

State Health Policy Consortium: Support Services Request  
**The Pacific Northwest Health Policy Consortium**  
**Alaska, California, Idaho, Oregon, and Washington**  
**June 9, 2010**

**Section A: Summary of Proposed Research**

Preparations for interstate exchange of health information are at different levels of development in each of the states of the Pacific Northwest (Alaska, California, Idaho, Oregon, Washington), but all are in early stages. At the same time, interstate exchange of health information is already occurring in specific border (or bilateral) markets (for example between Alaska and Seattle, Washington, and between Portland, Oregon and Vancouver, Washington.) The proposed Pacific Northwest Health Policy Consortium (PNWHPC ) will explore and begin to develop two parallel approaches to improving information exchange between the five states. First, we will evaluate specific near-term challenges and solutions in defined border markets, prioritizing by patient volume and specific policy challenges reported by health care provider organizations. Second, we will explore and, if agreed upon by participants, begin to develop over a longer time frame model legislation (or a related approach) that could be adopted by each of the states participating in the consortium.

**Section B: Introduction and Problem Statement**

**Participating States and Their Representing Entities**

The proposed Pacific Northwest Health Policy Consortium will be comprised of state leaders and key stakeholders from the states of Alaska, California, Idaho, Oregon, and Washington.

- Health Information Technology Oversight Council, Oregon
- Idaho Health Data Exchange
- Office of the Deputy Secretary of Health Information Technology, California.
- Office of the Health Information Technology Coordinator, Alaska
- Washington State Health Care Authority

In addition to state representatives, we will request the involvement of major provider organizations, including but not limited to:

- Indian Health Service
- Kaiser Permanente (California, Oregon, Washington)
- Oregon Health & Sciences University
- Our Community Health Information Network (OCHIN)
- Peace Health (Alaska, Oregon, Washington)
- Providence Health Systems (Alaska, Oregon, Washington)
- St. Alphonsus Regional Medical Center and affiliated hospitals (Idaho, Oregon)
- Veterans Administration

We will focus on specific border markets identified on the basis of current information exchange activity. These border markets have been initially identified to include:

- Alaska and Seattle, Washington
- Boise, Idaho and Eastern Oregon
- Columbia Gorge region (Oregon and Washington)
- Coeur d'Alene, Idaho area and Spokane, Washington area
- Portland, Oregon and Vancouver, Washington (Southwest Washington)
- Southern Oregon (Medford area) and Northern California

### **Problem Statement**

Interstate health information exchange in the Pacific Northwest is already occurring in the absence of well-developed legal or policy frameworks or state-to-state agreements. This request for support services seeks to bring together provider organizations already engaged in the interstate exchange of health information with state policy makers to identify what works currently, what challenges exist and how best to facilitate interstate health information exchange on the local level (in specific border markets) and over a longer time frame, explore a legal and policy solution between all states in the consortium.

### **Efforts by Participating States to Date**

At the recent conference hosted by the Office of the National Coordinator of Health Information Technology (ONC) for State Health IT Coordinators, an informal meeting between the State HIT Coordinators of the five states in the Consortium took place and general agreement was reached that a common approach to Health Information Exchange between the states was desirable. This meeting was a follow-up to other telephone and in-person discussions between LaDonna Larson, (Executive Director, Idaho Health Data Exchange), Carol Robinson, (Oregon Coordinator for Health IT and Director, Health Information Technology Oversight Council), Jonah Frohlich (Deputy Secretary of Health Information Technology, California.), Richard Onizuka, (Director, Health Care Policy, Washington State Health Care Authority), and Paul Cartland, (Alaska Coordinator for Health IT)

Oregon is in the process of consulting with provider organizations in the State of Oregon (e.g., Our Community Health Information Network (OCHIN)) to understand current provider system approaches to the interstate exchange of data. The proposal before you anticipates working with Kaiser Permanente, PeaceHealth (Alaska, Washington, Oregon), other Portland area hospitals with relationships to Southwest Washington (Vancouver area), and other provider organizations with current relevant experience in, or that are currently attempting to solve problems with, the interstate transmission of health information. Other states participating in the consortium will suggest major providers whose patient populations experience the need for interstate exchange. A summary of current practices by organizations such as these in the five participating states will be created. We anticipate that these existing information exchange practices will play a role in developing policy recommendations.

In addition, each of the states in the Consortium were participants in the HISPC project, with California participating on the Interstate and Intrastate Consent Policy Options Workgroup, Alaska participating on Inter-organizational Agreements Workgroup, Idaho participating on the Harmonizing State Privacy Laws Workgroup, and Oregon participating in the Consumer Education and Engagement Collaborative.

