

Using HIT to Transform Health Care: Summary of a Discussion Among State Policy Makers

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States are finding health information technology (HIT) an essential tool in any plan that seeks to improve the efficiency, affordability, safety, and quality of their health care systems. Well-designed HIT can improve the delivery of health care by enabling providers, payers, consumers, and government agencies to exchange timely, relevant information. In addition, policy makers recognize that the data collected can be used in analyses useful for planning and decision making by both purchasers and patients. HIT can support efforts to improve both patient-centered and population-based health care.

Some states have led in this area; more are just getting underway, forming plans that define essential roles and strategies. In 2005 and 2006, 24 states enacted 36

HIT-related bills or issued 10 executive orders; 29 percent of these state initiatives focused on HIT implementation. Significant effort is being spent on assessment, policy development, and planning of statewide HIT/Health Information Exchange (HIE).¹

This *State Health Policy Briefing* is intended to help state policy makers determine what role they will play in HIT development, how their state will use HIT, and how they will address critical barriers to success. It is based on a day-long preconference seminar organized by the National Academy for State Health Policy (NASHP) during which state policy makers exchanged information and experience, and learned from leading states and experts. The information in this report is drawn from the material presented at the meeting, a short survey participants completed prior to the meeting, and discussions during the meeting. Finally, meeting participants reviewed a draft of this report in order to ensure it accurately and completely captured the discussions.

Using HIT/HIE to Transform Health: Two State Visions

During the seminar from which this *Briefing* was developed state officials from Arizona and Florida anchored the discussion, describing how their states are implementing and using HIT/HIE. These states were selected because they share the goal of using HIT to transform health care, even though their approach to achieving that goal differs.

- Arizona policy makers worked with other stakeholders to create a single, statewide, comprehensive, Web-based Medicaid health information network (HIN) that would provide an infrastructure for the other stakeholders' HIT

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implementation efforts.

- Florida policy makers used seed funding and incentives to grow multiple regional health information organizations (RHIOs) rooted in local communities and which met minimum criteria established by the state to support a statewide health information exchange.

“The Florida Health Information Network’s goal was to expand the infrastructure for meaningful data exchange by stimulating the growth of a network of local RHIOs to generate a critical mass of electronic patient data that would demonstrate value to healthcare providers.”

LISA RAWLINS, DIRECTOR
QUALITY AND PROCESS IMPROVEMENT
BROWARD HEALTH

FLORIDA: BUILDING A STATEWIDE HIT NETWORK FROM THE GROUND UP

At the meeting, Lisa Rawlins from Florida’s Broward Health presented Florida’s vision for statewide implementation of HIT, while Anthony Rodgers of the Arizona Health Care Cost Containment System (AHCCCS) presented Arizona’s vision for using HIT.

Federal actions spurred Florida’s work to create a statewide Health Information Network, according to Rawlins.² In April 2004, President Bush established the Office of the National Coordinator of Health Information Technology (ONCHIT) for the purpose of transforming health care through HIT. Three months later, ONCHIT proposed a *Framework for Strategic Action*, and the Secretary of Health and Human Services (HHS) called for the establishment of a nationwide health information network. Start-up funds for this work were made available from the Agency for Healthcare Research and Quality (AHRQ), ONCHIT, Health Resources and Services Administration, Centers for Medicare and Medicaid Services (CMS), and the National Library of Medicine.

Florida took immediate action in response to the federal charge. In May 2004, Governor Jeb Bush created the Governor’s Health Information Infrastructure Advisory Board (GHIIAB) to promote and support the development and implementation of a Florida Health Information Network (FHIN). About the same time, the Florida legislature began hearing testimony from numerous state health care professionals about implementing HIT. By the end of the year, the legislature passed and the Governor signed the 2004 Affordable Health Care for Floridians Act. Among its

many provisions, this act directed the Florida Agency for Health Care Administration (AHCA) to develop interoperable HIT that permits secure, private information sharing and called for the creation of electronic health records (EHRs).

