

# An Assessment of Louisiana's Health Information Exchange Capacity and Recommendations for a Path Forward

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*Presented to:*



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# Executive Summary

## *Background*

Few states would benefit more from a strong health information exchange (HIE) capacity than Louisiana. A well-functioning set of HIE services would prove to be an extraordinary asset for (1) coordinating care among physician offices, rural hospitals, and health systems; (2) enabling an advanced public health infrastructure for insights into emerging health problems; and (3) building a resilient data exchange and data availability capacity in preparation for natural disasters.

Yet despite significant investments, the good will and dedicated efforts of many, and the general recognition of the need, there has been limited progress in broadly advancing health IT-enabled data sharing in the state. Louisiana is not alone in having much work to be done; many HIE programs around the country have buckled under the weight of a misaligned fee-for-service payment system and struggled to offer services with broad value recognition. At the same time, many HIE programs have succeeded. These efforts have found their niche, the right set of services on which to focus, and have executed with an incremental strategy built on the foundational requirement of strong relationships.

In this report, HIE refers to a broad set of electronic clinical information sharing which can support treatment, care coordination, care management, quality improvement, research, and other purposes. Further, HIE is not referring to any specific entity, but to a capacity to achieve the data sharing objectives described above. That capacity is best achieved through a range of coordinated efforts enabled by many organizations. Which HIE purposes are prioritized and pursued is a function of health outcomes impact, value to users, technical feasibility, and the ability to financially sustain the service offerings.

The term health IT encompasses a set of underlying capabilities upon which HIE can be developed. Importantly, it includes provider adoption and use of certified electronic health record (EHR) technology but also, for example, solutions for enabling electronic clinical quality measurement.

There have been many organizations and programs in Louisiana that have expended tremendous effort to surmount the barriers to achieving broadly-used and valued HIE services. These organization have also engaged in supporting improvements in connected and high-quality care through many other health IT initiatives, including provider EHR adoption. The Louisiana Health Care Quality Forum (herein, the Quality Forum) and their programs represent an important multi-stakeholder partnership, though there remains only moderate progress on their data sharing efforts. The Louisiana Public Health Institute (LPHI) and their Greater New Orleans Health Information Exchange effort (GNOHIE) and more recently, their REACHnet program, are initiatives that should contribute to the state's forward-looking strategy. Beyond these entities that have engaged in HIE specific work, there are numerous other organizations

and expertise housed within them that represent data and human capital assets that are part of the solution.

This report makes practical and specific recommendations for a path forward.

## ***Engagement***

The Louisiana Department of Health (LDH) engaged the Audacious Inquiry (Ai) team to develop an objective, fact-based assessment of the current status of HIE efforts throughout the state and make recommendations for a forward-looking strategy and perspective on future investment of public resources.

Audacious Inquiry is a health information technology and policy company. The company has a long history of deploying and operating HIE technology as well as providing strategic advisory services. Ai has worked closely with many HIE efforts in a range of states and regions to implement and/or operate HIE services, including Maryland, Florida, D.C., West Virginia, Utah, Delaware, and Philadelphia. On the strategy development and advisory services front, Ai has worked with the Office of the National Coordinator, numerous states, and many HIE organizations. We have used that on the ground experience and perspective to shape the interview feedback into specific recommendations.

We conducted 29 interviews with 38 individuals over roughly 33 hours in September and October. We also reviewed technical and process documents, prior reports, past Implementation Advanced Planning Document (IAPD) 90/10 funding requests, and other relevant background materials. Additionally, Ai team members participated in weekly Health Information Technology Advisory Committee (HITAC) calls and observed other meetings of relevant players in Louisiana health IT.

This report will include our observations and perspective with a focus on areas in which changes, or new direction, could streamline efforts, act as a catalyst, and define a new sense of urgency. The underlying aim of this effort is centered on developing a realistic path forward that takes into account issues related to sustainability, HIE services, and governance. Included within this report are specific actions and the associated rationale behind them.

## ***General Findings***

**Despite significant investment, there has been limited progress among data exchange efforts throughout the state.** We note that there are a number of hospitals that participate in LaHIE to some degree as connected sources of data, but we found limited use of the actual HIE services offered by LaHIE. The major service offerings described by LaHIE include the ability for providers to “query” or search for data, the routing of public health data to LDH, and sending emergency department (ED) notifications through the Louisiana Emergency Department Information Exchange (LaEDIE) service.<sup>1</sup> Our interviews suggested generally low use of these

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<sup>1</sup> <https://www.lhcqf.org/for-providers/lahie>

services. GNOHIE has also faced challenges, but in part due to the generally-held perspective that its focus should remain on its federal Beacon Grant founding role as a network among safety net clinics. Additionally, as its name suggests, the effort has been localized within the Greater New Orleans area. Both the Quality Forum and GNOHIE have struggled to generate any meaningful or sustaining revenue from their services, a requirement to continue to engage CMS and ONC for the funding of future HIE and Health IT related projects.

**There are significantly strained relationships among the key partners whose collaboration is necessary to make progress.** This challenge is particularly pronounced in the current and unproductive dynamic associated with the Quality Forum's relationship with LDH. A core aspect of the Quality Forum's role as a convener and multi-stakeholder collaborative is to thrive as a relationship broker, including with state partners, among otherwise competitive or misaligned interests. Yet, the Quality Forum is currently in conflict with LDH related to the department's re-assessment of projects funded by federal and state resources, a re-assessment that we believe is prudent when relying so substantially on public resources. While Quality Forum's issues with LDH may be the most acute, there are other important organizational relationship and trust challenges that should be surfaced with an aim of improvement over time, rooted in progress against shared goals. We believe that hospitals are critical participants in any data sharing network and, as such, the Louisiana Hospital Association (LHA) must be more deeply engaged as a central partner. We also observed that the nascent HITAC Committee could benefit from additional program support and structure. Beyond the Quality Forum situation, we found other relationship challenges to be related to the absence of a well-defined and cross-organizational governance structure and accompanying set of processes.

**There are not well-defined or broadly communicated goals and objectives associated with establishing HIE capacity.** Many HIE initiatives are rooted in the general premise that patient information has been historically held in data silos and that by sharing that information patient care will improve and the cost of care will decrease. While we believe that hypothesis is generally accurate, the details of how data is shared and the nuances in provider workflows, what connectivity should be prioritized, and how HIE services should be deployed are all important factors. The LDH objective of broad-scale clinical quality measurement to support value-based payment is ambitious and requires substantial coordination and trust with and among the provider community. Calculating clinical quality measures at scale is an extraordinary challenge with which even the most successful organizations have struggled. Many of the goals setting processes historically have relied on the Quality Forum prioritizing projects to receive federal funding rather than a more holistic and inclusive prioritizing setting process. Absent a collaborative goal setting process inclusive of a both state and non-state interests, clear and achievable HIE goals will remain elusive. Use of Medicaid 90/10 enhanced (IAPD) funding are not currently tied to measurable goals and objectives developed through a collaborative process.

**GNOHIE's founding focus on safety net clinic connectivity has broader potential value than is currently realized.** Creating a statewide data sharing network has rarely been achieved through the connectivity efforts of one entity. Instead, most enduring data sharing networks have been a product of relying on various types of "hubs" or sub-networks. One such example is an HIE organization creating one connection to a health system that covers many hospitals. Successfully demonstrated in other states, the existing partnership between GNOHIE and the Louisiana Primary Care Association (LPCA) could be substantially built upon to serve an important set of providers and the patients they treat.

**There are other resources in Louisiana that could contribute to the State's HIE capacity.**

Through our process we noted a number of organizational and data assets that could contribute to establishing greater capacity for HIE in Louisiana. Those assets include existing data collection, management, and reporting activities housed with LHA and other entities. They also include the Patient Centered Outcomes Research Institute (PCORI) REACHnet project, housed within LPHI, includes the deployment of sophisticated and HIE-relevant technology infrastructure. While the program goals are primarily tied to enabling the collection of de-identified data for research purposes, with the appropriate level of stakeholder buy-in, there could be future convergence of near-term HIE efforts and the REACHnet program.

**The Quality Forum role as the Regional Extension Center made important progress, but EHR adoption in the state remains low.** The Quality Forum's past role acting as Louisiana's Regional Extension Center has generally been effective in serving a subset of primary care providers.<sup>2</sup> While this report is focused on HIE rather than EHR adoption, we cannot adequately address one without addressing the other. EHR adoption among providers in Louisiana remains low.<sup>3</sup> The state continues to be in great need of this type of expertise and institutional knowledge to advance adoption and use of EHRs. Both private sector and state-employed provider organizations have identified the Quality Forum as a critical resource to the successful deployment and utilization of EHR technology.

