people to think about their community and how care is provided in a new way
- **Be willing to start small and grow big**
- **Start where the energy is**
- **Have a vendor management strategy**
- **I already knew this but...**
 - Collaboration and trust are not built overnight but can be achieved when the parties are willing to work together and take ownership in the process
 - Don't discount the naysayer – listen
 - Don't short cut the process by eliminating the planning but be willing to jump into implementation too.
 - It is very easy to talk about what the technology can and should do but actually making it work is a different story
- **Do not underestimate the security, privacy and legal issues!**
 - Be prepared to address what the law says and what the community wants to do. The Memphis community started with legal advice but felt strongly some of the privacy issues boiled down to ethics not law.
 - Budget for legal fees
- **There may not be an answer to the question**

Questions?

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