In 2006, in response to the recommendations of both the legislative committee and the GHIIAB, the Florida Legislature approved \$2 million in funding for AHCA to administer, manage, and monitor grants to nonprofit organizations, regional health information organizations, public health departments, or state agencies for projects to advance the development of the FHIN. Over the next two years the legislature appropriated an additional \$1.5 million to further these efforts.

According to Rawlins, the FHIN maintains a state-level server that functions as the highest level server to make data communications among RHIOs and HINs more efficient and timely and increase the effectiveness of health information exchange. “The Florida Health Information Network’s goal was to expand the infrastructure for meaningful data exchange by stimulating the growth of a network of local RHIOs to generate a critical mass of electronic patient data that would demonstrate value to health care providers,” Rawlins noted.³

AHCA used the seed funding appropriated by the legislature to support the development of the local stakeholder collaboratives that compose the FHIN. Specifically, AHCA offered three types of grants, as dollar-for-dollar match for local funding, to non-profit organizations seeking to establish a RHIO:

- Planning grants to support development of HIE strategic plans among health care stakeholders in a community.
- Implementation grants to support projects that bridge competing provider organizations with HIE and demonstrate sustainability.
- Training grants to support provider training to encourage use of electronic health records systems.⁴

Ten local RHIOs were formed with this funding and were given the responsibility of bringing providers together

About the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government.

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for the purpose of sharing health care data and integrating disparate computer systems into a health care data network that permits sharing of EHRs.⁵ To support the local RHIOs, AHCA undertook four initiatives:⁶

1. *Implementing the Core Functions and Services of the FHIN.* Core functions address business operations of the network such as a master patient identifier, record locator service, registration/certification, secure communications, etc. Core services address essential business steps such as developing minimal clinical dataset, interfacing with laboratories, pharmacy networks and hospital electronic medical records (EMR), and e-prescribing.
2. *Developing and implementing a summary roadmap for Florida.* Working with the eHealth Initiative, AHCA interviewed RHIO representatives. The information gathered in these interviews was used to develop a report on the status and future of HIE and a roadmap to identify services that will improve utilization and long-term sustainability of the RHIOs.⁷ The eHealth Initiative Roadmap detailed guidelines to assist the RHIOs in identifying geographic markets or medical trading areas, targeting users and expected beneficiaries, and projecting value to be gained per beneficiary. The eHealth Initiative Roadmap also looked at potential revenue, costs, and risks of each platform of exchange.
3. *Developing a business plan for the FHIN.* The business plan was developed in partnership with the Blue Cross Blue Shield of Florida (BCBSF). BCBSF donated a development team to produce the business plan, the Blueprint for Building Sustainable Health Information Exchange. The Blueprint's objectives include reduced RHIO startup and operational costs; shared development, infrastructure, and maintenance costs; and active stakeholder participation. The Blueprint seeks to avoid RHIO competition and encourage further growth by leveraging the RHIOs' current infrastructure, access to relevant data, and combined buying power. The Blueprint developed a revenue model based on subscription fees and transaction costs over a five-year period. BCBSF projected that the FHIN would become self-sustaining if the state provided \$25.8 million over the first three years of its operation.
4. *Helping the RHIOs implement the eHealth Value and Sustainability Model (VSM).* eHealth's VSM provides tools, products, and services that RHIOs can use to address their greatest challenges: secure funding, sustainability, privacy and security, governance, and other technical issues. The business model chosen

will plan for functionalities that generate the highest financial returns with the least risk.

The future of the FHIN and the local RHIOs depends on continued support from the state and federal governments during this critical period, and at the same time, developing a strong sustainability model in order to achieve long-term independence.

ARIZONA: USING HIT TO TRANSFORM HEALTH CARE

According to Anthony Rodgers of Arizona, states cannot sustain their current health care systems, which produce variable quality and outcomes, operate inefficiently, and are inaccessible to many people. Instead, states need to work with stakeholders to implement systems that use HIT/HIE to achieve these five objectives:⁸

- integrate health care delivery,
- increase transparency of health care cost and quality,
- promote productive interchange between provider and patient,
- enable consumers and patients to make informed decisions and actively participate in their own care, and
- enable health care providers to provide cost effective care management and use clinical decision support tools to reduce cost and improve quality.