**Despite challenges there is remarkable support to plot a productive path forward.** Given the challenges, conflicts, and frustrations voiced by many, each of our interviews still held a common thread woven between them. There is a will to make progress and an appetite, indeed a hunger, to explore and engage in new strategies and tactics. We noted a sense of urgency among many we interviewed. Yet, the nature of the problems and risks can allow the urgency of a moment or a newly released statistic to fade. Poor health and expensive care have existed in the state for decades. Disasters, notably Hurricanes Katrina and Rita, but also the more recent flooding in and around Baton Rouge, have devastated the state. To ensure urgency is not lost following a recovery, many in the disaster preparedness and response field remind us that each day further from the last disaster is one day closer to the next. On the

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<sup>2</sup> <http://dashboard.healthit.gov/quickstats/pages/FIG-REC-Priority-Primary-Care-Providers-MU.php>

<sup>3</sup> <http://dashboard.healthit.gov/quickstats/pages/FIG-Health-Care-Professionals-EHR-Incentive-Programs.php>

public health front, the threat of the Zika virus is yet another dramatic reminder of the need for a technology infrastructure capable of contributing to a response. A strong health IT and HIE capacity is not sufficient against such complex and significant challenges, but it is fundamentally necessary.

## ***Recommendations***

**Formalize the role of the HITAC Committee and Establish a Statewide Collaboration and Governance Process (SCGP).** LDH should formalize the role of the HITAC Committee as an overarching governance body to support establishing goals and objectives and provide coordinated guidance to the entities that, in aggregate, contribute to Louisiana's health IT capacity. Of note, throughout this report, the term governance refers to organizational governance concepts and not data governance. LDH should enter into a contract with a partner (or provide budget to the Committee to do so) to act as staff to HITAC providing structure and subject matter expertise to the Committee's work. The Committee should have a core responsibility of supporting the Statewide Collaboration and Governance Process, a model borrowed from New York where the New York eHealth Collaborative coordinates across the State's numerous HIE efforts.<sup>4</sup> Given the significant public resource investments by LDH, combined with the intended future reliance on these capabilities, the Secretary of Health should retain the ability to re-constitute the HITAC Committee in the event of a significant governance failure, an approach the state of Maryland has taken within its HIE governance model. Lastly, the HITAC Committee should have responsibility for operating a reporting framework with respect to use of public resources. Accountability for use of public resources ultimately lies with the Secretary of Health.

**Bring the State Designated Entity Role inside LDH and develop an authority and an associate program to designate or certify entities to provide HIE services in Louisiana.** HIE should be pursued as an overall capacity within the state enabled by a range of assets rather than through a single entity. In reality, this is how HIE is already evolving in both Louisiana and around the country. There are various organizations throughout the state, many of which are referenced above, that contribute to an overall capacity for HIE. By bringing the SDE responsibilities inside LDH and developing a designation process, LDH can manage administrative and oversight processes and also engage certain types of HIE activities under the governance umbrella of the SCGP enabled through the formalized HITAC Committee. This designation process could also qualify an entity to receive IAPD funding from LDH. Special caution should be given to the breadth of the definition of HIE and what activities should be regulated by LDH, aiming to develop a narrowly tailored program in which entities seek designation rather than having it thrust upon them. Too expansive a definition could encumber market forces that are contributing to progress.

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<sup>4</sup> <https://www.health.ny.gov/technology/infrastructure/>

**Pursue an early and high-value victory to re-energize progress on HIE in Louisiana.** While the organization supporting the notification service may change, the underlying clinical and financial value cases associated with hospital encounter notifications have been consistently proven throughout the country. Medicaid should set a goal, in partnership with the entity responsible for enabling the service, to have a notification sent to a primary care provider for at least 50% of all Medicaid hospital discharges within 18 months. This type of a notification process measure is correlated to reductions in unnecessary utilization.<sup>5</sup> The intent of such a goal is to focus on an achievable and well-defined initiative, so to that end, this goal could be modified to focus on particular regions or an alternative percentage goal. The key point is to collectively define the goals then achieve it. We recommend broadening the scope of the notifications beyond the ED and into other hospital settings and including a range of subscriber organizations that are permitted to request notifications on their patients or members. These organizations should include ambulatory providers, Medicaid and commercial health plans, hospitals (for readmission alerts), ACOs, and public health for certain disease monitoring. While an ADT notification service should not be misconstrued as the end objective, it is a high-value, low-complexity service on which cooperation, trust, and future progress can be built.

**Conduct a competitive selection process to determine how best to enable a statewide notification service.** This competitive process should involve a detailed analysis as to how the organization would enable the notification value cases described in this report. Numerous stakeholders indicated a strong interest in subscribing to a notification service. For this service to reach its full potential in terms of adoption, care coordination improvement, and HIE revenue generation, complete hospital connectivity throughout state is important. To that end, the competitive selection process, focused on Louisiana-based non-profit organizations, should carefully review the feasibility of each respondent's proposed plans for achieving full statewide hospital ADT connectivity and include specific reference to the ability to engage all Louisiana hospitals.

While the Quality Forum has meaningful existing hospital connectivity and could be considered for this role, the lack of progress to date in garnering broad use of the services should raise caution. LHA, through its ShareCor subsidiary, has also historically engaged in the collection of identifiable data from hospitals and offered analytics solutions to its members. Additionally, LHA has engaged in cross-facility patient identity management by creating a unique identifier based on demographic data contained in the hospital discharge data set. Many hospitals throughout the state have not participated in the current LaEDIE solution, or only in limited ways. Yet, this is the most achievable and valuable service for Louisiana to deploy in the near-term. While LaHIE has established connectivity with a partial notification solution, LHA is also in a strong position to garner the support of its members with the aim of executing on a statewide notification service quickly. In order to ensure a broad range of interests can be effectively represented, the notification service solution provider should work collaboratively with LDH by

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<sup>5</sup> [http://ainq.com/inquiry/wp-content/uploads/2014/12/JHCP-ENS-case-study\\_final.pdf](http://ainq.com/inquiry/wp-content/uploads/2014/12/JHCP-ENS-case-study_final.pdf)

codifying the relationship through a Cooperative Endeavor Agreement (CEA) and/or designation and providing oversight through the formalized HITAC Committee. In order for this model to properly function, the notification service solution provider must agree to operate within a governance framework and IAPD-supported funding model to advance hospital participation.

**The Quality Forum should be considered for a role in ambulatory provider engagement to support increasing EHR adoption and use and in driving use of notification services.** Through EHR adoption is low in Louisiana, the Quality Forum experience operating the REC program could benefit the state on a go forward basis. LDH should increase the scale and scope of the investment in this area of work. LDH can leverage additional IAPD funding to increase provider EHR adoption efforts and support the Quality Forum's initiatives to accelerate adoption in the face of Federal, State, and commercial payment reform efforts. Additionally, the Quality Forum should have responsibility to promote effective use of hospital notifications delivered to ambulatory providers, independent of whether they provide the notification service themselves. It is an important step to deliver a hospital notification to a provider effectively. However, there are a host of best practices on process flow, patient engagement, scheduling, and billing that must accompany the deployment of a notification service for it to have a meaningful impact.

**Fund GNOHIE to focus on deploying a statewide FQHC network in partnership with the Louisiana Primary Care Association.** GNOHIE's history is rooted in a Federal Beacon Grant that funded a focused effort to establish connectivity among safety net clinics in New Orleans. Among our many interviews, we consistently heard positive comments about GNOHIE but a general view that the organization's role is limited to New Orleans and focused on safety net clinics. We identified significant opportunity to build on that program history and general community perspective to develop a statewide FQHC network, thus making ambulatory FQHC data available through the statewide HIE infrastructure in the most efficient way possible. LDH should encourage building on the existing GNOHIE and LPCA relationship and invest IAPD resources in GNOHIE to establish connectivity to their HIE technology with all FQHCs throughout Louisiana. This focus is not meant to exclude GNOHIE's other HIE activities, but rather to prioritize this particular effort on which future success could be built.

