

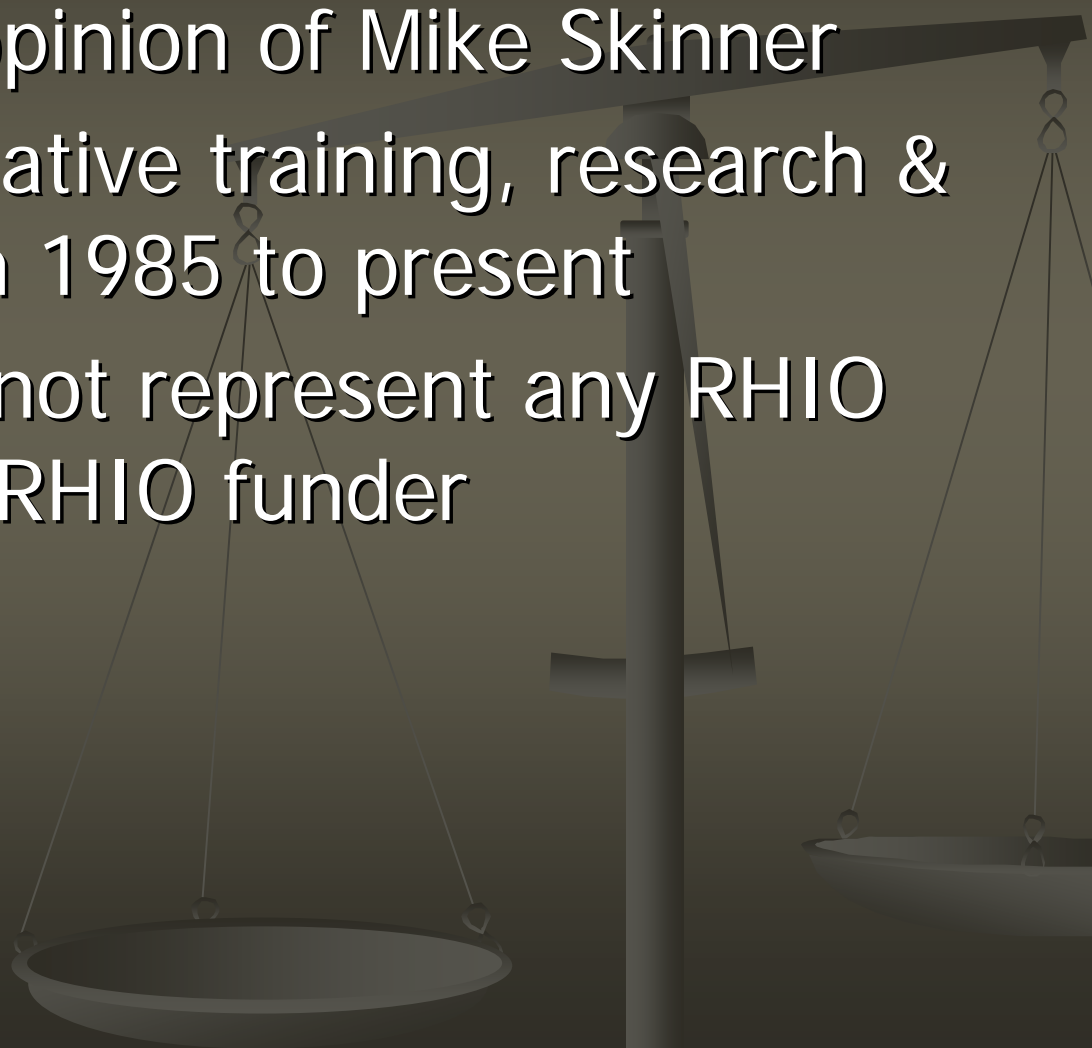
RHIO Lessons Learned

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Health-e-LA

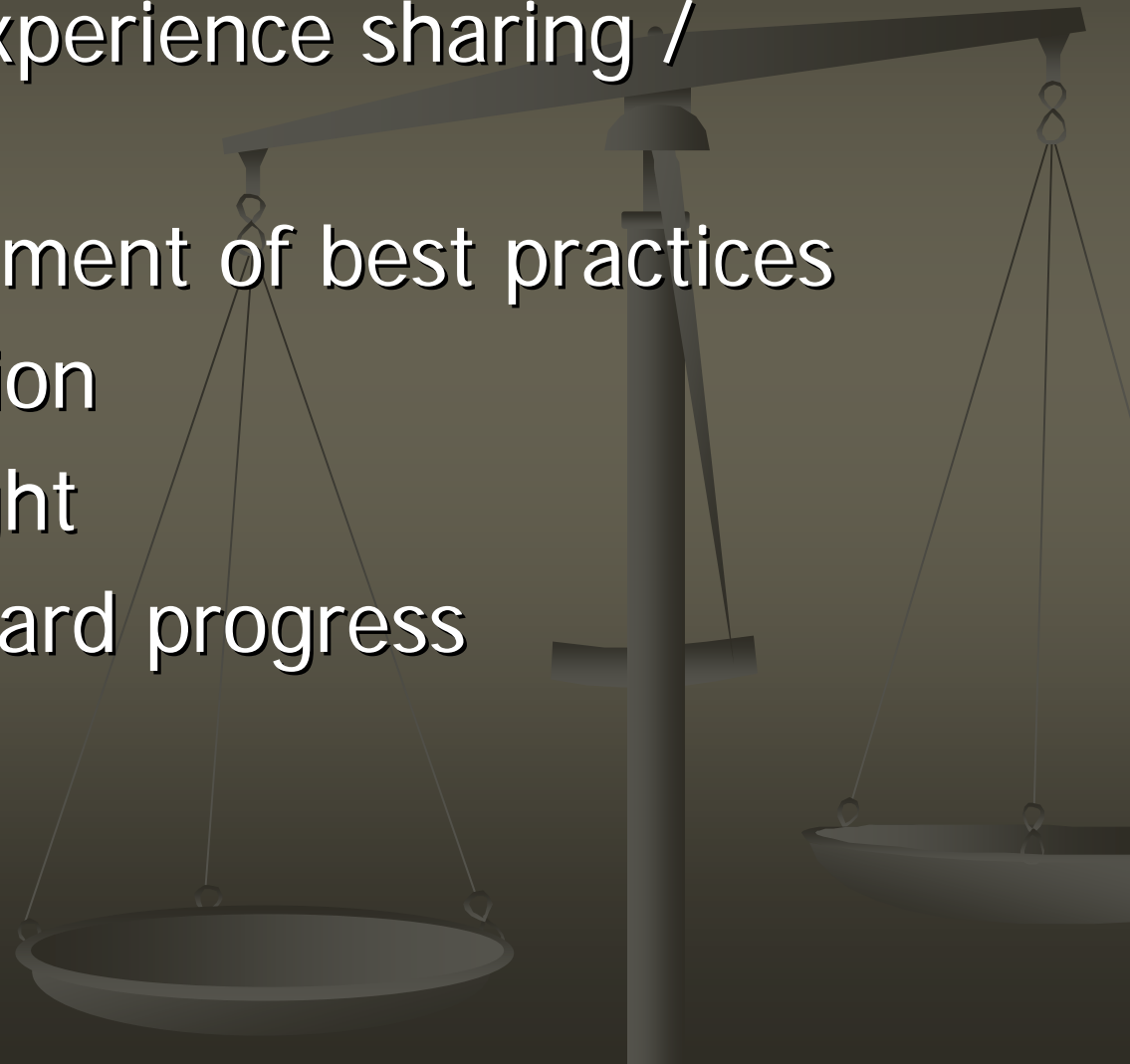


Personal Opinion

- Content is the opinion of Mike Skinner
 - Based on cumulative training, research & experience from 1985 to present
 - Presenter does not represent any RHIO organization or RHIO funder
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Presentation Objectives

- Knowledge & experience sharing / education
- Further development of best practices
- Clarify information
- Stimulate thought
- Encourage forward progress



Purpose/Mission of RHIO



- Improve Patient Health / Save Lives
 - How?
 - Facilitate access to *existing* relevant clinical data
 - Secure, compliant
 - Complete, accurate
 - Timely (at the moment of care)
- Reduce costs of care
 - Eliminate redundant diagnostic services
 - More efficient administration & operations
 - Better overall health means fewer encounters

What's It Worth?



Semi-unconscious female in the emergency room. Age unclear. A snowboarding accident. Some identification, and close friends present. Obvious multiple fractures. Head laceration.

With a minimally deployed RHIO in place, a fast, easy, and secure query reveals an **outside lab test** from 3 days ago is available and immediately accessible. Relevant clinical **data is considered during treatment**. Lab data is among the top 3 most important data sets, and one of the most interfaced.

In the absence of this data, the patient is treated with quickly discernable visual information, quickly obtainable diagnostics or information available from the patient, family or friends – **treated as though there was no other data**.