This transformation, according to Rodgers, begins with the statewide adoption of interoperable electronic health records. This first step is an investment that will reduce system-wide inefficiencies and provide technology that will enable states to improve patient safety and health care outcomes and ultimately save money. The importance of Medicaid data in the development of the statewide HIE cannot be overstated and is often the catalyst which begins other HIE networks. Rodgers believes that the short-term spending will reap long-term savings: "Significant return on investment can be achieved within this decade by leveraging our Medicaid programs to lead and support the acceleration of the adoption and deployment of electronic health records and standardize infrastructure for health information exchange."⁹

HIT/HIE can greatly improve the ability of a state to deliver Medicaid services in rural or remote areas. A participant from Missouri offered Missouri's Chronic Care Improvement Project (CCIP) as an example of an HIT investment paying off in long-term savings and improved care in rural areas. Using a federal grant, Missouri added remote disease monitoring for selected Medicaid beneficiaries. The system uses a central processing unit that can support tech-

nologies such as automated blood pressure cuffs or scales. The information collected from the beneficiary is transmitted through a telephone line to providers. This home monitoring service, along with telemedicine consultation, reduces costs for Medicaid programs through reduced transportation needs and lower emergency room/hospitalization visits because of better disease management.¹⁰

“Significant return on [HIT/HIE] investment can be achieved within this decade by leveraging our Medicaid programs to lead and support the acceleration of the adoption and deployment of electronic health records and standardize infrastructure for health information exchange.”

ANTHONY RODGERS, DIRECTOR
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Connecting providers with interoperable electronic health records is a first step. The next step, as envisioned by Rodgers, is to connect patients to their individual providers. This will offer consumers health care cost and quality information that is relevant to their individual needs. Arming consumers with timely, relevant information will enable them to better assess their health care choices and improve their interactions with providers. This, in turn, will enhance a patient’s ability to communicate directly with his or her providers. Improved communication with coordinated care is the hallmark of the patient-centered medical home and a medical home is a hallmark of high quality, high performing, and cost-effective health care system.¹¹

Challenges and Opportunities

NASHP staff consulted an array of policy makers and national experts while developing the meeting agenda. In the course of those discussions, three major challenges faced by states seeking to implement and use HIT were identified:

1. forming and/or working within a public/private partnership,
2. finding funding for implementation and sustainability, and
3. ensuring privacy and security of health information.

The meeting featured discussions of each of these

barriers. Two discussants kicked off each discussion – one offering a national and one a state perspective on the issues. Further, participants completed a short survey before the meeting. The survey asked participants to describe their HIT accomplishments, innovations, and challenges. Information from this survey was distributed at the meeting and incorporated into the discussions.

This section of the paper summarizes the discussion on these three significant challenges, looks at strategies for addressing these challenges, and presents further concerns and questions.

ESTABLISHING PUBLIC/PRIVATE PARTNERSHIPS

According to Patricia MacTaggart of The George Washington University, the 2007 eHealth State Survey identified common priorities and barriers as states work with stakeholders to develop and expand regional activities and connect to statewide activities.¹² Some of the key issues identified were:

- Stakeholder trust and participation. Early collaboration is key to establishing trust. For example,
 - Florida created statutory authority to work with technology vendors and build on that talent, which helped break down barriers between the public and private sectors.
 - Indiana has multiple electronic health information exchanges governed by a combination of public and private members.
- Stakeholder education. Meeting participants noted that it is important to agree to use common language, definitions, and terms with stakeholders at the onset.
- Alignment of ehealth needs with stakeholder and clinical benefits. By providing valuable products that benefit all stakeholders, the incentive to partner becomes evident. For instance,
 - Florida shares quality measures and patient safety feedback with providers and consumers through a public Web site.
 - Indiana has fostered public/private collaboration by offering medical providers access to a database that combines information from its Immunization, Surveillance, and Disease registries. Providers can use this information to make more informed decisions about their patients’ health care needs.
- Low HIT adoption by health care providers. States can lead by providing technology such as e-prescribing to help spur adoption. Also, by providing standard

data sets and patient identifiers, states can remove barriers to HIT interoperability that often inhibit private investments.¹³