**The HIE function of querying for health information should be enabled through evolving national networks and EHR vendor capabilities.** The ability for a provider to search for health information from outside of their organization or local EHR is the service generally thought about as a core capability when envisioning the purpose of HIE. Many HIE efforts around the country, and the HIE vendor technologies that support them, have focused on this service as a primary offering. Yet, there are enormous challenges in deploying this service effectively at scale. As the EHR vendor market continues to consolidate and individual vendors increase market share (both in Louisiana and nationally), the ability to search for data across EHR vendor-led data sharing networks, notably CommonWell and Carequality, is becoming increasingly viable. The vendor-led approaches have significant advantages, particularly

pertaining to enabling efficient workflow for providers. At this stage in the evolving maturity of these national networks, attempting to develop a state-level network will be a distraction from other important endeavors and which may ultimately be displaced by vendor-led progress. LDH should convene the leadership of CommonWell and Carequality and establish a goal of making Louisiana the nation-leading users of these networks.

**Created a focused and collaborative health data collection program under the 2015 Data Collection powers and duties assigned to LDH in Title 40:1173.3.<sup>6</sup>**

This statute provides LDH with authority to collect information from provider facilities and practitioners for the purpose of cost and quality measurement. This authority is an extraordinary asset, but one that should be managed and executed against incrementally with proactive communication strategies and commitment to the core principle of transparency. While this statute and the programs it could enable may not be traditionally thought about as HIE, ambulatory practice connectivity and current hospital reporting are related areas with relevant overlap. At base, we believe any use of the authorities in §1173.3 should begin through a pilot program and expanded upon in close coordination with key partners and their associations.

**Focus IAPD funding requests on a limited set of initiatives to support achieving specific goals and objectives.**

The on-going use of federal funds is critical to support development of Louisiana's health IT capacity. The recurring IAPD approval process creates natural opportunities to evaluate project funding requests to ensure they are both pragmatic and aligned with an articulated set of measurable goals and objectives. While these federal resources can be instrumental to program success, they can also motivate a broad range of project funding requests that each dilute one another and detract from a sharpened focus on a specific set of goals. To that end, we recommend re-evaluating IAPD funding requests to ensure they can be tied to goals and objectives established by LDH as well as through the SCGP. Funding should be allocated to projects that are tied to goals and aligned with a broader healthcare system change in Louisiana. Traceability of funding to intended outcome improvement is critical. As Medicaid's role across the state changes with various efforts, LDH should also assess how IAPD-funded projects may tie directly into Medicaid Enterprise Systems (also known as Medicaid Management Information Systems (MMIS)) and Medicaid programs, as a longer-term funding mechanism may exist to support health IT infrastructure beyond the conclusion of the HITECH program in 2021.

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<sup>6</sup> <http://law.justia.com/codes/louisiana/2015/code-revisedstatutes/title-40/rs-40-1173.3>

# Supporting Rational and Specific Actions

The remainder of the report below is an expansion upon the recommendations presented above with additional rational and background. Embedded within each sections are specific actions that we recommend pursuing, along with broader structural and processes improvement opportunities to create stability for sustained progress. We have organized the additional details into the broad categories of Governance, Organizational Roles and HIE Services, and IAPD Funding Use. Many of the recommendations are disruptive in the near-term, but we believe necessary to re-establish the platform from which cooperative and productive activity can emerge.

## ***Governance***

A well-defined governance model inclusive of key stakeholders is the basis for cross-organization collaboration. The model should incorporate a decision making and oversight construct that offers the flexibility for market-driven solutions to evolve but to also ensure collective priorities can be established and pursued. Each of the topics below is a component that will contribute to the construction of a governance model in which the recommendation above can be executed.

## **Guiding Principles, Mission, and Vision**

The development of guiding principles should be a process led by a newly-defined statewide collaboration and governance process described further below. The exercise itself has collaboration value, but also results in a set of guidelines against which future decisions can be evaluated. We have offered a sample set of principles below for consideration.

**Transparency:** Commit to collaboration, making available the priorities, decisions and metrics.

**Accountability:** use of public resources must be paired with an accountability and transparency framework.

**Usability:** engage Providers / End Users to assure workflow integration & adoption to maximize value.

**Security:** confirm industry best practices are met or exceeded, balanced by usability.

**Privacy:** Build trust through appropriate patient / consumer engagement and data sharing policies.

**Standards:** Leverage national standards, policies, technology where possible; build modularly w/ open APIs.

**Competition:** affirm that competition is productive, but not on the availability of data itself.

## **The HITAC Committee and a Statewide Collaboration and Governance Process**

The existing HITAC Committee is currently inclusive of a wide range of relevant stakeholders, many of whom were interviewed for this report. The current charter of the HITAC Committee reads *“The primary goal of the Advisory Committee is the improvement of Health Information Technology (HIT) and Health Information Exchange (HIE) in Louisiana through the meaningful advising of the Secretary of the Louisiana Department of Health (LDH) on policy matters.”* The HITAC Committee is currently in a strong position to manage a newly-defined Statewide Collaboration and Governance Process. In order to play that role effectively, we recommend that the Committee Charter be updates and that HITAC be formally established by an official act

of the State government and provide committee member appointments to a range of public and private stakeholders, similar or the same as those currently serving on the current Committee. We also recommend that the Committee be provided a budget with which to engage contracted staff to facilitate the work of the Committee. Following these steps, LDH should rely on the Committee for managing the governance of Louisiana's health IT efforts.

This type governance tool is in place in numerous forms throughout the country, though this particular approach has been operational in New York as part of the Statewide Health Information Network of New York (SHIN-NY).<sup>7</sup> The central purpose in the New York model is to enable an open and transparent process that brings together key stakeholders in the State to contribute input and expertise on the development and implementation of policy and technical standards.

We propose that the HITAC Committee support these aims but also have responsibility for coordinating state-level strategic planning and road mapping. That is not to say that the HITAC Committee should have authority over an entity providing HIE services, but rather that they will be responsible for facilitating collaboration intended to result in more aligned efforts. To clearly define roles and responsibilities, we believe it would be helpful to rely on a basic method to create delineation. We would propose use of the RACI (Responsible, Accountable, Consulted, and Informed) model to organize the relevant set of stakeholders against a set of roles and activities.<sup>8</sup> The RACI model is a basic tool to visually represent roles and responsibilities.

- **Responsible:** This is the person or entity that has responsibility for actually doing the work.
- **Accountable:** The person or entity who is accountable for the correct and thorough completion of the work.
- **Consulted:** The people who provide information for the project and with whom there is two-way communication.
- **Informed:** The people kept informed of progress and with whom there is one-way communication. These are people that are affected by the outcome of the tasks, so need to be kept up-to-date.

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<sup>7</sup> <http://www.nyehealth.org/shin-ny/policy-governance/>

<sup>8</sup> [https://en.wikipedia.org/wiki/Responsibility\\_assignment\\_matrix](https://en.wikipedia.org/wiki/Responsibility_assignment_matrix)

**RACI - Roles and Responsibilities Chart**  
(with a few illustrative roles and activities)

	LDH	HITAC Committee	HITAC Staff	HIE Service Providers	HIE Participants
Healthcare Reform Strategy	A R	C	I	I	C
HIE Strategy & Roadmap	C	R	C A	C	I
HIE Performance Oversight	A	R	C	I	I
HIE Designation	R	C	I A	I	
HIE Policy Making	A	C	R	C	I

Responsible	Accountable	Consulted	Informed
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**The Role of the Secretary in the SCGP**

One objective of building increasingly sophisticated health IT capacity is to create a set of technology and services on which LDH can rely. These could include key services for Medicaid, Public Health, disaster preparedness and response, and so on. But, in order to confidently invest and rely on the guidance and strategic direction set by the HITAC Committee, the Secretary should retain the sole authority to reconstitute the membership of the Committee and/or revoke entity designation in the event of significant and demonstrable governance failures. This type of failsafe is in place in Maryland between the state and the entity providing HIE service and governance infrastructure.

**Louisiana Department of Health Role and the State Designated Entity**

Around the country, state government and state designated entities (frequently an HIE organization) have evolved and transformed over time in response to a series of factors. These factors include progress, a lack thereof, new entrants, a convergence or divergence of vision, and the relationships that are intertwined. The recent evolution of the HIE governance model in Colorado represents a helpful reference for Louisiana. Like Louisiana, Colorado has had two HIE organizations operating in the state; a statewide program called the Colorado Regional Health Information Organization (CoRHIO) and the Quality Health Network (QHN) that operates on the Western slope of Colorado. CoRHIO had historically acted in the SDE capacity until recently. The excerpt below is taken directly from the Office of eHealth Innovation in

Colorado.<sup>9</sup> It succinctly describes the rationale and the pivot taken to reassign SDE responsibility.

