



ACCEL Steering Committee

August 8, 2007
2:00 p.m. – 4:00 p.m.



Summary of Last Meeting – 7/11/07

- Approved governance success measures
- Steering Committee will review processes and outcomes every 6 months
- Approved hiring of incremental staffing for business process analysis and management during implementation and evaluation phases
- Clarified Steering Committee's responsibility for financial oversight of ACCEL resources
- Care Pathways leadership group presented their technology, milestone and implementation update for discussion



Outline/Agenda

topic	slide
▪ Meeting Objectives.....	5
▪ ACCEL funding and budget overview	6
▪ 2008 ACCEL Strategic plan.....	7
▪ Security and Privacy.....	14
▪ Appendices.....	21

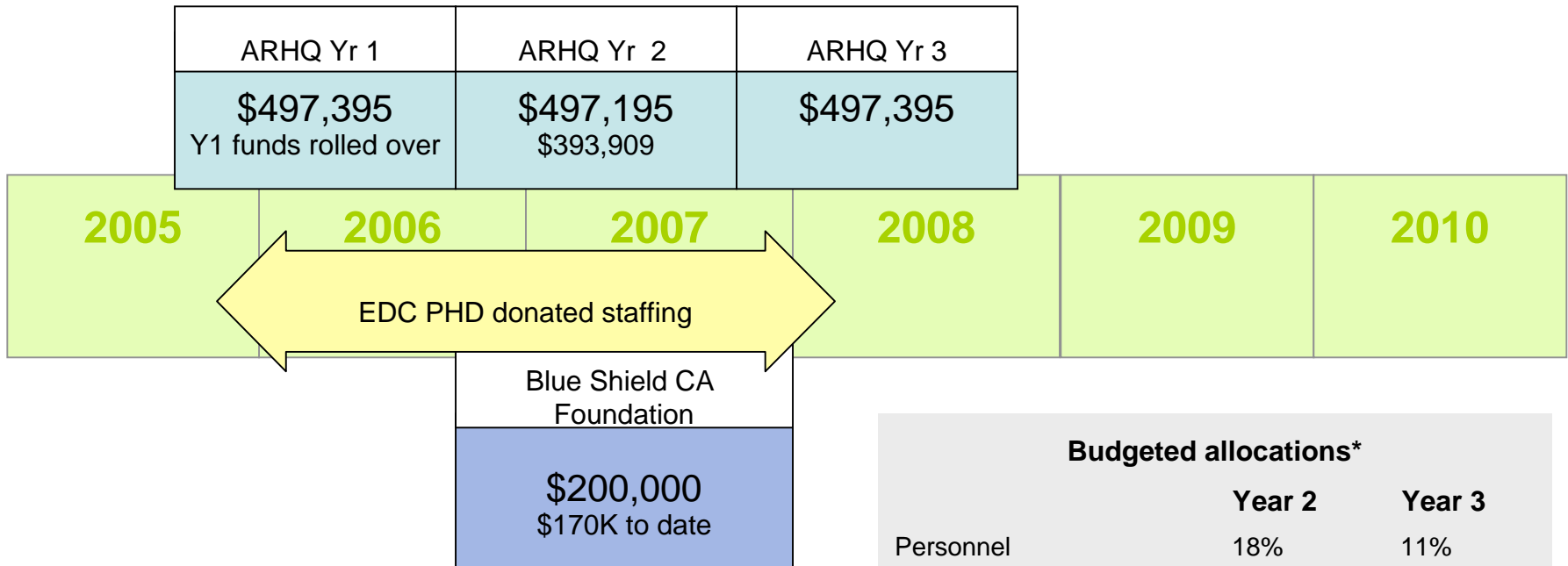


Meeting Objectives

- Review ACCEL funding and budget overview
- Review and discuss 2008 Strategic Plan: objectives, recommended approach, funding and evaluation
- Approve 2008 Strategic Plan
- Privacy and Security Workshop follow up. Discuss and approve
 - Guiding principles
 - Approach to common consent
 - Memorandum of understanding



ACCEL funding and budget overview highlights need to adopt a strategic plan and seek continued funding



Budgeted allocations*		
	Year 2	Year 3
Personnel	18%	11%
Consultants	57%	67%
Technology	22%	19%
Other	3%	3%

*using only ARHQ and BSCF resources

NOTE: total dollars from funding sources do not take into account budgeted expenses the Public Health Department is absorbing, e.g. Care Pathway staff.