The patient doesn't get to surprise her husband the way she planned. Or maybe she doesn't even know?? **The patient is pregnant**. Pretty important eh? Most consumers would agree. I would...

Especially if the patient were **my daughter...**

Or my wife...

Then v. Now

- Then: 80's & 90's
 - Centralized
 - Vendor-driven
 - Value proposition profit-centric
- Now: Now
 - De-centralized
 - Community-driven
 - Value proposition consumer-centric



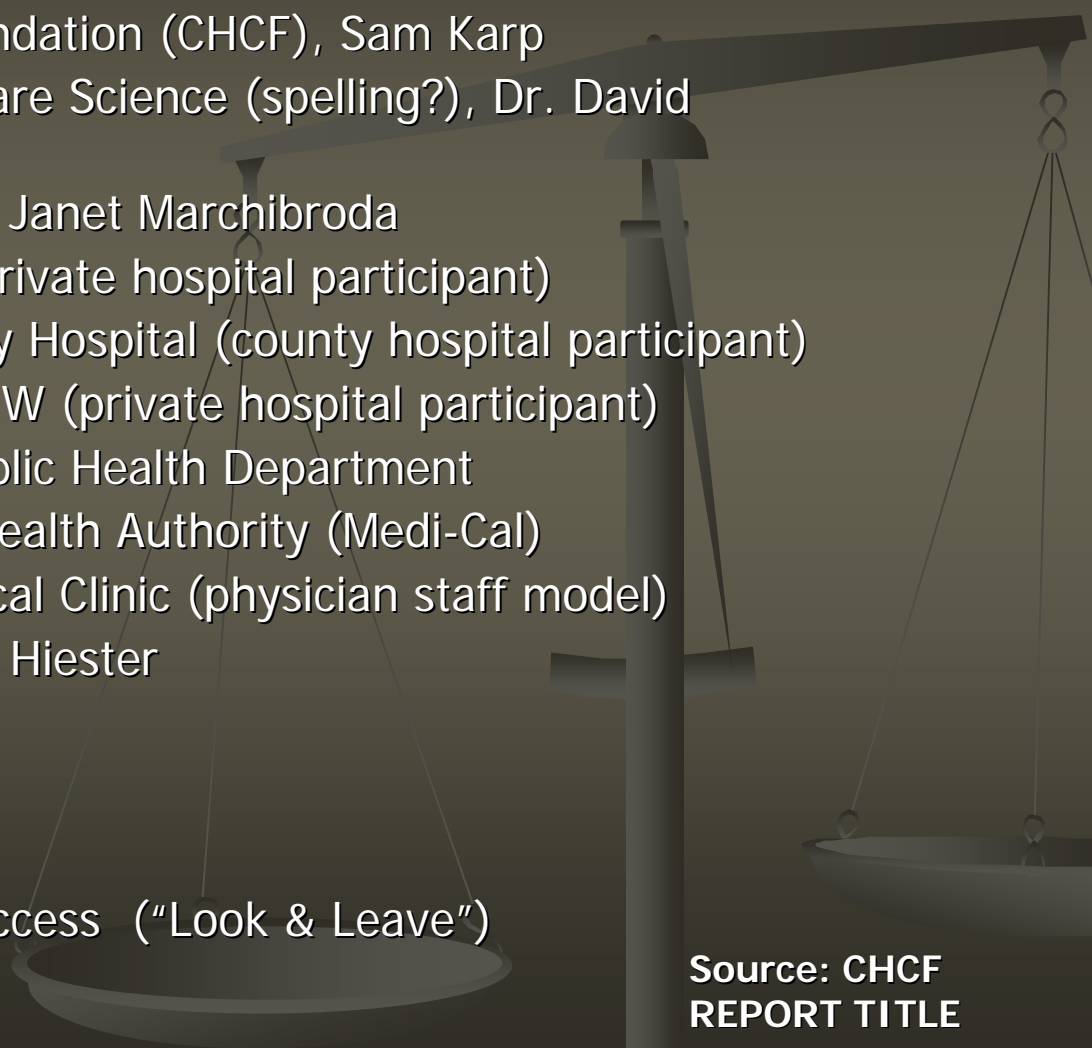


pi-o-neer (*pahy-uh-neer*)

n. one who opens up new areas of thought, research, or development; one who is first or among the earliest in any field of inquiry or enterprise

v. to open up or prepare (a way); to initiate or participate in the development of