*In order to further expand Colorado's Health IT infrastructure and accelerate interoperability across the state, broaden the use of actionable meaningful health information, design new value-based payments, and advance quality-based health outcomes a new independent body was established to provide leadership and alignment across public and private sector organizations, in addition to support Health IT initiatives already in progress. This new body, known as the Office of eHealth Innovation (OeHI), was created as a result of a recommendation from the State Designated Entity (SDE) Action Committee, which was formed by CORHIO to evaluate and propose a new organizational structure for the SDE function. Going forward, the OeHI will provide the SDE functions for Colorado, which includes administration, use and designation of federal and state funds enabling Health IT. In short, the Office of eHealth Innovation (OeHI) and the associated eHealth Commission were created in October 2015 through the office of the Governor in Executive Order B 2015-008. It was created to provide an open and transparent statewide collaborative effort to develop the common policies, procedures, and technical approaches needed to advance Colorado's Health IT network and transformational health programs. It is intended to help reduce barriers for effective information sharing and interoperability. At the same time it should help enable innovation of the state's Health IT infrastructure.<sup>10</sup>*

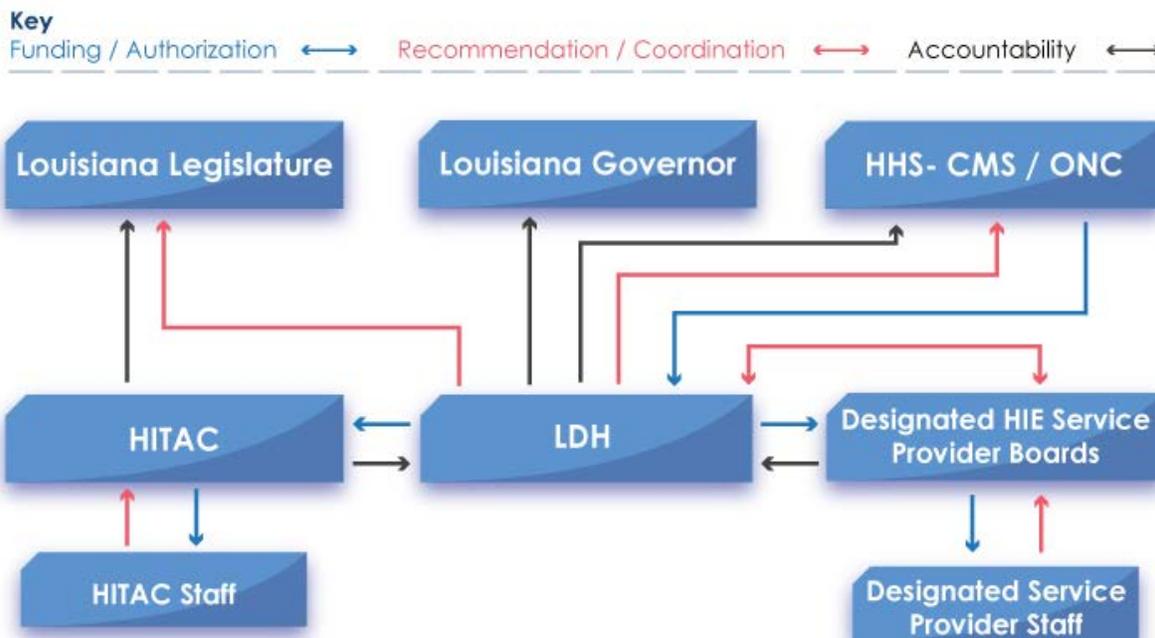
Given the existing responsibility to act as stewards of public resources and the significant interest the Department has in a high-performance data exchange infrastructure, especially to support Medicaid and Public Health, LDH should bring the SDE responsibilities inside the Department. That is not to say that LDH should operate HIE technology. In fact, we strongly recommend that the Department avoid having direct ownership or responsibility of technology operations. Encumbering technology operations with challenging processes inherent in state government could inhibit the ability to be nimble when necessary. Moreover, the skill sets needed to maintain and operate an HIE infrastructure are fundamentally different from those critical to the success of state health departments. Lastly, direct ownership and operation by the Department could (and previously has elsewhere) create a perception that the technology exists solely for the benefit of the Department, which could thwart data sharing and cooperation. The governance model outlined above encourages an LDH role that includes priority setting, regulation development, oversight, and enforcement. LDH should leverage its many roles and position itself as ultimate policy authority, program funder, contract manager, fiscal agent, and regulator to motivate HIE participation and use. A proposed governance framework is included below.

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<sup>9</sup> <https://www.colorado.gov/pacific/hcpf/ehealth-commission>

<sup>10</sup> <https://www.colorado.gov/pacific/sites/default/files/OeHI%20Organizational%20Charter.pdf#page10>

Lastly, developing HIE capacity by relying on multiple entities would benefit from a process to designate those entities that are providing HIE infrastructure. By developing a designation process LDH can pull certain types of activities under the governance umbrella of the SCGP enabled through the codified HITAC Committee. The designation process should qualify an entity to receive IAPD funding from LDH, both to promote interest in acting in this capacity but also to facilitate faster cycles times in engaging partners to execute against projects.

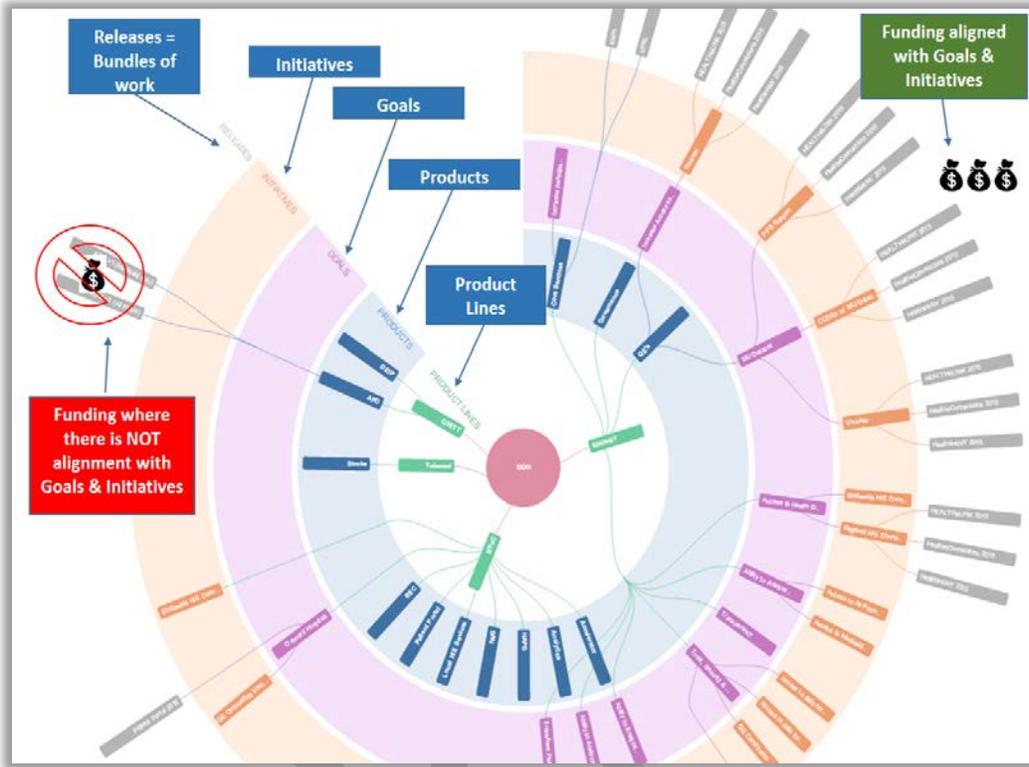


### Strategic Planning and Multi-Generational Roadmap

A key aspect of statewide strategy development is the creation of a multi-generational roadmap. In the near-term that roadmap should be tied to governance infrastructure and attainable projects related to notifications, ambulatory EHR adoption, and FQHC network development. The HITAC Committee should own the responsibility, with the support of Committee staff, to thoroughly define a comprehensive strategy and multi-generational roadmap. As new goals and initiatives are offered, they can be vetted against the guiding principles and viewed through the lens of the roadmap. These technology projects must be ranked and justified to be in alignment with the overall HITAC vision, mission, goals and initiatives.

The Strategy Wheel figure below is a visualization from one example tool intended for this purpose, which could be used by the future HITAC staff. The “strategy wheel” (not intended to be fully legible), shows linkages between goals, initiatives, products and releases. The “thread” (the fine lines in the strategy wheel figure below) link Releases to Goals & Initiatives for a specific Product (within a Product Line). In the example, you can see where funding is aligned with Goals & Initiatives (versus where funding is not aligned since there is no thread between

the Release and the Goals & Initiatives). These types of tools can also track strategy on other dimensions (versus time) and can be a repository for new ideas to be organized. Providing clarity and transparency on the overall strategy and a clear roadmap of priorities is a critical function for HITAC to facilitate across the entities supporting HIE projects.