2008 Strategic Plan

additional materials from July meeting are included in the appendix

A structured process that included review of all grant objectives and accountabilities was followed to develop recommendations for a 2008 strategic plan

What objectives do we want to achieve in 2008?



- Strategy Focus
- Scope
- Assumptions
- Decision areas
- Nat/State policy environment
- Review techn. project phases
- Assumptions
- Workgroup recommendations
- Techn. advances & uncertainties
- What we learned in 2007

**How will we get there?
approach**



- Options
- Pros/cons
- Risks
- Prioritize alternatives
- Range of returns
- Key risk factors & mitigation
- 3-year plan
- Annual business plan
- Budget
- Communication

How will we know success?



- Outcomes to measure
- Metrics



2008 **objectives** were proposed to answer the question, “What do we want to achieve?”

2004 - 2006	2007	2008	2009	2010
Phase 1 Organization	Phase 2 Mobilization	Phase 3 Automation	<p>2008 Objectives*:</p> <ul style="list-style-type: none"> • Implement patient <u>clinical data</u> exchange with Eastern Slope by 12/30/08 (assumes 2-way data demo. in '07) <ul style="list-style-type: none"> ✓ Refine common registration and authorization to include standard language across settings • Train all CHW in new Care Pathway processes by 3/1/08 • Develop QA program with inter-agency participation for Care Pathways by 6/30/08 • Complete a patient satisfaction survey with Care Pathways participants by 9/1/08 • Conduct at least 2 Community Advisory meetings and provide a summary of the feedback to the SC by 10/1/08 	
<ul style="list-style-type: none"> • Investigate interests, potential benefits, level of commitment • Engage and align organizations • Develop project business case • Prepare overall project plan • Establish and kick off project teams • Test processes & programs on a paper or fax basis 	<ul style="list-style-type: none"> • Establish governance committee • Determine governance success metrics • Initiate workgroups • Determine future funding and revenue plan • Determine overall ACCEL project functionality/phasing plan • Develop common consent agreement • Implement Care Pathways software • Implement eMPI 	<ul style="list-style-type: none"> • Develop HIE implementation plan • Develop stakeholder engagement and communication plan • Secure implementation resources (multi-year) • Revise phasing plan as necessary • Revise governance as needed • Monitor programs & establish quality improvement targets • Pilot data exchange to include clinical info (ie, labs) • Preliminary evaluation of Care Pathways 		

Implementation options, risks and required resources were analyzed to recommend an **approach**.

Options	Staff change	Risks	Actions
Kill-joy: Stop now. Close down programs. We don't have the resources.	Negative FTE	<ul style="list-style-type: none"> • Missed opportunity for quality of care improvement • Misalignment with national and state agendas 	<ul style="list-style-type: none"> • Write final grant reports • Terminate staff • Share learnings with appropriate agencies
Conservative: Tread water. Continue present programs. No new development.	0	<ul style="list-style-type: none"> • Missed opportunity for quality of care improvement • Maintenance without development diverts resources from other, more productive activities • Stakeholders tire of the project and lose interest 	<ul style="list-style-type: none"> • Continue with existing plan • Decide whether or not to reapply for grant funding
Moderate: Continue implementing technology and programs in a phased way. Absorb short term pain for long term gain. Timeline ~5 yrs.	+1.5 – 2.0 FTE (Est. based on growth)	<ul style="list-style-type: none"> • Personnel, priorities or political shifts in consortium members, undermines development plan 	<ul style="list-style-type: none"> • Add BA(s) or manager(s) • Build integrated implementation plan • Identify critical decision points for SC
Thrill-seeker: Pull out all stops. Each stakeholder antes up the resources required to finish in 3 yrs. or less. Just do it.	+4.0 FTE (Est. based on speed & growth)	<ul style="list-style-type: none"> • Too much, too fast. Cultural change may not keep up with process change. 	<ul style="list-style-type: none"> • Build integrated implementation plan • Fast track grant/funding plan & sustainability plan



How will we **evaluate** our success? What is success for network partners?

