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Real Solutions for RHIO Problems

Pioneering data exchange groups seek sustainability by solving business problems for members.

David Rath

Rich Temple is like many healthcare executives contemplating the startup of a regional health information organization: With so many issues to tackle, he's not sure where to begin.

The CIO at St. Clare's Hospital, Denville, N.J., sits on the EHR/EMR committee of the New Jersey Hospital Association, which is taking a leadership role in launching a statewide RHIO. "Everything is moving so fast, we don't know when to jump in," Temple says. "It's pretty daunting."

Some NJHA members, although eager to participate, are afraid that any work they do now will be made obsolete as federal data standards evolve. But funding issues pose even bigger obstacles than technical questions about creating patient indexes. Temple says payers stand to gain the most benefit from RHIOs, yet hospitals seem to be picking up the lion's share of the cost. And although the committee members have looked at grants to fund their startup, they would like to develop a sustainable model from the beginning.

"We want to do it without having to go back and grovel for money every year," Temple says.

First movers, lessons learned

For projects in the startup phase, some help has arrived. Veterans of the very few efforts that have actually started exchanging clinical data are beginning to relate war stories about their early struggles.

The New York-based organization Connecting for Health, sponsored by the Markle Foundation and the Robert Wood Johnson Foundation, in April released what it calls a "Common Framework" of technical and policy structures demonstrated to work in projects in Massachusetts, Indiana and California.

Carol Diamond, M.D., chair of Connecting for Health, says the framework is "technology agnostic" and gives startup RHIOs issues to consider before they sit down to negotiate with other stakeholders. "People have told me that it saves them an enormous amount of time and money by helping them realize, up front, some of the key issues that need to be addressed regarding things such as contract language," she says.

Even the most advanced RHIOs are still working on their business models, says Diamond, who is also managing director of the Markle Foundation's health program. The difficulty of establishing sustainable funding "is not just a RHIO issue," she stresses. "It's a larger issue of how to support information exchange and quality improvements given the constraints of the current reimbursement model."

Educational efforts such as Connecting for Health and the eHealth Initiative's (Washington, D.C.) Connecting Communities Toolkit can "make a prospective RHIO seem more feasible," says Michael Matthews, CEO of MedVirginia, Richmond, Va.

His RHIO went live with a clinical messaging system in January 2006 after several years in development. It now has 342,000 patients in its database and is recording 1 million transactions per month with 14 different physician groups. To advise other groups, it has created a "RHIO Lab" that

takes prospective project leaders through its business model, governance structure and a technology demonstration.

Playing to their own strengths

Although the assistance of RHIO veterans may condense the learning curve, those entering the fray say that each RHIO must be tailored to the specific characteristics of its local market. "RHIOs need to innovate locally," says Lori Evans, managing director of Manatt Health Solutions and acting CEO of the Taconic Health Information Network and Community (THINC) RHIO in upstate New York. "There's never going to be a one-size-fits-all model that's going to work across the country," she says.

RHIOs should use community resources and grants to help pay for the development phase, while looking to deliver value that people will pay for in the operational phase, Evans says.

The Taconic Independent Practice Association, in Fishkill, N.Y., an organization with 2,300 practitioners, led the partnership that created the nonprofit THINC. Drawing on its strong ties to local physicians, THINC has focused on getting doctors to use interoperable EHRs for a monthly fee and insurers and employers to reward physicians for improved quality.

"Pay for performance has to kick in to subsidize the physician contribution," says Evans, who sees one of her challenges as continuing to ease the tension that exists between payers and providers in the group.

MedVirginia was also built on the foundation of an already strong relationship with providers. It's an offshoot of a partnership called CenVaNet, which was created by 10 hospitals and 1,000 physicians to work on managed care contracts and chronic disease management.

"It would be so challenging to have to knock on the door of every data supplier and physician group trying to build trust," Matthews says. "The fact that we already had a track record with them made all the difference."

MA-SHARE, the statewide RHIO in Massachusetts, rolled out a statewide e-prescription gateway in June 2006. It gets member organizations to invest upfront by making in-kind donations and paying yearly subscription fees.

"You have to appeal to people's enlightened self-interest," says John Halamka, M.D., MA-SHARE's CEO. "You have to solve proprietary business problems for them using the RHIO. We ask hospitals, 'Would you pay \$50,000 to solve your e-prescription issues?'"

Halamka says MA-SHARE is making steady progress toward sustainability. "2005 was the year of the handout, 2006 is the year of the grant and 2007 will be the year of business sustainability," he says, adding that next year more than 50 percent of its revenue will be from subscription fees.

Looking Stateside

If most local RHIO efforts are still in the development stage, what's happening at the state level?

A May 2006 report produced by Avalere Health LLC found that although states can play a vital role and some have made impressive gains, many characterizations of progress have been overstated and few projects are yet exchanging clinical data.

Funded by the federal Agency for Healthcare Research and Quality, Washington, D.C.-based Avalere's report also found states that have been at it the longest, such as North Carolina and Utah, have made the most progress. Smaller states such as Hawaii and Rhode Island also have an advantage because

there are fewer stakeholders to round up and they have experience doing statewide health projects.

The report notes that states are also grappling with the idea of using RHIOs to measure quality.

"There is this tension about how front and center states want to be that they're interested in using this to evaluate the quality of care," says Shannah Koss, vice president of Avalere Health and co-author of the report. "Many physicians hear the word measurement and think it's going to be used to penalize them. So some states have taken the quality issues off the table for the time being and are just focused on getting the technology in place and used."

Marc Overhage, M.D., credits the success of the Indiana Health Information Exchange (IHIE) in part to the enlightened leadership of member organizations.

A stumbling block for many RHIOs is a lack of trust. "People think someone is going to take their data and do something bad with it," says Overhage, IHIE's CEO. "But with the right leaders, you can get past that. You can convince them that if we do it right, we're going to see improvements in patient care and safety."

Indianapolis-based IHIE handles more than 30,000 clinical messages a day and 3,200 physicians are using it.

No one left behind

Some leaders in health IT adoption are leveraging their expertise to engage smaller organizations in health information exchange. Geisinger Health System in northeast Pennsylvania wants to move gradually toward regional integrated data access, and that means bringing along small, rural hospitals with fewer resources.

Geisinger, which has had an EHR since 2002, is involved in a data exchange pilot project with two local hospitals outside the Geisinger system. The plan is to expand to a larger geographic area of five to six counties. The RHIO is creating a governance scheme involving eight organizations.

The project, which has 2.7 million patients in a master patient index, will exchange laboratory results, pathology reports and discharge summaries.

"These smaller hospitals don't have the money or the IT teams to focus on projects like this," says Jim Walker, Geisinger's chief medical information officer. "But I'm convinced that for health information technology to advance, we've got to find ways for robust organizations to share with the smaller ones or it will never work."

When RHIO project leaders express frustration about the difficulty of organizing, financing troubles or the slow pace of change, Diamond encourages them to take the long view. "Health information exchange is not a destination, it's an ongoing process that's essential for our healthcare system," she says. "It's going to take sustained focus and energy, and we've got a long journey ahead of us."

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