NOTE: Strategy wheel diagram is for illustrative purposes and not intended to be fully legible

## ***HIE Services and Organizational Roles***

Reconciling the broad promise of HIE against the practical realities of current service availability and use reveals the importance of an incremental strategy for service development. A multi-generational roadmap should envision achieving increasing capabilities, but our on-the-ground experience continues to support a focus on defining manageable scopes of activity that can build toward a broader capacity. Our overall recommendations may be perceived as limited, or not as ambitious as the state requires to achieve the promise of HIE. Yet, ambitious goals without a practical way to execute against them prove to be detrimental as faith is lost and a once shared vision decays into a mirage. Instead, we find defining pursuits with known success metrics and delivery dates results in services being relied upon and creates a shared sense of accomplishment. It also establishes the basis upon which more can be achieved. The details offered below should not be misconstrued to result in a preferred end-state if executed well, but is the starting point and sets the trajectory from which a roadmap created through the SCGP can pick up.

## Near-Term Focus on Notification Services

ADT-based notification services have consistently proven to offer a disproportionately strong value case for a broad set of stakeholders, given the relatively minimal financial investment and technical simplicity necessary to enable them. One measure of HIE service viability is to evaluate if the given service is clinically valuable, technically accomplishable, and financially sustainable. Notification service offerings meet these criteria. But, as is the case with most health IT projects, there are nuances of how the service is deployed and offered. Notification services have clinical and financial value to ambulatory practices, hospitals, health plans, public health, and other entities with evolving care management responsibilities for a patient. Enabling the service requires only ADT data from hospital participants, and while that data is certainly individually identifiable and constitutes protected health information (PHI), we have found a significantly lower barrier for providers to share ADT data compared to lab results or other more comprehensive clinical documents, both in terms of willingness and technical ability. While there are a significant number of applications of ADT-based notifications services, we have highlighted those that we believe hold significant value.

Priority Value Cases	Value Case Description
<p><b>Notifications to Primary Care Providers</b></p>	<p>Primary Care Providers (or specialist acting as a principle care provider) submit a panel of their patients (or send a scheduling feed) to the notification service solution provider. PCPs, or administrative staff, receive real-time or daily summary notifications and contact patients as necessary to facilitate follow-up or post-discharge care planning. Some health plans, including Medicare, reimburse for Transitional Care Management, inclusive of calling the patient within 48 hours of discharge, which is made much more feasible by the notifications. These reimbursements are financially significant.</p>
<p><b>Notifications to ACOs, PCMHs, and other Value-Based Arrangements</b></p>	<p>Providers within advanced payment models (APMs) or other value-based payment arrangements submit attributed patient panels to the notification service solution provider. Notification are in turn routed to those providers in support of improvements in care coordination and care management with the aim of avoiding unnecessary utilization.</p>
<p><b>Notifications to Health Plans</b></p>	<p>Health plans, including Managed Care Plans and other Medicaid populations (e.g. DDA), submit their member panels to the notification service providers. Notifications are routed to health plan care managers. We have found that the basic ability to route the member phone number provided during the hospitalization to</p>

	the health plan significantly increases the member “reach rate” (i.e. the ability to contact the member).
<b>Hospital Readmission Notifications</b>	Because hospitals are already sending ADT messages to the notification service solution provider, discharge messages can be used to automatically add a discharged patient to that hospital’s notification list for a defined period (e.g. 30 days). If that patient is readmitted or has a subsequent ED visit, a notification can be triggered to the readmission coordinators enabling improvements in care coordination.
<b>Public Health Notifications</b>	Louisiana, through a LDH and LSU HCSD collaboration, led important work many years ago to develop the Louisiana Public Health Information Exchange (LaPHIE) focused on alerting relevant public health officials when an HIV patient that had fallen out of care was hospitalized. Similar capacity could be broadened and other public health initiatives supported by submitting relevant panels of patients to the notification service solution provider.
<b>Patient Locator/Family Reunification Service</b>	By having all ADTs flowing, the notification service solution provider could readily establish a service whereby disaster response officials could be provided access to hospital registration data across the state, enabling missing patient location and family reunification services. This type of service is available based on the same data flows in other states and regions.

**Selecting a Notification Service Solution Provider**

Both GNOHIE and LaHIE have offered some form of notifications service. An important aspect of the value case is in the completeness of hospital participation and in the completeness of the notifications to a given subscriber (i.e. the entity requesting notifications for a panel of patients or members). The LaHIE approach, LaEDIE, has focused on ED-specific notifications to managed care organizations. We noted some strong support for LaEDIE from one managed care plan, but generally muted support more broadly. During our interview process we could not ignore the majority view that LaEDIE has yet to meet expectations of most stakeholders. On the one hand, LaHIE (and therefor LaEDIE) has roughly 77 hospital ADT connections which is an important level of connectivity. But, we also noted that some of that connectivity is limited to both ED-specific ADT messages and filtered by some hospitals to attempt to only send ADTs for Medicaid members to LaHIE. That filtering approach limits the ability to pursue other applications of notification services as outlined above. More importantly, through our interview process, the lack of details provided on the accuracy of LaEDIE or its breadth of deployment and our inability to speak with Quality Forum leadership did not assuage the

underlying concern that the relationship and cooperation framework necessary to achieve success is absent from the Quality Forum solution.

LHA has expressed a significant interest and is in the initial stages of pursuing an approach to enable a broad notification service on behalf of their members. As a potential alternative to the LaEDIE solution, there is an opportunity for LDH to partner with LHA to accelerate a statewide notification service aimed at achieving the range of use cases beyond the ED and beyond Medicaid. This type of partnership opportunity contributes to the overall HIE capacity in the state. Engaging with the association in an approach that enables them to offer a valuable service to their members while also achieving other notification and HIE goals has strong interest alignment. The balanced view of this approach raises concern that the hospital association would be in control of a data exchange asset critical to Louisiana's overall HIE capacity. In order to effectively control for that dynamic, LDH would need to enter into an MOU or CEA to establish the parameters and expectations of the relationship. Additionally, the SCGP and ideally, and LDH HIE designation process, would also afford additional protections to broader interests. Another concern would be the LHA ability to establish connectivity with nearly all of the hospitals in the state, including all rural hospitals, quickly. We see significant opportunity in this model, but it would require LDH to be "all-in" and promoting the model as the best course for the state. Lastly, the cost to re-establish or migrate connectivity to a future LHA solution is not an extraordinarily expensive undertaking. ADT connectivity is a relatively basic technical undertaking and we believe there is a financing model, described below, to account for the majority of the expense.

With the history and dynamics noted above, we believe the best course of near-term action is to conduct a selection process focused on reliance on LaHIE or LHA for statewide notification service. LDH could also engage in a lighter weight pre-designation process to identify qualified but limited Louisiana non-profits to compete to provide the statewide notification service. The selection process should include questions pertaining to, among other things, the following sections.

- 1) Technical approach to enabling notifications
- 2) Ability to meet the value cases described above
- 3) Ability to garner total statewide hospital participation
- 4) On-going financing model

### **Reliance on National Networks for Query Services**

Pursuing a query-based HIE capability as a service of an HIE entity (like LaHIE or GNOHIE) requires tremendous commitment and consensus across numerous organizations. The policy and legal framework to support query is inherently more complicated than notification services. There is a reason why many health information exchanges pursuing this path have failed; it is extraordinarily difficult to maintain this commitment without providing value to those whose cooperation is required along the way.

There is a general agreement in the healthcare community that the ability for a provider to electronically search for and find patient data in real time has significant value and can have positive impacts on the safety, quality, timeliness, and ultimately, the cost of care. Most query-based HIE efforts set out with a primary goal of improvement in these areas. However, a pivotal challenge is the speed with which an HIE can reach the tipping point—that is, arriving at the necessary distribution of facility participation in a medical trading area, data saturation level, volume of utilization, and breadth of the user base—to generate enough consistent clinical and financial value for paying participants that utilization grows on its own, and the HIE services become ubiquitous. For query-based HIEs, reaching the tipping point may take significantly longer than many have anticipated and may require a different set of expectation-setting processes. Forecasting this tipping point and developing an appropriate strategy to increase the odds of reaching it, has only recently begun to become possible, given the short histories of the vast majority of HIEs. In retrospect, the ultimately fatal failures of some early HIEs offer valuable lessons for future efforts. Importantly, we have found that the point at which the value of clinical data exchange becomes apparent on a continuous basis is further along the maturity curve than many HIEs recognize. The investments and cooperation necessary to create a relevant query network are likely untenable.