Santa Barbara – Background



■ Pioneers & Champions

- California Healthcare Foundation (CHCF), Sam Karp
- Quovadx, Inc. formerly Care Science (spelling?), Dr. David Brailer
- HRSA / eHealth Initiative, Janet Marchibroda
- Cottage Health System (private hospital participant)
- Lompoc Valley Community Hospital (county hospital participant)
- Marian Medical Center-CHW (private hospital participant)
- Santa Barbara County Public Health Department
- Santa Barbara Regional Health Authority (Medi-Cal)
- Sansum Foundation Medical Clinic (physician staff model)
- MidCoast IPA, Dr. George Hiester

■ Demonstration Project

- definition
 - De-centralized data access (“Look & Leave”)

Timeline Recap

- The “demonstration” was successful – technology, at last, wasn’t the main barrier:
 - Master patient index (MPI)
 - Identity/develop correlation services (algorithms)
 - Record Locator Service (RLS)
 - Peer-to-peer (P2P)
 - Legacy Systems / Edge Repositories
- 1998-1999 – “Public data utility”
- 1998 – 2004 Informally Governed
 - Technical Advisory Committee (TAC)
 - HIT personnel from community participants (including Quest Diagnostics, formerly Unilab)
 - Clinical Advisory Committee (CAC)
 - Clinical / healthcare personnel from community participants
 - Project Management
 - Primarily by CareScience / Quovadx
- 2000 – 2004 CareScience / Quovadx Development
 - Primary funding from CHCF
 - CHCF owns source code
- 2004 – SBCCDE, Inc. formed (501c3)
- 2004 – President Bush Executive Order
 - National EMR networks by 2014
 - HHS Secretary Thompson
 - Office of the National Coordinator for HIT (ONCHIT) – Dr. Brailer
- 2004 – Quovadx acquires CareScience



Source: CHCF
REPORT TITLE

Lessons Learned

- Form community-based governance, ownership & sense of “investment” *early*
 - Someone *will* drive – but they pick the radio station
 - **Obstacles: Risk-taker (pi-o-neer) reputation; Acknowledgement of need; Need for community-based unity & political support**
- Value statement must be irrefutable – fait accompli – when compared to risk – and expressed *early*
 - Projects based on generalized value propositions are supportable *only* until an investment (cash or labor) or an assumption of risk is required – **then the value proposition is called into question**
 - Fact- or evidence-based
 - Formalize & post *conspicuously*
 - Clearly demonstrate
 - **Obstacles: Lack of representative RHIO operations data; tendency to express value as average/overall health improvements versus specific patient impacts**

Lessons Learned

- Risk/Liability: Define, Acknowledge & Mitigate (all parties)
 - Indemnification: it has to be a multi-way street
 - RHIO risk perceived as exponential (“many-to-many”)
 - Align or organize with/under local, state or federal government
 - Lobby for “safe harbor” legislation
 - **Obstacles: Lack of representative case law; laws and variations by state are not well understood by executives – education is expensive; interpretation of law; compliance with “sensitive data”; legacy systems**
 - *If the value doesn't overcome the risk (real or perceived), failure is likely*
- Treat government funding (and “start-up” funds from any source) as secondary/tertiary, not primary, and develop sustainable financial plan *early* that relies on local stakeholders or benefactors
 - Creates remote, disconnected sense of ownership
 - **Obstacles: Value/risk equation; mis-aligned agendas & objectives among competing stakeholders/benefactors**

Technology



- The technology worked.
 - It was fast, secure, highly available.
 - Functionality testing, data integrity, and security testing methodologies were highly effective & successful.
 - But, legacy systems in healthcare are still rampant – HL7 & batch is here for a while.
- Interfaces were NOT a significant problem.
- Peer-to-peer complicates some disclosure compliance issues (PACS)
- Bottom Line: Technology isn't *the* barrier.

Other Thoughts

- Open source systems (OSS) may offer solutions to indirect RHIO costs (EMRs, PMSs, interfaces, data management)
- Deployment of open & proprietary tool sets and federally funded products (including service oriented applications – SOA) can significantly reduce startup and operational costs
- The end user clinician is ready & willing – literacy levels are high, turn-over is reducing.
- A RHIO has to offer access to more data than they already have access to for it to be attractive

The Bottom Line

- Who's driving?
- Where's the value?
- What's the risk?
- Who's paying?
- Yellow, "charter", consensus without governance implies lack of decision making – makes vulnerable, stasis – loudest voice then drives – a decision implies risk



Questions and Answers