An effort is also being undertaken by OCHIN and Douglas County Independent Practice Association (DCIPA) in Oregon and Cal RHIO in San Francisco, California, to work with the Social Security Administration to speed electronic transmission of health records for determinations of eligibility for disability claims. This activity will be evaluated for lessons relevant to interstate transmission of health information.

### **Work by Previous ONC Funded Interstate Exchange Initiatives**

We have reviewed some of the available material from ONC and RTI concerning past initiatives. We noted with interest the HISPC seminar series presentation "Intrastate and Interstate Consent Policy Options Collaborative" by Linda Attaria, Patricia A. Markus, and William P. Mitchin (June 19 2009) which outlines a proposed process for developing policy solutions in the area of interstate differences in patient consent rules among a group of states, and anticipate borrowing from the recommendations made in this document. We take seriously the authors' suggestion that a realistic timeframe for developing an interstate compact is in the two to seven year range, and depends significantly on the level of commitment to the process by members of the consortium. The work of the Interstate Disclosure and Patient Consent Requirements Collaborative (based on work by the states of IN, NH, NY, OK, RI, UT, VT) will also inform the work of this project. An interesting proposal from Indiana suggests the creation of a Data Exchange Engine to answer structured queries concerning permissibility of data transmission between any two states. It will be valuable to explore this and other approaches to automating the retrieval of information about interstate exchange. Finally, we have not found evidence that current NHIN Connect or NHIN Direct efforts have specifically addressed interstate legal and policy differences but will monitor these efforts as they develop.

### **Section C: Justification**

**Evaluate Barriers** - The proposed meetings of the PNWHPC will evaluate existing barriers to interstate exchange in the Pacific Northwest, including such issues as variations in consent models for the exchange of information, differences in types of information subject to special handling, differences involving minors, and other issues identified by participants from State technical staff, provider organizations, and external (RTI provided) technical subject matter experts and policy experts. The evaluation of existing barriers, at a level of procedural, technical and legal specificity sufficient to move toward solutions, is perhaps the most important process to be initiated under this project.

**Evaluate Legal Options in Regional Legal/Political Context** - Because movement toward a shared legal framework is likely to be a multi-year process, it is important to begin reviewing and soliciting Consortium member preferences concerning possible legal approaches. Among the legal options described by past HISPC participants that will be evaluated are:

1. Develop and Propose a "**Uniform Law**": A uniform law approach would involve the adoption by five states of a common approach to consent and related privacy issues.
2. Develop and Propose a "**Choice of Law**" Provision: Consider the possibility that states would adopt a provision that enables states to agree on which state law will control when PHI is exchanged between states with conflicting laws.
3. Develop and Propose an "**Inter-state Compact**": A compact would supersede conflicting laws between states that join the compact.
4. Develop and Propose a "**Model Act**": A model act approach resembles a uniform law, but might not be adopted in its entirety by the participating states.

We will consider the legal and policy environment for implementing these different approaches, as well as enforcement mechanisms, liability challenges and related issues. As a result of this process the five states will develop an understanding of how they wish to move forward on the

legal and policy front. In addition, health information technology policy makers associated with the effort will be able to make recommendations to their state. If there is consensus we will begin a multi-year process to implement one of these approaches.

**Involve Major Provider Organizations** - One of the critical lessons emerging from Oregon's Health Information Exchange (HIE) planning process is the extent to which large provider organizations are already engaged in the exchange of health information internally, and are likely to be significant players in the interstate exchange of information. This project will actively involve existing health systems at the Chief Information Officer (CIO), Chief Privacy Officer and technical levels in presenting their current approaches to, and challenges in, exchanging data across state lines. The results of these consultations will be used to understand current needs, develop interim data exchange solutions in specific border markets and provide guidance for the long term policy process. By surveying CIOs and their health systems, gaining their active participation in regional efforts and prioritizing challenges by patient volume and other market considerations, we can make specific policy recommendations that can result in narrowly defined near-term policy initiatives that may still make a significant difference for interstate information exchange, prior to the development of more comprehensive regional or national legal solutions.

**Begin Planning for Provider Registry Interoperability** - The Consortium will also collectively consider how State HIE provider registries/directories (should they come to pass - California, Oregon and possibly others are known to be considering their creation) can be designed for future interoperability.

