Overcoming Ten Non-Technical Challenges of RHIOs

Executive Insights
Regional Health Information Organizations (RHIOs) are community-based organizations that must look like, act like, and operate like a business when in fact the stakeholders come from many different industry sectors and are sometimes competitors. Now that technology has matured to meet the connectivity and data-sharing requirements for RHIOs, these newly formed organizations are tackling the non-technical challenges related to governance, financial sustainability, meeting customer needs, and adherence to standards and government regulations. Here are the top ten challenges and insights from the pioneers on how to address them.

**Challenge #1: A common vision and purpose**

It is essential that RHIO participants share a common vision and purpose. Otherwise, conflicting ideas of why participants should work together could force the RHIO into gridlock. One way to achieve common purpose is for every stakeholder to understand the value proposition for themselves, for the other participants, and for the community at large. This understanding should be captured explicitly in a vision statement that addresses both the "why" and the "what" of forming a RHIO. To stimulate action, the vision should be sufficiently broad to engage all parties, yet sufficiently focused to provide a useful starting point. For example, the vision statement crafted by the Utah Health Information Network (UHIN) accomplishes both (see sidebar).

**Challenge #2: Leadership**

The role of the RHIO executive is highly visible in the community and is highly political. This person will be responsible for organizing a diverse group of people around a common purpose, and for achieving a tangible result. This person must be an evangelizer with expert organizational skills in order to keep the initiative moving forward, while building trust and sustaining community commitment. In some cases, selecting a leader from a neutral third party can help to manage the balance between collaboration and competition. In other instances, selecting a well-known and well-respected leader from a participating institution who has a track record in community-wide collaboration is the most effective approach. The successful leader must be passionate about the RHIO’s vision because success requires immense personal energy and commitment. He/she must also be innovative because each community must find its own path to the right agenda and solution.

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The long range goal of Utah Health Information Network (UHIN) is to provide the healthcare consumer with services that reduce cost and improve healthcare quality and access.

In support of this vision, UHIN names five key activities:

1) Create an electronic value-added network,
2) Link community healthcare participants,
3) Support interchange of financial and clinical information,
4) Standardize healthcare transactions and healthcare reporting, electronic interface development, and communications services, and
5) Gather and provide data to a statewide data repository.

Source: www.uhin.com
Challenge #3: Effective governance

An effective governance structure provides the necessary framework for making the many decisions that define and guide the RHIO effort. Because participants come together for different business reasons, it is not surprising that governance models also differ. Someday the industry may arrive at a common roadmap for defining tax treatment, legal identity, organizational structure, charters for the board of directors, and inclusion of stakeholders. But until then, each RHIO must determine which solution best fits its circumstances. For example, if a governmental agency is part of the RHIO, the RHIO may be able to operate as a public or quasi-public authority, thus qualifying for tax-exempt status.

RHIOs involve numerous stakeholders, so keeping governance simple, yet effective and adaptable, can be a challenge. There are now enough RHIOs beyond the initial stages of formation to provide some useful working models. For example, the community-based Santa Barbara County Care Data Exchange in California focuses on the development of technology and infrastructure for patient information exchange as its main service, so it modeled its governance structure after a community utility.

Leaders from RHIOs who are further along advise that reaching consensus about such things as information sharing can be a showstopper. In these circumstances, the process of designing a governance structure should include the perspective of patients.

Today inter-organizational systems — systems shared by more than one company — are common in the e-connected business world. One of the lessons about governance is that it should be consistent with the mission and the purpose for pursuing interoperability in the first place (e.g., economies of scale, process leverage). Over time, more governance structures for managing community-wide data exchanges in healthcare will be tested, yielding a greater choice of models to emulate.

Challenge #4: All stakeholders at the table

Even though RHIOs intend to provide a local or regional service, not all participants will be local. National laboratory service providers — and pharmacy benefit managers (PBMs) in particular — provide critical patient information, but are accustomed to managing much broader regions. This can make it difficult to gain their interest and commitment. Still, propositions that highlight mutual benefit can get their attention. For example, national and regional laboratories currently compete to provide efficient, timely results turnaround for physicians. These laboratories often must mail or fax result reports to physician practices. Switching from manual to electronic delivery yields real cost-savings and adds convenience for physicians. One RHIO, the Indiana Health Information Exchange, is able to charge $0.80 per transaction in exchange for this value.
Challenge #5: Collaboration and competition

RHIO leaders must acknowledge the fact that some participating organizations could also be direct competitors. Left unaddressed, the appearance of a conflict of interest can inhibit the sharing of data and information about business practices. Such conflicts, however, can often be set aside in light of greater opportunities to be realized.

For example, the Western North Carolina Health Network began its RHIO effort by leveraging the relationships and trust that already existed among its network members. They identified areas in which collaboration was natural, such as group purchasing and patient quality care initiatives. In other areas where the sense of competition was much stronger, they sought compromise.

Helping these organizations come to agreement on how to deliver common services in a way that protects all participants is the job of RHIO leadership. In the Western North Carolina example, executives found that all participants were willing to share their data so long as the technical architecture allowed each organization to retain control over their own data and store it themselves.\(^{(5)}\)

While working with RHIO participants, leaders must also keep in mind that too much collaboration can become a concern, specifically in terms of legal liability. A RHIO should regularly conduct legal reviews of its practices to ensure that its participating organizations are not in danger of violating any antitrust or restraint of trade provisions that may be in effect.

Challenge #6: Focus and priorities

Health information interoperability changes the flow of information and can benefit more than one stakeholder at a time. While it can be tempting to tackle a broad array of initiatives for the largest possible win-win, doing so can stretch resources too far. Setting and excessively aggressive schedule — particularly in the early stages — can cause a RHIO to stall or fail.