1. **Steering Committee:** outcome metrics already approved
2. **HIT program metrics** with 4 audiences: ACCEL network, AHRQ & BSCF (funders), other decision makers in EDC, other rural counties
 - Does the implementation of ACCEL activities lead to reduced reliance on ED?
 - What savings are generated by reduced ED visits?
 - What are the specific Care Pathway outcomes?
 - # of newborns and children with health insurance
 - # of children with a medical home, using the medical home
 - # of newborns with a medical home who have received IZ immunizations & well baby visits in the first 8 months of life
 - Primary care providers who have secured pediatric mental health consults for difficult to treat pediatric cases
 - # of providers accepting referrals from Care Pathways
 - # of Providers/partners adopting ACCEL technology
 - Patient and provider satisfaction
3. **Network partners:** self-reported reduction in uncompensated pediatric care (at ED and affiliated clinic sites)



Conclusions & recommendations for 2008 strategic plan

- Political agendas, internal work to date and evaluation of risks and resources favorably position us to continue a **moderate** course of development.
- Previously approved 2007 High Level Technology Plan is consistent with a moderate approach
- Funding and resources continue to be a challenge, but are surmountable under these conditions:
 - Attain multi-year grant funding for further development
 - Hire appropriate implementation resources to manage implementation & evaluation efforts such as a business analyst to work in lockstep with the IT PM
 - Continue a focus on building the fundamentals of HIE
 - Communicate interim results to increase community awareness of successes and to explore possible community support or fundraising
- In 2008, we will achieve:
 - Substantive administrative & clinical data exchange through Care Pathways & HIE
 - Improved administrative efficiency through patient & clinician satisfaction with HIE
 - Expanded community involvement through an advisory group



Action item

Committee Decision:

2008 objectives, approach and evaluation

Approve, revise or reject



Privacy & Security



Privacy & Security workshop discussion takeaways

- Patient consent process requires multi-level education to implement.
 - Policy and technology define implications for network vs. participant consent process
 - Policies for prompt management of consent errors is key to maintaining patient & network confidence
- Development of good privacy and security policies requires broad participation (agencies and functions) to build trust and honesty.
 - Find workgroup format that works best for stakeholders
 - Use clear charters, timelines and outcomes to drive work
- Develop audit processes to: monitor appropriate use, determine that technology is working, and evaluate participant satisfaction/adoption
- Keep it simple! Capitalize on pilot/formative stage processes using practical language that is easy to reference and update
 - Build on existing consents and transfer to electronic format
 - Document decisions and agreements
 - Start with single Memorandum of Understanding and BAA signed by all participants.
 - Save Participation Agreement for full scale implementation of HIE
 - Delay entity formation until need/benefit is clearly established
- Initiate community/consumer engagement process to establish HIE as a trustworthy initiative

(Chartpad discussion notes from 7-23 workshop are included in the appendix)



Adopt **pragmatic guiding principles** to privacy and security that sequences work over time

The objective is to prioritize and focus on critical elements that will

- permit implementation to proceed
- conserve use of resources
- build trust among participants

Operationally, this means

- identifying common language
- Integrating with current processes
- building off existing documents and agreements
- developing a realistic timeline
- Identifying resources



Adopt an **inclusive consent process** using common language that applies to ALL network participants

Definitions

inclusive consent process assumes patients consent to ACCEL HIE unless they specifically decline or “opt out”

common language means that the wording for ACCEL HIE patient consent is identical across all network participants regardless of registration process

applies to all network participants indicates that patient consent verified at any location applies to all ACCEL network participants (“global vs. local”)

Rationale

Maximum acceptance, simplicity and comparative ease of implementation outweigh potential risk of inadequate patient understanding

Implications

All or nothing consent policy may be more controversial

Process for withdrawal of consent must be developed across all all participants

Patient education and notification efforts should be consistent across all network participants

Connecting for Health Policy Principles

- Openness & Transparency
- Purpose Specification and Minimization
- Collection limitation
- Use Limitation
- Individual participation & Control
- Data Integrity and Quality
- Security Safeguards & Controls
- Accountability & Oversight
- Remedies



Adopt Memorandum of Understanding to formalize evolution of ACCEL network participation

Rationale

Single MOU to be signed by all participants is simpler to execute and represents a more appropriate format for formative pilot phase of project development.

Complete Participant Agreements are not necessary until the HIE pilot activities are complete.