Colorado: “partner early and partner often”

The state of Colorado has advanced HIT/HIE adoption and use by forming strong public/private partnerships. “Partner early and partner often,” has been the mantra of Colorado Department of Health Care and Financing Director Joan Henneberry. This focus has led to making the most of the private sector’s expertise and resources to advance state-wide efforts. Strong public/private partnerships will also enable progress to last into future state administrations.

The Colorado RHIO (CORHIO), whose board includes ex-officio members such as the State’s Medicaid director and chief information officer, is an excellent example of a public/private partnership that has been a major HIT/HIE driver in the state. The CORHIO received a \$5 million AHRQ grant in 2005 to build a prototype for interoperable EHR exchange between four major health care systems in the state.

Public/private partnerships: strategies and considerations from the discussion

Meeting participants agreed that state government agencies or public sector programs cannot “go it alone” in their plans to implement HIT/HIE and still achieve the benefits of widespread interoperability. Successful statewide implementation and use of HIT requires partnership and “buy-in” between multiple segments of state government and the private sector.

State-level efforts, such as described in Florida, are demonstrating that collaborative public/private partnerships can accelerate and finance HIT adoption and change the behavior of providers and consumers. State policy makers involved with HIT initiatives have found that valuable contributions of resources and expertise are offered from the private sector, which can help build and sustain momentum for building HIT capacity. A growing number of state level HIT initiatives are forming formal nonprofit public-private partnership organizations (e.g., state-level RHIOs). These efforts demonstrate the value and importance of early multi-sector and multi-stakeholder engagement to capitalize on opportunities to advance HIT adoption. They also highlight the challenges to be met in reconciling public and private sector operational strategies that enable shared HIT investments, such as structuring state procurement processes to avoid bias.

Capitalizing on public and private sector resources to advance HIT – examples of collaborative state level strategies

- West Virginia staff worked with vendors to advance HIT adoption. State staff screened vendors using an electronic survey, then hosted educational sessions where those vendors that passed the screen demonstrated products and answered technical questions from state staff.
- The Rhode Island Quality Institute actively meets with providers to promote agreement on data collection standards and HIT adoption.
- The Colorado state-level RHIO is supported by local private health plans (through initial grants and in-kind support) and engages the state Medicaid and public health agencies as part of the governing board. A nonprofit private health information and policy analysis organization, the Colorado Health Institute, serves as an incubator for the HIT organization, provides in-kind organizational leadership, and helps support the state’s HIT, quality, and safety initiatives through its data analysis and policy studies.
- An independent consortium in New York forged a public/private partnership to seed development of local health information exchanges that would be linked together as part of a statewide HIT framework. Public agencies – Medicaid and public health – play lead roles to leverage public funding and set contractual standards for health information exchange.

Working in partnerships can build state expertise and forge key relationships. Some meeting participants have found that working in partnership with the private sector can build the expertise of state staff. Colorado, for example, supports staff participation in workgroups and task forces in order to develop in-house talent and strengthen partnerships. By placing state executives from the Attorney General’s office, Governor’s Office, and Department of Health Care Policy and Financing on public/private task forces, the state has enabled these agencies to forge key relationships, develop consensus, and educate task force members. Task forces often include representatives from the medical and insurance industry, large employers, and local health departments – all important stakeholders.

States can take action to facilitate public/private partnerships. Some states have furthered public/private partnerships through legislation or executive orders that ease rules or restrictions. In West Virginia, public/private partnerships are exempt from state government rules, so it does not have a RFP process or procurement rules, although these partnerships do not have 501(c)3 status.