**Coordinate with Regional Extension Centers and with Major Provider Organizations** - This effort will emphasize coordination with the Regional Extension Centers including OCHIN in Oregon, Qualis Health in Washington and Idaho, Alaska eHealth Network in Anchorage, California based RECs such as Cal-REC and the Local Initiative Health Authority for Los Angeles County (and others to be identified) in order to avoid duplication of effort and to ensure that we are addressing issues that are relevant to the smaller providers that RECs may serve.

### **Knowledge Transfer**

The proposed activities will be documented and our conclusions made available to other states. The purpose of the PNWHC is to forge agreed upon legal and policy goals for the five participating states and a strategy that each state can pursue to converge upon those shared goals. Whether the best approach is to move toward a uniform law, a model act or some other vehicle is the first question to be decided. We will report on the process we used to reach a decision and the decision that we reach. Following that decision, PNWHC participants will be asked to evaluate specific challenges and to develop a common proposal with variations suited to each state, and potentially to develop solutions for each significant bilateral relationship (border market.) We will report the challenges we faced and the solutions we develop on a local level.

We believe that the process of engaging provider organizations currently engaged in interstate exchange in border markets and state policy makers provides a potentially useful model for other states. We will describe and report how health provider organizations and state policy makers work together to develop solutions. As we document the process of developing a shared legal framework for information exchange we plan to share our findings and approaches with the ONC.

### **Alignment with Office of the National Coordinator of Health Information Technology**

Among the ONC's missions are both promoting the development of HIT infrastructure and supporting health IT policy coordination and strategic planning for health information exchange. The proposed project supports both a near term development agenda (solutions needed in higher volume state border markets) and a longer term policy and legal development agenda (a shared legal framework for regional information exchange.) Our inclusion of both a near term more practical focus and a longer term more policy and law oriented focus enables us to begin to make progress within a one year time frame while laying the groundwork for the more extensive future challenge of interstate legal reconciliation. Since those future legal reconciliation efforts are complicated by potential future Federal pre-emption approaches to inter-state information exchange, this two-fold approach seems prudent.

### **Section D: Desired Outcomes**

At the conclusion of this project we will have created: (1) Better documentation of existing practices, and taken steps toward the resolution of specific identified challenges, in higher volume border markets; (2) A shared basis of understanding for the development of a regional legal and policy approach to interstate exchange; (3) The ability, if desired by the participating states, to move toward legal reconciliation according to one of several potential models.

We believe that project success will be supported by a clear focus on achieving six specific outcomes.

1. Create a network of high level designated representatives in each of the five states with a shared focus on interstate exchange and policy responsibility for this issue in their own states.
2. Describe and document solutions and challenges now faced by providers exchanging information in Pacific Northwest border markets.
3. Develop recommendations and approaches for interstate HIE in local border markets.
4. Build a comprehensive five state map of existing legal and policy challenges at a detailed level. Use and adapt the HISPC Template model to define challenges. Among five states this will amount to up to 11 bilateral relationships. The practical significance of each relationship will depend on patient volume.
5. Legal Issues: Foster a greater understanding of how where the impediments to interstate exchange lie and how a common legal framework might develop.
6. Select, or advance discussion of, a preferred legal strategy, including options such as (a) Uniform law; (b) a "Choice of Law" Provision; (c) an Inter-state Compact; (d) a Model Act, or (e) other options that might emerge. Educate participants, discover preferred approaches, and outline multi-year path toward this kind of legal solution.

As our work proceeds we will also track potential Federal efforts that may supersede or alter the shape of regional solutions, and incorporate those Federal efforts into the work of the five states. In addition to the goals we have adopted above, RTI has suggested some priorities that projects may wish to adopt, and four of these are closely aligned with this proposal, including:

1. Work toward agreement on the purposes for the exchange of information that will be enabled through the interstate exchange and the privacy policies related to those purposes.
2. Work toward developing a governance infrastructure or dispute resolution mechanism to resolve policy issues as they arise within multistate regional exchanges.

3. Work toward agreement on health information organization patient consent policies and designing common forms, evaluate current and planned approaches to consent policies and explore opportunities for harmonization.
4. Work toward developing model state privacy laws to facilitate interstate exchange within a region. Explore interest in model laws.

RTI suggests four other issues that project applicants may wish to address, but that we have identified as being of secondary priority at this time, including:

5. Addressing liability issues related to interstate exchanges.
6. Harmonizing medical record retention laws.
7. Addressing challenges to interstate exchange presented by the Clinical Laboratory Improvement Amendments.
8. Conducting demonstrations to test the privacy and security features of interstate exchange.

### **Section E: Project Schedule and Table of Milestones**

The following timeline with timeframes and milestones will be adjusted to actual calendar dates on project initiation. This schedule includes bimonthly status meetings with the RTI project manager reflecting our anticipation of close involvement with RTI in managing the project.