Implications

MOU is integral to the ACCEL consent process - it needs to be in place to define the scope and limits of the information exchange **before** patients can consent

Legal counsel and Steering Committee need to define key elements to include

For practical purposes, El Dorado County contracting style and timeline likely to dominate

Action items

Committee Decisions:

1. Pragmatic approach to privacy and security
2. Implementation plan for inclusive common consent
3. Implementation plan for Memorandum of Understanding

Approve, revise or reject



Next meeting: Wednesday, September 12

Agenda items

- Memorandum of Understanding update
- Privacy & Security Workgroup charter
- Care Pathways check in
- Discussion of funding and revenue sources

August 8, 2007
SC Meeting Appendices



Appendices



With the previously approved Technology Plan* and the HIE business case as a foundation...

2004 - 2006	2007	2008	2009	2010
Phase 1 Organization	Phase 2 Mobilization	Phase 3 Automation	Phase 4 Evaluation	Phase 5 Actualization
<ul style="list-style-type: none"> Investigate interests, potential benefits, level of commitment Engage and align organizations Develop project business case Prepare overall project plan Establish and kick off project teams Test processes & programs on a paper or fax basis 	<ul style="list-style-type: none"> Establish governance committee Determine governance success metrics Initiate workgroups Determine future funding and revenue plan Determine overall ACCEL project functionality/phasing plan Develop common consent agreement Implement Care Pathways software Implement eMPI 	<ul style="list-style-type: none"> Develop HIE implementation plan Develop stakeholder engagement and communication plan Secure implementation resources (multi-year) Revise phasing plan as necessary Revise governance as needed Monitor programs & establish quality improvement targets Pilot data exchange to include clinical info (ie, labs) Preliminary evaluation of Care Pathways 	<ul style="list-style-type: none"> Expand data exchange to include more data points and/or more sites Evaluate impact of increased automation on administrative efficiency Evaluate impact of increased automation on clinical outcomes Provide comprehensive facilitation and training for the new practices Establish resources for ongoing maintenance Communicate progress to community stakeholders 	<ul style="list-style-type: none"> Establish continuous improvement infrastructure Determine future phase plans Revise governance as needed Connect to CalRHIO Evaluate impact of ACCEL overall Publish findings of ACCEL programs

* Each phase relies on external grant subsidies, a commitment from participating organizations to resource committees and deployment of governance best practices



Initial HIE business case was approved by the Steering Committee, but flagged for further analysis and refinement to build a long term plan for sustainability

- Although the vast majority of HIE business cases result in negative ROI, there is deep rooted belief that that HIEs can dramatically improve the quality of patient care, increase administrative efficiency and reduce medical errors
- Unlike traditional projects that primarily focus on financial return, most HIEs measure initial success by how effectively its investments help to improve health and health care (Mark Smith, CEO, CHCF, "Health IT Social Investment", www.chcf.org, 2007)
- Initial ACCEL business case provides directional information and, consistent with most other HIE business cases, indicates a negative ROI
- Next steps for ACCEL financial analysis
 - Revise financial model once critical decisions have been made regarding revenue approach, technology vendors and speed of implementation
 - Determine what funding sources will be pursued for long term sustainability



A review of internal work done to date, indicates EDC can be a leader in the establishment of an HIE

... if resources can be secured

Brainstorming about where we want to be in 2008 has occurred across multiple groups:

- HIE Business Case completed by Financial Team
- Identification of clinical data elements by Provider Capacity Team
- Learnings from Care Pathways technology implementation planning
- Solid commitment by ACCEL provider network
- Review of funding
- Allocation of resources by members of the Steering Committee within their organizations
- Consultation with technology, legal and health care experts (HTMS, Tennessee Midsouth e-health Alliance, CalRHIO, Mendocino MedNet, Santa Cruz Chronic Care Network, AHRQ)
- Review of ACCEL's overall Technology Project Plan (see Appendix A)



2008 Steering Committee Meeting Plan

(Note: Schedule subject to change based on committee progress. Aug & Dec meetings optional.)