FUNDING AND SUSTAINABILITY

Funding to create the HIT infrastructure and sustain its op-

erations is a major challenge for states. According to Patricia MacTaggart, many states are using Medicaid funding to both develop and sustain their HIT efforts. Medicaid offers two sources of funding for HIT development and implementation:

- Medicaid Transformation Grants fund innovative systems that can improve Medicaid's efficiency, cost-effectiveness, and quality of care.¹⁴
- Numerous state Medicaid agencies are using federal Medicaid matching funds through the Medicaid Information Technology Architecture (MITA) initiative to replace and enhance their existing Medicaid Management Information Systems (MMIS) to accommodate and promote HIE and HIT.¹⁵ MITA is intended to foster integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program.¹⁶ CMS has developed a MITA toolkit to assist states to standardize systems and data contained in the MMIS which enable Medicaid's participation in HIE. States are eligible for a federal financial match of 50 to 90 percent to help with these transitions if they go through a prior approval process.¹⁷

Wisconsin: five-year roadmap to achieve statewide electronic health record adoption and health information exchange

Wisconsin's eHealth Action Plan weaves together three strategies in a coherent, whole-systems approach to transformation of the health care sector:

- Improve quality, safety, and value by establishing the eHealth technology platform to provide needed information at the point of patient care.
- Encourage the development, alignment, and implementation of value-based purchasing policies and actions across the public and private sectors.
- Link health information technology and HIE plans to prevention and disease management activities.

These strategies rely on joint public-private ownership with active collaboration and coordination of related system improvement efforts. Over the next five years, it is the goal of the eHealth Action Plan to have electronic health records across the state.

The state received \$3 million in start-up funding in the first round of Medicaid Transformation Grants to create a regional health information exchange framework, infrastructure, and system. This regional system, the Wisconsin

Health Information Exchange (WHIE), enables multiple hospitals, clinics, and health care institutions to access rapidly and securely the medical history of patients enrolled in Medicaid and the General Assistance Medical Program (GAMP) in Milwaukee County. The WHIE is the state's only established Regional Health Information Organization, serving nine counties in Southeast Wisconsin.

The mission of the WHIE is to provide a system in which diverse stakeholders collaborate to enable secure, confidential exchange of health information between authorized users. The WHIE's vision is to create a system where health professionals and patients can access secure information, when and where they need it, to improve the safety, quality, and efficiency of health care.

The state intends for the WHIE to be self-supporting based on user fees. Providing products such as e-prescribing and clinical messaging of laboratory results will demonstrate value and increase user participation. Participation by large group physician practices is seen as key to sustainability, as 70 percent of physicians in the state belong to large integrated group practices.

Building a health information network requires good business acumen, according to Janet Marchibroda of the eHealth Initiative and Foundation. Wisconsin has found that translating this acumen into a plan that demonstrates value, involves key stakeholders, and builds incrementally going after strategic wins will increase opportunities for success.

Funding and sustainability: strategies and considerations from the discussion

Most meeting participants expressed great concern about their ability to fund and sustain HIT in their states. Louisiana raised concerns about how to convert legacy computer systems to a modern architecture. One of the state challenges in Kentucky is how to sustain RHIOs in areas without a critical mass of people.

HIEs often depend on fees for ongoing funding – According to Marchibroda, there is no “one-size-fits-all” approach to funding and sustainability. However, the eHealth Initiative surveyed HIEs in 2007 and found that their operating revenue sources often included funding from fees assessed to either data users or data providers:

- transaction fees (assessed to both data providers and data users), and
- subscription or membership fees (also assessed to both users and providers).¹⁸

Adding value to promote sustainability – More states are using HIE data to develop business products and build

social capital. These new services add clinical data to claims data to produce meaningful data for chronic care management, electronic lab reporting, surveillance, and performance data reporting to purchasers or payers, and quality improvement reporting to clinicians.¹⁹ The eHealth Initiative recommends that states reflect four financing principles in the products they develop to further sustainability: meaningful incentives, phased approach, interoperability, and costs that reflect the benefit.²⁰

Using Medicaid funding to develop HIT – As suggested by MacTaggart, some states are turning to Medicaid funding to build their HIT infrastructure. The state of California, for example, plans to use the federal funding available for MMIS modernization to fund development of its HIT infrastructure as part of its next MMIS procurement.

