

	<p>THSA HIE Planning Engagement Meeting Agenda</p>
	<p>Meeting Name: Governance and Finance Work Group Date: 6/30/2010 Time: 9:00 am - 10:30 am CDT Location: Webinar Webinar: https://www2.gotomeeting.com/register/734848739 Conference call: 888-276-8689, access code 5273822</p>

In Attendance:					
Troy Alexander	X	Hank Fanberg	X	Jason Phipps	X
Jonathan Andrews	X	Tony Gilman	X	William Riipi	X
Susan Blue	X	John Haines	X	James Rodriguez	
Nick Bonvino	X	John Harris	X	Bill Sage	
Chrissy Borskey		Cindy Hielscher	X	Thomas Salas	
Bill Burge		Velma Jackman		Yvonne Sanchez	X
Shannon Calhoun		Jenifer Jarriel		Anna Sicher	X
Leslie Carruth	X	Kristen Jenkins	X	Tim Tindle	X
Kathleen Costello	X	John Joe		Brad Tucker	X
Theresa Cruz		Faraz Khan	X	Karen Van Wagner	X
Ray Davis		John Law	X	Belinda Wiegand	
Donna Deeb	X	Cheryl Mason	X	Carolyn Witherspoon	
John Delaney	X	Tomas Matthews		Leslie Wolfe	
Beverly Dowling		Jeana O'Brien		Patricia Young-Brown	X
Kimberly Dunn					

Agenda

#	Item Name	Item Owner
1	Introductions and meeting objectives	Bob Hoover
2	<p>Governance and Finance Work Group Status</p> <ul style="list-style-type: none"> ■ HIE definition ■ Implementation priorities ■ Review of project status – see slides. 	Bob Hoover
3	<p>Discuss overall project status and implications on Governance and Finance</p> <ul style="list-style-type: none"> ■ Presented to THSA board on June 24. This privacy framework was presented: top down and bottom up. Leverage what we do at local level to coordinate activities across state. ■ Environmental scan – still following up with non-respondents 	Bob Hoover
	<p>Review existing Sustainability Models</p> <ul style="list-style-type: none"> ■ Value cycle – HIEs provide value depending on data they have access to. If I have more data, I have more value. But data without capabilities doesn't drive adoption. □ Critical mass of adoption drives sustainable value. 	Bob Hoover

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	<p>□ To ask for fees before value – no revenue.</p> <ul style="list-style-type: none"> ■ Tim Tindle: Is value clinical as well as financial? Bob: Values are both. Tim Tindle: HIE problem is that large providers have data, but value financially is to payer. This is underlying issues for HIEs. Bob: Value viewed differently by different constituents; model must try to distribute cost equitably. ■ Dr. Blue: Need to get physicians to buy into this. Need big groups to buy in, value could be to make things easier for physicians dealing with multiple hospital systems, multiple logins. Don't want another login for the HIE. Could add value by assisting with this situation. Bob: Need to make simple for doctors to adopt, e.g., single path to data. ■ Slide 13: Data sources at bottom of pyramid and uses on top. When get critical mass of providers adopting, get value. There is a migration. Day 1 we won't have value that people are willing to pay for. Need to identify priorities for HIE services so can migrate to sustainable model that has value that people willing to pay for. ■ ONC talks about short term approach as a transition to implement services that have value to get to the point of an ongoing revenue stream. Transition period works toward critical mass of adoption. ■ Ann Kitchen: Care coordination often goes hand in hand with provider adoption. Bob: EMR to EMR referral drives provider adoption. ■ Troy Alexander: Where to include emergency preparedness? Bob: Would include this as well. ■ Bob: It's not about making a profit, it's about sustaining operations. Need to create funding streams to sustain existing operations and create new ones. E.g. in New York there are 10-12 HIEs, and each had different genesis. At state level, have principles to drive sustainability. But market differences drove each HIE. ■ Sustainable operations depend on perceived value. Future will have better opportunities to measure results. And values may change. ■ Tim Tindle: Economic disconnect between stakeholders and beneficiaries. Easy to agree at high level. Dr. Blue: It will be a struggle to balance providers who can benefit and payers who can really benefit. This will be ongoing struggle. ■ Bob: Constituents will benefit from technology at varying levels. Difficulty is in how we actually do this. ■ Nick Bonvino: Do we have participation of purchasers of health care? Darren from THSA Board is putting us in contact with them. Bob will have follow-up conversations. ■ Shannon Calhoun: Is sustainability for state plan or for model which all HIEs will adopt? Bob: We are responsible for building plan for sustainability of THSA and for individual HIEs that are to be recognized for potential funding. But we can not dictate plan for the HIEs. Tony: We have \$27.8M and we know it's not enough to fully integrate state. So we are developing plan to support operations at state level and capacity building at local/regional level. ■ Sustainability; Lots of plans are being published. We are reviewing other plans accepted by ONC. We have seen suggested savings according to slide 15. ■ Ann Kitchen: Have seen improved ER usage and length of stay. Value really adds up for certain populations. ■ Gary Kerl: Vendors gave us good slide for benefits during vendor presentation 6/29. Others are emailing sustainability examples. ■ Benefit: impact premium trend. If employer self-insured, employer sees value. ■ Providers #1 benefit: send EMR data to other providers and receive back. ■ If any one wants to add other benefits, please email Bob with specifics of benefits to add to sustainability model. ■ Sustainability at local/ regional level is important because will fail unless value to all. 	