RHIO participants should expect to encounter competing priorities. Competing priorities for data sources, for example, was one of the most significant challenges reported by the Indiana Health Information Exchange (IHIE). In today’s complex healthcare environment, executives must manage a variety of internal and external issues that divert attention and resources from interoperability projects. In California, for example, urgent issues include the seismic retrofit mandate, the MediCal waiver application, new nurse-patient ratio regulations and many more.\(^{(6)}\)

To satisfy these types of competing interests and at the same time get the best value, RHIOs must prioritize their opportunities across all categories. From supply chain management to patient clinical data, and medication histories to laboratory results, opportunities can be ranked in terms of importance and return on investment. In a RHIO, leaders must take extra care to acknowledge competing interests, such that no one sector either drives the agenda or holds it back. Ultimately, priorities will depend on a balanced assessment of cost, readiness, value, and local demand.
Challenge #7: Explicit benefits and value for stakeholders

The greater the number of organizations that participate, the greater the potential value to all constituents. However, RHIO participants must understand that they will get varying returns on their investments, depending on their role. In order to keep every stakeholder group equally committed, the business model of the RHIO must reflect these differences in the value received from the information exchange.

Often, patients and employers receive the greatest benefit from health information interoperability projects, yet contribute the least toward their development. This creates an imbalance between those who pay for the system and those who benefit. In order to keep incentives in line, the remaining stakeholders, such as providers and payers, can find ways to pass on some of the operating costs in the form of fees or surcharges.

Consider the business model of the Utah Health Information Network (UHIN), which has been financially self-sustaining almost from its inception. UHIN collects modest fees from participating healthcare providers and payers in exchange for providing a way for both parties to communicate using a single standardized format. Eighty-five percent of commercial claims are now paid within seven days, with lowered processing costs. This benefits everyone, as evidenced by the UHIN’s ability to bring aboard 100 percent of the hospitals, laboratories, local health departments, mental health centers, insurance companies, and other payers in the entire state. A recent study funded by the HHS Agency for Healthcare Research and Quality commented, “...UHIN’s financing model for administrative transactions may be the closest to the sustainable (RHIO) framework states are seeking.”

Challenge #8: Financial feasibility

There are essentially two financial challenges: 1) obtaining initial seed money to plan and build the RHIO and, 2) building a sustainable business model to keep the RHIO in operation once the initial money has been spent.

To date, initial funding has generally come from national and state governments in the form of grants. In other cases, interested parties have made sizable contributions to start-up funding and demonstration projects. One example of this is the Massachusetts e-Health Initiative, funded by Massachusetts Blue Cross and Blue Shield. These grants are attractive because they can typically be treated as sunk costs, which do not need to be recouped once the RHIO becomes operational. These types of grants are likely to become more common if the early RHIOs prove financial feasibility and deliver on their value proposition.

Crucial to the sustainability of a RHIO is the ability to collect fees that accurately reflect the value that each stakeholder receives from participating. To achieve this, RHIOs should consider as many different business models as possible, including service-fee models and transaction-fee models.

The Indiana Health Information Exchange (IHIE), for example, charges fees for every laboratory test or radiology result transmitted to doctors, in addition to asking area hospitals to contribute to the operating budget. Under this business model, the IHIE was able to begin sending out bills just a few months after it incorporated, and break even within about a year later. If your initiative, however, focuses on delivering different services, then you may not be able to duplicate this model.
Challenge #9: Agreement on data sharing

All stakeholders must agree on several key questions regarding data sharing. These include which data to share and under what circumstances, as well as the format and method by which to share them. Data sharing agreements, which are sometimes also called “license agreements” or “data distribution agreements,” generally prohibit the recipient from transferring the data to other users, or require that data transferred to other users only be used for specific purposes. Barring special circumstances, these agreements should be formal and legal partnership agreements and they should include provisions for the full spectrum of considerations, including penalties for violations.

Do not underestimate the time required to work these issues out. Leaders of early efforts all report having to deal with a wide range of viewpoints and varying amounts of initial trust. Complex consents, security controls, and acceptable data management practices all must be agreed upon before anything can move forward.

Simply obtaining patient consent can take a long time. Consent can be secured by allowing patients to opt in, or, as in the case of IHIE, by allowing patients to indicate that they choose not to participate. The Volunteer eHealth Initiative in Tennessee takes consent a step further. It allows patients to opt-in or out for each care facility, which increases the flexibility of participation, and captures many patients who otherwise would not have participated at all.

Regarding data management, a federated data management scheme has in some cases helped to address concerns of provider organizations by allowing them to retain control over the patient data. The Indiana Health Information Exchange, which transmits a broad scope of data among a large number of participants, was built on a foundation of more than a decade of data exchange to emergency rooms in the community.

Challenge #10: Privacy and security

Privacy and security are increasingly sensitive issues in health information exchanges. They can be challenging to manage, but they should not be considered an impenetrable barrier.

One of the areas in which RHIOs struggle is the lack of standards for policies, procedures, and system security controls. As more RHIOs come online, more policy models built by consensus get tested. Efforts to identify best practices in privacy and security practices will also continue to make progress in the coming years. For example, 34 states have joined the National Health Information Security and Privacy Collaboration (HISPC), one of many efforts to work toward consensus on the issue of exchanging patient data. Another such group is the Healthcare Information Technology Standards Panel (HITSP), which has already identified and delivered 90 standards that it deems relevant and suitable in the pursuit of interoperability specifications.
References

6. The California Challenge: Opportunities and Stakeholders Responses, from the California Regional Health Information Organization’s Summit I, April 19 2005