1. Timeframe: Staff Work (Day 1-59)
2. Milestone: Bimonthly status meeting with RTI project manager (Day 14)
3. Milestone: **Initial Meeting - Environmental Survey, Agenda Setting** - (Day 60)
4. Timeframe: Staff Work (Days 61-119)
5. Milestone: Bimonthly status meeting with RTI project manager (Day 74)
6. Milestone: **Policy and Legal Challenges and Solutions** - (Day 120)
7. Timeframe: Staff Work (Days 121-179)
8. Milestone: Bimonthly status meeting with RTI project manager (Day 134)
9. Milestone: **Provider Organization Challenges and Solutions** - (Day 180)
10. Timeframe: Staff Work (Days 181-239)
11. Milestone: Bimonthly status meeting with RTI project manager (Day 194)
12. Milestone: **Final Meeting - Findings and Next Steps** - (Day 240)
13. Timeframe: Staff Work (Days 241-364)
14. Milestone: Status meeting with RTI project manager (Day 254)
15. Milestone: **Final Report to Participants** - Month 12 (Day 365)

### **Section F: Key Personnel**

**Paul Cartland** is the Health Information Technology Coordinator for the State of Alaska. Paul Cartland joined the Department of Health and Social Services in summer 2007 as project manager for the MMIS Replacement Project. In October 2009 Paul was named as the State's Health Information Technology Coordinator. Paul came to the state health and social services department with almost 25 years of program/project management experience. From spring 2000 through fall 2001, he worked for Yukon Fuel Company where he managed the development of a web based fuel and freight tracking system to enable customers in rural Alaska to obtain information on the status of their fuel and freight deliveries. Subsequently he spent four years as the program manager for Secure Asset Reporting Services managing the development of the SARS web based asset tracking system. Immediately before moving to the state Department of Health and Social Services, Mr. Cartland served as the project manager for AT & T Alascom from

November 2005 through June 2007. Paul was president of the Alaska chapter of the Project Management Institute (PMI) in 2008. He earned a bachelor's degree in Sociology from the University of the State of New York in 1981 and a master's degree in Systems Management from the Florida Institute of Technology in 1988. He is currently a Doctoral candidate in Project Management through Royal Melbourne Institute of Technology in Melbourne, Australia. He intends to finish that degree in 2011.

**Jonah Frohlich** is the deputy secretary for health information technology for the California Health and Human Services Agency. Previously, Mr. Frohlich was a senior program officer in the Foundation's Better Chronic Disease Care program, which focuses on improving the quality of care for Californians with chronic diseases. Within that program, his area of expertise is the use of health information technology to improve care. Mr. Frohlich's earlier Foundation work involved the management and development of national and statewide data exchange standards to support electronic health information exchange, as well as the development of chronic disease management registries. He also worked as a health care consultant for the Foundation, as the manager of reporting and analysis for Brown & Toland Medical Group in San Francisco, and as the director of product management for WebOS, Inc. in Baltimore. Mr. Frohlich has a degree in economics from McGill University in Montreal, Canada, and a master's degree in public health from the University of California, Berkeley.

**Ladonna Larson** is the Executive Director of the, Idaho Health Data Exchange. (See resume, Appendix B.)

**Carol Robinson** is Oregon's HIT Coordinator and Director for the Health Information Technology Oversight Council. Carol Robinson most recently served as the Interim Executive Director of the Oregon Health Fund Board, where she was responsible for shepherding the Board's health reform legislative proposals through the 2009 Legislative Session. Prior to that position, Ms. Robinson served as the Executive Director of Oregon Health Forum and as Publisher of Oregon Health News. Her experience in public policy development includes work across a broad spectrum of business issues with Oregon Business Association, where she served as Director of Public Relations and Development. She also has worked extensively in the area of education issues, serving as Legislative Coordinator for the Coalition for School Funding Now and serving in leadership roles in both local and statewide educational advocacy organizations.

**Richard Onizuka** is Director of Health Care Policy for the Washington State Health Care Authority (HCA), a cabinet agency providing health care for over 400,000 covered lives in the Basic Health Program and the Public Employees Benefits Board. He oversees policy development, legislation and programs related to Governor Gregoire's five point strategy for improving health care, including electronic medical records and health information technology, evidence based medicine, reimbursement reform to support medical homes, and the state's collaboration with the Puget Sound Health Alliance on developing a regional claims data warehouse. He has extensive senior management experience in the public and private sectors in Washington State and Colorado. He received his PhD in Clinical Psychology from the University of Kentucky, and is a Licensed Psychologist in Washington State.