Over the past few years, especially accelerating in the past 12 months, a range of national networks have evolved that enable query-based data exchange among their participants. The most notable of these networks include CommonWell, Carequality, and eHealthExchange. CommonWell and Carequality are sometimes referred to as “vendor-led networks” in that EHR vendors collaborated to establish the technical capacity to enable data sharing among their provider customers. CommonWell and Carequality include significant vendor participation, including the market leaders in acute care: Epic and Cerner.

Rather than attempting to make the case that hospitals and ambulatory providers using EHR vendor solutions that already participate in these networks should also connect to a Louisiana HIE for query, we recommend that the state rely on market-based solutions to create the capacity for providers to search for patient data. Specifically, LDH and the HITAC Committee should engage with the leadership of both CommonWell and Carequality and partner to establish Louisiana as the most connected state in the US leveraging these networks. While these networks enable query-access for limited purposes today, Louisiana could work closely with the network’s leadership to build broader use cases and capacity to support Louisiana goals.

### **Improving Ambulatory Adoption, Use, and Engagement**

There continues to be a significant need for expertise in supporting physician EHR adoption and use. EHR adoption among Eligible Professionals (the term for those providers that are eligible for Meaningful Use incentives) remains low.<sup>11</sup> While certain HIE services, including notification

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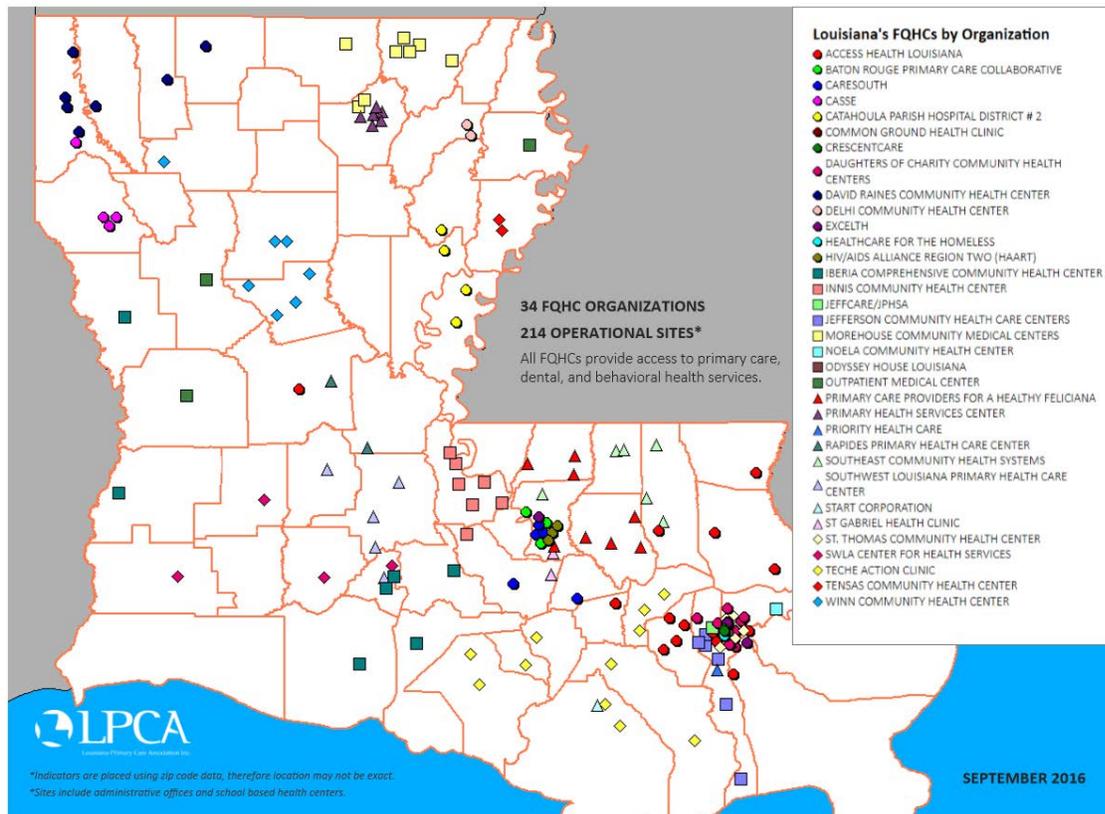
<sup>11</sup> <http://dashboard.healthit.gov/quickstats/pages/FIG-Health-Care-Professionals-EHR-Incentive-Programs.php>

services, can still be implemented and effectively used without the need for an EHR (i.e. notifications can be delivered through other secure methods), advancing beyond these initial services to increasingly impactful capabilities will ultimately require substantially higher EHR adoption rates. Beyond the current Meaningful Use program, the Medicaid Access and CHIP Reauthorization Act (MACRA) will add substantial motivation for providers to pursue EHR adoption. Louisiana will need a strong and stable ability to support this area of work into the future.

The Quality Forum has demonstrated a core competency in ambulatory provider support. The Regional Extension Center (REC) program was a core federal initiative focused on provider EHR adoption. While this effort has concluded, there are other avenues to continue substantially similar work. The IAPD funding mechanism, outlined in more depth below, could be leveraged to create an REC-like program to support provider EHR adoption and the associated implementation, workflow support, and optimization work that the Quality Forum has historically provided. In the near-term, we recommend working collaboratively with the Quality Forum to structure this program. Then, as the HITAC Committee becomes formalized, LDH could shift the oversight of the program to the HITAC and its staff.

### **Development of an FQHC-focused Network**

GNOHIE's Beacon Grant initiative, focused on safety net clinic connectivity, is a model that has been built upon in other states around the country where connectivity and analytics solutions have been established among FQHCs. Much of this work has occurred as activity that Health Center Controlled Networks (HCCN) engaged in with their FQHC members. HCCNs are defined by the Health Resources and Services Administration (HRSA) as "a group of safety net providers collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiencies through the redesign of practices to integrate services, optimize patient outcomes, or negotiate managed care contracts on behalf of the participating members." LPCA has established an HCCN in Louisiana through a HRSA grant. GNOHIE and LPCA have a history of collaboration around HIE activity. We believe there is opportunity to build on this past relationship through additional collaboration and with IAPD funding support.



Given the scale of the FQHC network (see image above) across Louisiana, we recommend a focused effort in partnership with the LPCA to establish FQHC connectivity to GNOHIE. An important objective of establishing this connectivity is to enable a single point of connectivity to the notification service solution provider. In this model, GNOHIE would maintain at least ADT-equivalent connectivity with each FQHC. Those FQHCs would route scheduling or ADT data to GNOHIE, who in turn, could route that data to the notification service solution provider to enable subscriptions. When an FQHC patient arrived at a hospital, the notification would be routed back through GNOHIE and then onward to the specific FQHC. GNOHIE has also worked with FQHC on deeper analytics capacity to support a range of clinical quality improvement functions. Building toward this capability on behalf of FQHCs and as part of the HCCN through collaboration with LCPA could offer significant value to the FQHC community and the patients they serve.

### REACHnet

The REACHnet program, housed within LPHI, has developed a technically-sophisticated informatics and research infrastructure with a surrounding pool of talented experts. The PCORI mandate is to develop programs and solutions to drive toward high quality, safe and cost effective patient-centered research through the creation of the National Patient Centered Outcomes Research Network, of which the Research Action for Health Network (REACHnet),

formerly the Louisiana Clinical Data Research Network (LaCDRN), is one of thirteen nodes. REACHnet was formed in March 2014 and was awarded PCORI Phase II funding through September 2018.

As the name suggests, REACHnet's primary focus is on enabling research through partnerships with provider organization and by creating a technology solution from which research could be conducted leveraging de-identified patient data. Looking forward, as the REACHnet partnership grows, there is future opportunity for the initiative to expand and converge with clinical data exchange efforts. Discussions along those lines are already occurring among certain partners in REACHnet. We believe it is a significant and complex pivot from de-identified research uses (and the focused data use agreements that accompany those uses) of data to identifiable clinical uses, but at this stage in the overall HIE capacity development REACHnet represents an asset to the state which could offer additional future value data exchange effort.