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	<ul style="list-style-type: none"> ■ Financing principles – slide 18+ ■ Feedback requested for principles listed in slides 19 – 22. ■ Board members don't see this being funded by one group. Funding levels could vary by groups. Funding will vary by value received. ■ Tim Tindle: It will be interesting - the devil is in the details. And getting constituents to agree. ■ Ann Kitchen: Detail issue: Sharing of mental health data has huge value. It is type of data in addition to amount of data. Especially medication and mental health data. Bob: We need to go after high value opportunities first for our implementation priorities. Need critical mass of value that drives adoption. ■ Dr. Blue: Change “consumer” to “patient.” Split employers from patients because needs are different. E.g. MS patient won't take medication because spouse will lose job with self-insured company. ■ Provider costs will be kept at a minimum. We want to minimize cost to providers to drive adoption (practicing physicians, not hospitals). Consider multiple fees e.g. EHR vendor fee, HIE fee, etc. Consider total costs across healthcare eco-system. ■ Need to fund ongoing investments to enhance services and provide ongoing services. ■ Working on what services will provide at state level. One potential approach at state level is membership dues – could be HIEs or data sources. Could fund ongoing THSA services. Comments? Tim Tindle: Technical solution will drive costs. E.g. central repository vs. peer to peer have different cost structures and value. When I use structure, do I get info out of it? Puts onus on THSA to provide value e.g. if hit rates are low, won't succeed. ■ Transaction fee – works if see value. ■ Dr. Blue: If individual providers could get tax credit for fees paid, the state would still save money. Would need legislation. Bob: At federal level, incentives created for Medicare and Medicaid for EHR adoption. Further dialogue to do at state. ■ Bob: Conversations with payers – they understand the value to members and they will participate in funding but want to ensure cost is shared and commensurate with value. E.g. VT state took full responsibility. ■ Slide 24: Peer to peer model doesn't work with existing technology. Tim Tindle: Totally disagrees. Bob: May work in future, but no community in U.S. is using based on readiness of community to do. Tim Tindle: Currently working with 13 organizations to do almost complete exchange of medical data real time. Bob: EPIC may be doing but other EHR vendors not ready to fully implement. So have transition to implement to ideal model. May exist in future. Today not fully deployed. Individual providers can't manage technology within their practice. Need HIE to manage it for them. Hank Fanberg: Strongly disagrees. Email is point to point connectivity. NHIN based on point to point connectivity. Tim Tindle: Enormous plethora of standards with XML documents. Requires centralized directory. Mimics manual processes today. Want more effort to investigate this opportunity. ■ Bob: Wants to identify benefits. There is a reality of what is in the field and working today. E.g. doctors in rural areas. Want picture on left to be simpler for each EHR. ■ Man: Easier to connect to one HIE than each provider. More efficient to create value. ■ Man: How do you pay for it? Can use THSA as gateway. ■ Bob: Focus on value to individual provider. Leave architecture discussion to Technology Infrastructure Work Group. ■ Other state plans: <ul style="list-style-type: none"> □ MN: Will issue certificates of authority to HIEs. Will establish uniform rates for services at state model. Plan accepted. Spoke to principles and timing but didn't delineate specific model. □ CA: Doing without federal, state or grant funding. Didn't dictate to individual 	

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	<p>HIEs.</p> <ul style="list-style-type: none"> ❑ MD: Added \$10M to pool from payer rates. Subscription fees for services as use cases added to model. ❑ FL: Want to balance value with different stakeholders. Looking at statewide approach to HIE. ❑ NY: Central State Health Info Network of NY, but do stand up regional HIEs. Regional HIEs build own sustainability models, but are reviewed at state level. ❑ VT: Taxing every claim at \$0.20. ■ Nick Bonvino: Will the plan have allocation with percentages by stakeholder group? Bob: We can't get to that level. Will have principles in plan. Too early to get to that level of specificity. ■ Tony Gilman: May not be required to get plans approved by ONC. Current approved plans do not go into great level of detail. ■ Dr. Blue: When were those plans initiated, and how mature are they now and how much % participation? Bob will try to get info for future meeting. ■ Bob: Rochester NY has \$56 fee per hospital claim to sustain HIE. Three payers participating, trying to get more. Albany NY: Moving to hospital claim surcharge. Buffalo NY: Health plans were 3 of the 7 charter members who allocated initial funding. 70% from payers, 20% from hospitals. Now redistributing once critical mass achieved. 	
4	<p>Preparation for next meeting</p> <ul style="list-style-type: none"> ■ July 13 at 10:00 a.m. in Lubbock TX. In person meeting and webinar. Bob Hoover will not be in Lubbock but will participate by webinar. 	Bob Hoover
5	<p>Open discussion</p> <ul style="list-style-type: none"> ■ Nick Bonvino: More difficult challenge is funding – before we can deliver value, we need initial funds. Would prioritize raising initial funds. Think about how to pay for state and local services initially. Bob: Hope that environmental scan will see ways to fund in markets. 	
	<p>Action items</p> <ul style="list-style-type: none"> ■ Bob Hoover requested email from any participants regarding specifics of benefits and sustainability examples to add to the sustainability model. 	

Supplemental Materials
<ul style="list-style-type: none"> ■ Session Presentation