### **Section G: Roles and Responsibilities**

All five states will participate as equals in defining challenges and arriving at consensus solutions and next steps. The State of Oregon has offered to play an organizing and convening role in the project. To the extent that staff work will be required to prepare for meetings, and to summarize meetings and reflect consensus and decisions back to the group, Oregon and other states will provide the necessary staff and we anticipate (if authorized) funding that staff time through the grant. We will welcome the opportunity to clarify with RTI what RTI considers to be an appropriate balance between project experts and State staff resources.

The border market analysis may require different levels of effort by the participating states depending on the specific bilateral legal and policy challenges and on the actual or potential volume of interstate health information exchange in specific border markets. A population analysis suggests that Oregon and Washington may therefore have a relatively higher level of involvement due to the Portland/Vancouver and Columbia Gorge population size, while, for example it may be the case that California and Idaho have relatively low interstate information exchange volume due to geographic separation. States will be asked to assist in recruitment of provider organizations involved in interstate exchange, and in the identification of private sector participants in those organizations. Notwithstanding specific bilateral and market area work, the overall policy framework will be contributed to equally by all participants, and the conclusions presented in the final report will reflect the consensus of the Consortium as a whole.

### **Section H: Specific Resources Requested**

Resources are requested to support:

- (1) the organization and convening of four meetings;
  - Initial Meeting - Environmental Survey, Agenda Setting
  - Policy and Legal Challenges and Solutions
  - Provider Organization Challenges and Solutions
  - Final Meeting - Findings and Next Steps
- (2) the time and travel costs for subject matter experts participating in the meetings;
- (3) the preparation of supporting materials for those meetings;
- (4) the recording and analysis of participant perspectives;
- (5) the generation of interim reports back to the group;
- (6) the generation of a final report regarding Consortium consensus planning for interstate HIE.

**Appendix A - Level of Support Requested**

Support Service	Detail	Support Requested	Explanation
RTI Subject Matter Experts (SMEs)	<p>The presence of an as yet undetermined number of SMEs at four meetings is required.</p> <ol style="list-style-type: none"> <li>1. Initial Meeting - Environmental Survey, Agenda Setting (In-Person)</li> <li>2. Policy and Legal Challenges and Solutions (Web)</li> <li>3. Provider Organization Challenges and Solutions (Web)</li> <li>4. Final Meeting - Findings and Next Steps (In-Person)</li> <li>5. Final Report to Participants</li> </ol>	<ol style="list-style-type: none"> <li>1. For each of 4 meetings two or three appropriate subject matter experts to inform Consortium members about subject under discussion. (8 hours x 3 SMEs x 4 meetings = <u>96 hours</u>)</li> <li>2. For each of four meetings sufficient state staff time to organize meetings, summarize meetings and present formalized consensus document to group. We estimate 160 hours / 8 hour meeting, for a total of <u>640 hours</u>.</li> <li>3. For final report, sufficient staff time to summarize year long process and generate final report on preferred policy direction for the Consortium, and possible external review by one or more SMEs. We estimate <u>160 hours</u> of staff time.</li> </ol>	<p>Because the four meeting plus final report process described here includes an intensive discovery and education process for the states, it is difficult to say in advance which SMEs will best inform our process. We look forward to working with RTI to identify the appropriate SMEs .</p>
State Level Subject Matter Experts	<p>State level subject matter experts may include recognized local leaders in issues related to interstate HIE</p>		<p>A key strategy of this proposal is to involve private sector organizations as participants in the process. We acknowledge that the application requests that we identify potential SMEs in advance, but we hope to work with RTI to receive approval for SMEs we identify as planning proceeds.</p>
Teleconferences	<p>Up to 8 Teleconferences for small working groups in different states.</p>	<p>Up to 8</p>	<p>Teleconferencing services will be used for small sub-group meetings between the four planned conferences.</p>

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Web Conferences	2 Web Conferences 25 Attendees (5/State)	2 meetings	Two of the planned four meetings will be conducted by web and telephone conference.
In Person (travel)	2 In-Person Meetings 20 Attendees (5/State)	Travel expenses for participants in meetings 1 and 4.	An in-person meeting will initiate the Consortium's efforts, enabling all participants to meet and establishing working relationships for the subsequent teleconferences and web conferences. An in-person meeting will conclude the process and lay the groundwork for future Consortium activities.

**Appendix B - Key Personnel**

(Please see the five CVs included with this package.)

**Appendix C - Letters of Intent from Five States**

(Please see letters of intent from Consortium members, included with this package.)