PRIVACY AND SECURITY ISSUES IN HIE

Medical providers, policy makers, and program managers need to access information about the care provided to patients in order to better serve individuals, to create tools consumers can use to make more informed judgments about their own care, and to improve the health care system as a whole. Yet, consumers need confidence that their health information will not be shared or used inappropriately. Over the years a thicket of national and state laws has developed to meet these two needs.

In 2007, the Health Information Security and Privacy Collaboration (HISPC) worked with 33 states and Puerto Rico to conduct an assessment of the variation in existing business practices, policies, and state laws to better understand the current landscape of privacy and security of health information. This assessment will help states harmonize policies and laws, reduce variations, and permit nationwide health information exchange. Five of the major privacy and security challenges and practical solutions identified by the HISPC for states are, according to reports published by AHRQ and ONCHIT and presented by Linda Dimitropoulos of RTI International:²¹

1. *Lack of awareness among stakeholders* – Few stakeholders fully understand the privacy and security implications of HIE. In response, 14 states are developing model outreach and education programs that feature such strategies as consumer and provider outreach and education, state and multistate privacy and security summits, and consumer advisory councils/committees.
2. *Inconsistency among privacy and security laws* – State privacy and security laws are often fragmented and inconsistent and do not relate to HIE, because these

laws were developed for paper-based work flows. Nine of the HISPC states are working on solutions that include cataloging and mapping existing laws and developing model legislation to harmonize laws that cross state borders.

3. *Inconsistency in patient consent requirements* – State requirements governing patient consent and authorization for the release of information vary widely. Eight states are working to create more consistency among these requirements by standardizing the patient consent process, harmonizing consent language, and developing model consent forms.
4. *Lack of minimum standards for data security* – Minimum standards for authentication, authorization, access controls, and information audits are needed. Four states are working on solutions that include developing a “solutions building block,” that is, trusted digital identities for authentication, authorization, access control, data integrity and digital signatures.²²
5. *Lack of state-level privacy and security oversight* – State-level governance and oversight is needed to ensure that privacy and security issues are addressed as HIE spreads across the states. Six states are working to establish state leadership to address this concern. Their solutions include developing Governor-level task forces and privacy and security boards. This will provide a mechanism for communicating and coordinating plans between states nationwide to ensure harmonization among the states and territories.

In 2008, state teams will continue to work collaboratively to reduce variation and ensure harmonization nationwide.

West Virginia: principle-based approach to ensuring privacy and security

In August 2006, Governor Joe Manchin signed an executive order giving the chair of the West Virginia Health Care Authority (HCA) the responsibility for protecting the privacy of personally identifiable information (PII) collected and maintained by all executive branch agencies. This order requires that a team be developed to create a privacy infrastructure across the entire Executive Branch; the Chief Privacy Officer leads the team and is located at the HCA.

The vision for this privacy program is to ensure that West Virginia’s state government implements best practices to protect personally identifiable information, improves data quality and protection, and builds the value that privacy

brings to the West Virginia state government trusted brand. The program is grounded in law and balances individuals' right of privacy against others' need and right of access.²³ Pursuant to the Executive Order, the state adopted privacy principles, which serve as the framework for the entire program, including policy development.

In the spring of 2006, the West Virginia Legislature passed into law Senate Bill 170, which established the West Virginia Health Information Network (WVHIN). The WVHIN is charged with promoting the design, implementation, operation, and maintenance of a fully interoperable statewide network to facilitate public and private use of health care information.