### **Quality Measurement Program Leveraging Title 40:1173.3 Authority**

Data collection and quality measurement is central to Medicaid value-based payment programs. The technical complexity, accuracy challenges, and stakeholder collaboration aspects of a large scale clinical quality measurement program are substantial. While the authority that has been given to LDH is significant, we believe a measured approach that is closely coordinated with the provider community is necessary. While, generally speaking, provider quality measurement is a topic laden with inherent tension, we believe there are steps that can help ease the strain. Specifically, beginning with a pilot initiative, conducting on-going provider engagement processes, and collaborating with provider associations can be helpful in making progress against the inevitable need to measure provider performance to support value-based payment programs.

One approach worth consideration is the development of a specialized registry through a partner organization or vendor relationship. As permitted under Meaningful Use Stages 2 and 3, LDH can declare a specialized registry (Public Health Registry Reporting or Clinical Data Registry Reporting) to collect data for public health purposes and/or record information about the health status of patients and the care they receive.<sup>12</sup> The Centers for Disease Control and Prevention (CDC), ONC, and CMS have purposefully delegated this authority to states to permit the widest definition of a specialized registry. Instead of LDH referring to the mandate for data collection purposes, we recommend LDH declare a specialized registry that could support the collection of cost and quality measurement data. If a LDH intends to declare such registry as a Specialized Registry for Meaningful Use purposes, LDH would update the State Medicaid Health IT Plan (SMHP) to identify how the registry would collect data from providers and how LDH intends to use the collected data. In addition, the inclusion of this declaration in the SMHP allows LDH to engage CMS for IAPD funding to support the development and onboarding of providers to such registry. Once operational, providers participating in the Meaningful Use

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<sup>12</sup> [http://www.cdc.gov/ehrmmeaningfuluse/docs/readiness\\_guide\\_v3-0-final-508.pdf](http://www.cdc.gov/ehrmmeaningfuluse/docs/readiness_guide_v3-0-final-508.pdf)

program can meet one of their population and public health objectives by reporting data to the specialized registry.

### ***IAPD Funding Use and Forward Looking Strategy***

HIE efforts in Louisiana have had substantial reliance on state and federal funding. While that is not inherently negative, developing services which can be financial sustained into the long run, beyond design, development, and implementation (DDI) focused funding, must be considered when setting objectives, defining priorities, and requesting funding.

### **IAPD Background**

CMS issued guidance on funding availability through the IAPD process in State Medicaid Director (SMD) Letter #10-016 (August 17, 2010)<sup>13</sup>, SMD Letter #11-004 (May 18, 2011)<sup>14</sup>, and a 2013 guidance document, “CMS Answers to Frequently Asked Questions (9/10/2013)”<sup>15</sup> (2013 guidance). These documents outlined an ability for state Medicaid agencies to support HIE investments proportional to the benefit that would inure to the Medicaid enterprise, Medicaid providers, and Medicaid beneficiaries. The funding which Louisiana has availed itself of over the past few years is DDI funding (i.e. not operations and maintenance funding) and is made available at a 90/10 federal to state match rate. It is a substantial resource for States to make investments into HIE capacity. On February 29, 2016, CMS released State Medicaid Directors (SMD) letter 16-003<sup>16</sup>, which allows States to use enhanced 90/10 funding on costs associated with connecting “Eligible Professionals and other Medicaid providers” or on costs for other “activities that promote other Medicaid providers’ use of EHR and HIE” and can also be matched at the 90 percent HITECH matching rate. This announcement from CMS is essentially an expansion for how IAPD 90/10 funding under the HITECH program can be used to finance a broader set of provider connectivity and technology efforts.

### **Louisiana’s Use of IAPD Funding**

There are significant considerations related to forward looking federal funding requests. An important aspect of the strategy evaluation is assessing Louisiana’s use of state and federal resources and ensuring funded projects align with the goals and needs of constituents throughout the state, as defined through the HITAC-led SCGP. We believe that the current review of IAPD funding requests is appropriate, particularly in the context of two specific risks. First is the potential for ineffective and incomplete spending of requested federal funding. The multitude of projects included in prior requests can dilute the ability to execute against a more targeted set of initiatives. The inability to effectively deliver on IAPD funded projects puts at risk future funding for Louisiana if the State is unable to maintain CMS confidence in the ability

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<sup>13</sup> <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10016.pdf>

<sup>14</sup> <https://www.medicare.gov/Federal-Policy-Guidance/downloads/SMD11004.pdf>

<sup>15</sup> <https://www.medicare.gov/Federal-Policy-Guidance/downloads/FAQ-09-10-2013.pdf>

<sup>16</sup> <https://www.medicare.gov/federal-policy-guidance/downloads/SMD16003.pdf>

to execute against projects for which funding has been requested. Second, it is a core function of the state to ensure use of funds is being appropriately documented and expended by any sub-recipient. As the stewards of State and federal funding, it is the State's obligation to ensure the funds can be accounted for against project work.

Developing an IAPD funding request is challenging in that many compelling needs may exist which project sponsors will highlight could benefit from funding. In this report, we have opted not to provide an assessment of relative value or appropriateness of any past IAPD funding requests. Rather, we point to the need for an effective process, which includes a strong understanding of the IAPD funding mechanism, to prioritize which projects to include. Beyond the base determination of whether the project fits within the DDI and HITECH boundaries inherent in the funding mechanism, we have found other basic but important considerations. The most important of these evaluations include:

- Does the project contribute to the goals and objectives established through the SCGP?
- Are there milestones and timelines during the lifecycle of the project that allow incremental success to be demonstrated – both to the state and CMS?
- What funding will be required to sustain the service / capability beyond the project and where will such funding come from?
- Does the organization responsible for delivering the project have the base capacity and qualifications to execute?
- Does the project solely benefit Medicaid and/or Public Health beneficiaries? If not, how has the state engaged other organizations that could potentially benefit from this project? Are such organizations supportive of the funding request and demonstrate commitment?
- Are there any major detractors from the project that should be considered?

These questions should be addressed prior to including a project in an IAPD request. LDH should maintain a project evaluation checklist to ensure these topics and others required in the IAPD request process are reasonably addressed, as CMS will require LDH to demonstrate due diligence of these IAPD requests.

### **Forward Looking IAPD Strategy**

As a mid-term financing strategy consideration, it is important to note that the HITECH 90/10 funds will conclude in 2021. While a four-year runway provides reasonable visibility, we suggest LDH begin positioning for a transition to operations funding and coordinating with CMS to identify how best to move forward. In consideration of the above, LDH should engage in a detailed evaluation of what HIE services can be justifiably linked to support of Medicaid operations. The Medicaid Enterprise Systems/MMIS FFP pathway permits 75/25 funding for operations and maintenance activities, such that those services are in support of Medicaid business operations and sustains/matures a state's Medicaid Information Technology

Architecture (MITA).<sup>17</sup> Additionally, the MMIS funding authority does not expire in 2021 as the HITECH authority does. This approach could support a longer term plan for sustaining certain HIE and Health IT capacity for Medicaid.

## Conclusion

As a conclusion, we thought it would be most valuable to discuss where to begin. That is, while this report has organized feedback and perspective heard from a range of stakeholders into a set of tactical recommendations, to convert recommendation to action we have offered specific thinking below on how best to take immediate term next steps. The recommendations in this report can be decomposed into individual projects that have an initial set of decision making and planning activities. We have offered a beginning of a plan as an appendix.

There have been major federal and state programs that have sought to catalyze the creation and use of health information exchange infrastructures. These programs and the associated investments have propelled substantial progress in many regions throughout the country. They have also revealed the financial alignment challenges that have stood in the way of large scale success. While programmatic and financial support of HIE at the state and federal level has been critical, a historically missing pillar for long-term success has been a payment system that motivates data sharing as a key aspect of the ability to perform successfully. That tide is recently and rapidly shifting under MACRA as well as Commercial and Medicaid payment reform initiatives. The remaining ingredient for future success in Louisiana is a well-structured governance model and process that can represent a broad set of interests while organizing and prioritizing investments in data sharing activities.