Meeting	When	Topics	Desired Outcomes
#1	Jan	<ul style="list-style-type: none"> •Review Charter/Responsibilities/Decision-making •2008 Committee meeting plan •Governance structure & success metrics revisited 	<ul style="list-style-type: none"> •Approval of charter, role, decision approach •Agreement to meeting plan •Decision to keep/change SC structure
#2	Feb	<ul style="list-style-type: none"> •2009 ACCEL strategic plan draft discussion •Care Pathways check-in: overall plan and progress •EMPI progress review 	<ul style="list-style-type: none"> •Approval of 2008 strategic plan •Program course correction, if needed
#3	Mar	<ul style="list-style-type: none"> •Care Pathways check-in: evaluation •Care pathways QA plan review •Press release review 	<ul style="list-style-type: none"> •Approval of press release
#4	Apr	<ul style="list-style-type: none"> •Recommendations from Provider Group for prioritizing clinical data elements •Technology vendor contract review/expansion 	<ul style="list-style-type: none"> •Approve prioritized data elements •Approve expansion of technical contract
#5	May	<ul style="list-style-type: none"> •HIE business case refinement •Discussion of revenue recommendations 	<ul style="list-style-type: none"> •Decide revenue generation for HIE/refine funding plan
#6	Jun	<ul style="list-style-type: none"> •Outstanding partner agreement issues 	<ul style="list-style-type: none"> •Resolution of partner agreement issues
#7	Jul	<ul style="list-style-type: none"> •HIE pilot design and approval for lab exchange 	
#8	Sept	<ul style="list-style-type: none"> •HIE pilot check in 	
#9	Oct	<ul style="list-style-type: none"> •TBD 	
#10	Nov	<ul style="list-style-type: none"> •TBD 	



Privacy & Security Workshop Discussion Notes

‘Black and White Issues’

Consent

- Opt out assumes patient is in unless says ‘I want out’
 - This approach yields greatest participation
 - Technology will determine if “global opt out” is possible – usually it is limited to point of care
- Opt in assumes patient is out unless says ‘I want in’
- Patient consent needs to account for notification and identify the process

Clarify de-identified vs. anonymized data

- De-identified can get back to ID whereas anonymous data cannot be ID’d
- Understand implications for notification and consent policy
- Need to account for PH reporting requirements

Need policy for episodes when consent is withdrawn

Opt out process requires

1. Education among ALL staff
2. Prompt remediation if errors
3. Development of educational messages directed at consumers at POS

HISP (Health Info Privacy & Security) guidelines can be used to ID issues and goals

Decide structure for conversations

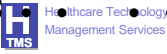
- Allow space for honesty about security among participants
- ID minimum standards

Security Breach

1. HIPAA breach vs HIE policy determines interventions responsibilities and patient notification requirements
2. Audits at HIE and participant levels with differ but need to coordinate
3. If breach identified at HIE level, coordinate with participant org ASAP (within 1 hour)
4. HIE reserves right to turn off access (to individual or participant) if issue not resolved promptly

Privacy & Security

Workgroup structure for ACCEL will include participant privacy officers and legal reps with crossover participation from IT Security Workgroup. Vicki recommends for Privacy workgroup



- Counsel set aside “legal” view and focus on operations
- Bring ALL stakeholders to the table to make sure all participants and functions are represented. This is key to building trust.
- IT Security Workgroup needs to include in HIM and IT
 - Need safe environment where weak links can be safely ID’d
 - Group should establish minimum standards

1. Get commitment from participant orgs and stakeholders to support participants in work groups (time, resources)
2. Follow structured agendas with focused discussions and targeted outcomes
3. Report workgroup participation back to Steering Committee
4. Don't shortchange workgroup participation and development – need cross fertilization to build trust & momentum
5. Build charters and reinforce with mottos, reminders.
 - Frequently revisit what group is to do, what it is not to do
 - Clarify roles of participants

Gerry Hinkley- Participant Agreements

Don't focus on Participant Agreements at this point – wait until HIE has been pilot and is going to full implementation mode. 2009 is likely target

Care Pathways project:

- Build on existing consents and transfer to electronic format
- Modify processes to capture efficiencies in automation
- MH Care Pathway: treat as process outside HIE. Use memorandum of understanding now and build into larger HIE later.

For eMPI pilot:

- Keep simple--use pilot model template
- Develop statement of work, timeline and evaluation objectives
- Save full blown participant agreements for HIE implementation
- Document all decisions and actions

Recommend user friendly manual approach to agreements rather than formal contracting style. This engages participation and actual use of the agreement for reference.

Authorized users
Privacy policies

Develop a PA that is amendable without going to all signatories

Annual review and update approved by Board

Update sent to participants with option to discontinue

Develop processes that maintain commitment of participants to stay with the effort

Overall: start with single MOU and common BAA signed by all participants

Develop auditing process to verify that technology is working and working well (participants are happy)

Caution against forming new entity now:

1. IRS guidelines for HIE tax exemption due in late 2007
 - Primary purposes for entity formation: enforcement and admission of new participants