WVHIN has established a formal governance structure, including a committee focused on consumers, employers, and privacy. Because WVHIN is a state agency, it participates in the state's privacy team and is building its privacy program around the state's privacy principles. According to Sallie Hunt of the HCA and WVHIN, this principle-based approach has enabled stakeholders in West Virginia to understand and discuss, using scenarios, what existing laws require. They can also identify, by single topic or principle, additional privacy requirements important to local values and culture. West Virginia's privacy principles include:

- accountability by assigning roles and responsibilities to assure application of principles related to personally identifiable information,
- notice regarding who is collecting, maintaining, and sharing PII and why,
- minimum necessary and limited use of PII,
- consent and authorization,
- individual rights/individual participation, and
- security safeguards.²⁴

Privacy and security: strategies and considerations from the discussion

Meeting participants discussed how mistrust and misinformation about consent and authorization have plagued efforts to implement and expand HIE. Some important points from the discussion include:

- The work of the HISPC states will inform others. The 33 HSPIC states are scheduled to convene again in March 2008. During the meeting, state participants will provide their unique framework for addressing and answering privacy and security issues in health information exchange and will provide guidance for other states wishing to do the same.
- It is important to plan to address security breaches.

Despite intensive efforts to ensure security and privacy, no system can be '100 percent safe.' Good security and privacy protections will include requirements related to responding to a security breach. Conversation centered on the need to create reasonable security systems, including reasonable responses (and compensation) to breaches

- Legally sufficient consent may not be the same thing as meaningful consent. Some meeting participants expressed concern that consumers may sign a 'global' consent form when they obtain care or insurance coverage because they believe they must do so in order to receive the care or the coverage – without realizing the wide latitude such consent forms allow. A legislator's story of a constituent who had lost her job and insurance and was declined subsequent coverage based on a drug purchase she made in cash at a local drugstore illustrated this concern. Since many consent forms are signed in provider offices, participants believed that enabling providers to better advocate for their patients was one way to address the problem.

Conclusion

Increasingly states recognize the importance of health information technology and their ability to foster HIT adoption and use to transform health care. States pushing ahead in HIT adoption have identified, and are starting to address, three significant challenges:

- Public/private partnerships – States can play a significant role in convening stakeholders to develop HIT initiatives, regardless of whether the state ultimately leads the group or not. These partnerships are necessary – neither the public nor the private sector can succeed alone.
- Funding – States can leverage federal and private funding to help create and sustain health information network (HIN) infrastructure. Medicaid funding may be a particularly promising source of start-up funding. To sustain their HIN, however, states need to offer valued products and services to increase stakeholder investment and participation, including:
 - combining clinical and claims data to produce meaningful data for chronic care management,
 - reporting electronic lab and performance data to purchasers or payers, and
 - producing quality improvement information for

clinicians.

- Privacy and security – States have an important role to play in addressing privacy and security issues. They can take actions such as:
 - reviewing and, if necessary changing, state law to more cohesively and comprehensively address the issues,
 - educating providers and consumers regarding privacy and security issues, and
 - establishing privacy principles across all branches of state government

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GLOSSARY OF HEALTH INFORMATION TECHNOLOGY TERMS USED IN THIS BRIEFING

EHR – electronic health records

EMR – electronic medical records

FHIN – Florida Health Information Network

GHHIAB – Governor's Health Information Infrastructure
Advisory Board (Florida)

HIE – health information exchange

HIN – health information network

HISPC – Health Information Security and Privacy
Collaboration

HIT – health information technology

MITA – Medicaid Information Technology Architecture

MMIS – Medicaid Management Information Systems

ONCHIT – Office of the National Coordinator of Health
Information Technology

PII – personally identifiable information

RHIO – regional health information network

VSM – eHealth Value and Sustainability Model

WHIE – Wisconsin Health Information Exchange

WVHIN – West Virginia Health Information Network

Notes

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- 11 The joint principles of the Patient Centered Medical Home Model (PCMH) developed by the AAP, AAFP, ACP, and AOA, among others include: personal physician; physician directed medical practice; whole person orientation; coordinated and/or integrated care; quality and safety; enhanced access to care; and payment that reflects value. See <http://www.pcpc.net/node/14> for more information.
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- 13 Ibid.
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