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<sup>17</sup> <https://www.medicaid.gov/medicaid/data-and-systems/mita/index.html>

# Appendix A – Action Plan

ID	Task Mode	Task Name	Duration	Start	Finish
1	➔	<b>Formalize role of the HITAC Committee and establish SCGP</b>	<b>35 days</b>	<b>Mon 1/2/17</b>	<b>Fri 2/17/17</b>
2	★	Assess current committee make-up and identify any relevant gaps in representation and/or operations	3 days	Mon 1/2/17	Wed 1/4/17
3	★	Identify and pursue LDH, Legislative, or Executive Action to formalize role of HITAC	32 days	Thu 1/5/17	Fri 2/17/17
4	★	Draft charter document defining the SCGP	2 days	Thu 1/5/17	Fri 1/6/17
5	★	Engage in goals and objective-setting activity to define priorities	5 days	Thu 1/5/17	Wed 1/11/17
6	➔	<b>Establish HIE Designation Authority and Process</b>	<b>20 days</b>	<b>Mon 1/2/17</b>	<b>Fri 1/27/17</b>
7	★	Develop a designation core objectives document	5 days	Mon 1/2/17	Fri 1/6/17
8	★	Engage stakeholders (including current HITAC members) for input into document	10 days	Mon 1/9/17	Fri 1/20/17
9	★	Identify initial set of potential designated entities	5 days	Mon 1/23/17	Fri 1/27/17
10	➔	<b>Conduct Selection Process for Notification Service Provider</b>	<b>15 days</b>	<b>Mon 1/30/17</b>	<b>Fri 2/17/17</b>
11	★	Develop notification service requirements document	10 days	Mon 1/30/17	Fri 2/10/17
12	★	Establish statewide goal for notifications (e.g. Medicaid notification goal in body of report)	5 days	Mon 1/30/17	Fri 2/3/17
13	★	Release proposal request to LHA and the Quality Forum (and potentially others)	5 days	Mon 2/13/17	Fri 2/17/17
14	➔	<b>Fund Quality Forum to focus on ambulatory EHR adoption</b>	<b>27 days</b>	<b>Mon 1/30/17</b>	<b>Tue 3/7/17</b>
15	★	Develop IAPD update funding request to include EHR adoption and support	5 days	Mon 1/30/17	Fri 2/3/17
16	★	Partner with Quality Forum to define the program objectives and success criteria	5 days	Mon 2/27/17	Fri 3/3/17
17	★	Identify Medicaid priority practices for notification service connectivity & adoption	2 days	Mon 3/6/17	Tue 3/7/17
18	➔	<b>Fund GNOHIE to develop statewide FQHC data sharing network in partnership with LPCA</b>	<b>10 days?</b>	<b>Mon 1/30/17</b>	<b>Fri 2/10/17</b>
19	★	Convene GNOHIE and LPCA leadership to establish objectives and success criteria	5 days	Mon 1/30/17	Fri 2/3/17
20	★	Develop IAPD update to include funding request to support establishing network	5 days	Mon 2/6/17	Fri 2/10/17
21	➔	<b>Created a focused and collaborative health data collection program under Title 40:1173.3</b>	<b>15 days</b>	<b>Wed 3/8/17</b>	<b>Tue 3/28/17</b>
22	★	Identify limited quality measures pilot and limited data collection plan in near-term	5 days	Wed 3/8/17	Tue 3/14/17
23	★	Conduct a series of sessions and feedback collection processes on plan	10 days	Wed 3/15/17	Tue 3/28/17
24	★	Engage providers and associations most directly affected to define initial and target uses of data	10 days	Wed 3/15/17	Tue 3/28/17

## Appendix B - Interview List

Interviewee	Role	Organization	Interview Date
Jay Besse	Chief Data Officer, Center for Public Health Informatics	Louisiana Department of Health	09/26/2016
Michael Carrone	Program Manager, Health Informatics, Office of Behavioral Health	Louisiana Department of Health	09/16/2016
Thomas Carton, PhD	Director of Analytics	Louisiana Public Health Institute	09/14/2016
Kendra Case, RN	Chief Operating Officer	Louisiana Healthcare Connections	10/03/2016r
Kim Chope	Contract Compliance Coordinator	Amerigroup	10/07/2016
Daniel Cocran	Chief Financial Officer	Louisiana Public Health Institute	09/14/2016
John Couk	CMO	LSU HCSD	10/19/2016
Oscar Diaz	CEO	HarmonIQ Health Systems Corp	10/25/16
Ayame Dinkler	Chief of Staff	LCMC Health	09/23/2016
Rebekah Gee, MD	Secretary	Louisiana Department of Health	09/28/2016
Alicia Guidry, PhD	Health IT Coordinator	Louisiana Department of Health	09/26/2016
Jimmy Guidry, MD	State Health Officer, Medical Director	Louisiana Department of Health	09/21/2016
Tammy Hall, MD	Director, Bureau of Performance Improvement, Office of Public Health	Louisiana Department of Health	09/26/2016

<b>Wes Hataway</b>	Vice President, Legal Affairs	Louisiana State Medical Society	09/15/2016
<b>Glennis Johnson</b>	Director, Information Management	Amerigroup	10/07/2016
<b>Mary Johnson</b>	Implementation Manager, Office of Public Health	Louisiana Department of Health	09/26/2016
<b>SreyRam Kuy, MD</b>	Chief Medical Officer, Medicaid	Louisiana Department of Health	09/14/2016
<b>Errol Labat</b>	Director, Enterprise Risk Management & Audit Consulting	BlueCross BlueShield of Louisiana	10/06/2016
<b>Ann Kay Logarbo, MD</b>	Chief Medical Officer	United Healthcare	10/07/2016
<b>Angela Marshall</b>	Program Manager, Medicaid	Louisiana Department of Health	09/16/2016
<b>Lee Mendoza</b>	Project Manager, Office of Aging and Adult Services	Louisiana Department of Health	09/13/2016
<b>Robert Moerland</b>	Chief Information Officer	Louisiana Public Health Institute	09/14/2016
<b>Kristy Nichols</b>	Vice President of Corporate Affairs	Ochsner Health System	10/05/2016
<b>Frank Opelka</b>	Special Projects Manager	Louisiana Department of Health	09/13/2016
<b>Virginia Plaisance</b>	Manager, Medical Management	Amerigroup	10/07/2016
<b>Rosanne Prats</b>	Executive Director, Emergency Preparedness & Response	Louisiana Department of Health	09/21/2016
<b>Brian Richmond</b>	Chief Technology Officer	Louisiana Health Care Quality Forum	10/06/2016

<b>Nadine Robin</b>	Health IT Program Director	Louisiana Health Care Quality Forum	10/06/2016
<b>Paul Salles</b>	President	Louisiana Hospital Association	09/15/2016
<b>Raman Singh, MD</b>	Medical Director	Louisiana Department of Corrections	10/04/2016
<b>Jen Steele</b>	Medicaid Director	Louisiana Department of Health	09/26/2016
<b>Alan Thriffiley</b>	Project Manager	LSU HCSD	10/19/2016
<b>Greg Waddell</b>	Vice President of Legal, Government, and Regulatory Affairs	Louisiana Hospital Association	09/15/2016
<b>Clayton Williams</b>	Executive Director	Greater New Orleans Health Information Exchange	09/14/2016
<b>Wayne Wilbright</b>	CEO	LSU HCSD	10/19/2016
<b>Jeff Williams</b>	Chief Executive Officer	Louisiana State Medical Society	09/15/2016
<b>Lynn Witherspoon, MD</b>	Chief Medical Information Officer	Ochsner Health System	10/04/2016
<b>Henry Yennie</b>	Program Manager	Louisiana Department of Health	09/21/2016

## Appendix C – Glossary

ACO	Accountable Care Organization
ADT	Admission Discharge Transfer
Ai	Audacious Inquiry
APM	Advanced Payment Models
CEA	Cooperative Endeavor Agreement
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CoRHIO	Colorado Regional Health Information Organization
DDI	Design, Development, and Implementation
EHR	Electronic Health Record
FQHC	Federally Qualified Health Center
GNOHIE	Greater New Orleans Health Information Exchange
HCCN	Health Center Controlled Network
HIE	Health Information Exchange
HITAC Act	Health Information Technology Advisory Committee
HITECH	Health Information Technology for Economic and Clinical Health Act
HRSA	Health Resources and Services Administration
IAPD	Implementation Advance Planning Document
LaCDRN	Louisiana Clinical Data Research Network
LaEDIE	Louisiana Emergency Department Information Exchange
LaHIE	Louisiana Health Information Exchange
LDH	Louisiana Department of Health
LHA	Louisiana Hospital Association
LPCA	Louisiana Primary Care Association
LPHI	Louisiana Public Health Institute

MACRA	Medicaid Access and CHIP Reauthorization Act
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
ONC	Office of the National Coordinator
OPH	Office of Public Health
PCORI	Patient Centered Outcomes Research Institute
RACI	Responsible, Accountable, Consulted, Informed
REACHnet	Research Action for Health Network
REC	Regional Extension Center
SCGP	Statewide Collaboration and Governance Process
SDE	State Designated Entity
SMD	State Medicaid Director
SMHP	State Medicaid Health IT Plan
SHIN-NY	Statewide Health Information Network of New York
QHN	Quality Health Network