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President's Page
Can You Hear Me Now?

Perhaps the most transformative innovation improving health care in North Texas in years is almost upon us. In the next 3 months, the first 13-county regional, cross-system, Health Information Exchange will go on-line. The benefits of having medical connectivity and access to a patient's complete medical history in real time in cyberspace are intuitively enormous. Can anybody say, "one-stop shopping?

Being able to gather medical information from across hospital systems and among all physicians' offices electronically in a timely fashion will render enormous healthcare delivery dividends. For example, accessing a patient's medical history from his internist's office may help avoid ordering unnecessarily a repeat test. Pulling up a previous office EKG in the middle of the night and determining that those EKG changes you are seeing in the Emergency Department actually are pre-existing may save an expensive admission and nuclear stress test. It will significantly reduce the number of unnecessary redundant tests that are performed in the emergency setting because we don't have ready access to the patient's history. I cannot tell you how many times in my own office experience that a patient is referred for a second opinion regarding an abnormal blood test, echocardiogram or coronary angiogram, and we don't have the pertinent records at the time of the initial office visit. The value of the visit is minimized, and often we have to schedule another appointment or telephone conference for when we have access to the information. Both the physician's and patient's time is wasted, and higher cost is introduced into the system from the need to schedule unnecessary clinic time and redundant tests. But more importantly, the patient is placed at risk because diagnosis and treatment plans are delayed. In this regard, an HIE can have an enormous beneficial impact on both the quality and cost of health care.

Wait a minute! Isn't that a major vision of health system reform? This is exactly the type of innovative development that Eric Topol, MD, talks about in his epic tome, "The Creative Destruction of Medicine: How the Digital Revolution will Create Better Health Care."

As I write this piece in mid-August, we are in the midst of the West Nile Virus epidemic in Dallas County. As part of DCMS' recommendation to the Dallas County Commissioners Court in support of aerial spraying, we suggested that the County could actively monitor the area hospital EDs for unusual visits or upticks in symptoms that could be associated with the use of an aerial pesticide. An HIE would be the perfect technology to help monitor the evolution of an emerging regional health emergency such as this and coordinate an emergency response.

HIE Players and HIE Impact

The HIE in North Texas will encompass 13 counties (Collin, Dallas, Denton, Ellis, Fannin, Grayson, Hunt, Johnson, Kaufman, Parker, Rockwall, Tarrant, Wise). Total patient population served in 13 counties is 6,595,234. All licensed physicians in the 13-county region will be invited to participate (that's 11,796), as will all licensed hospitals in the region (137). So far 80 percent of the hospitals and 60 percent of the physicians have signed letters of agreement. The goal is to have 100-percent participation of all physician and hospital providers.

The North Texas HIE is one of 16 Regional HIEs sanctioned by the State of Texas through a statewide HIE cooperative grant. The HIE in the Metroplex was created and is governed by the North Texas Accountable Healthcare Partnership (www.ntahp.org), a 501(c)3 nonprofit entity. The Partnership board is unique among healthcare cooperative enterprises in that it is populated with stakeholders representing physicians, hospitals, employers, insurance carriers, and patients (consumers) as equal partners. Through a strategy of data sharing, defined metrics and public accountability, the mission of the Partnership is to promote and reward local healthcare clinical performance that is coordinated, transparent and value-based. Fundamental to the success of this strategy is the simultaneous creation

and support of the regional Health Information Exchange. The Partnership HIE will allow for the establishment of patient registries as well as point-to-point data exchange to improve real-time sharing of clinical data.

The Winding Path Toward an HIE

This is an enormous project and it has undergone multiple false starts. The HIE experience in the United States is littered with the shipwrecks of failed attempts. To better understand the challenges of establishing an HIE, it is helpful to review the whimsical winding historical journey of the health information exchange in North Texas.

In late 2004, Congressman Pete Sessions' Healthcare Task Force met at Presbyterian Hospital. The conversation included a briefing about President Bush's efforts to engage physicians and the healthcare industry into the world of electronic records. Les Secrest, MD, and Michael Darrouzet, our EVP/CEO, represented DCMS.

In March 2005 Congressman Sessions wrote a letter to his advisory group to explore the introduction of a Regional Health Information Organization into the Dallas healthcare market. Later that month the task force hosted an initial meeting that included Congressman Sessions; John Gill, MD; Joel Allison, president and CEO of Baylor Healthcare System; and DCMS staff. After months of discussion, this initial effort failed primarily because of a lack of an effective governance structure and excess vendor influence. The first attempt ended.

In 2006, a second effort was attempted with the formation of the North Texas RHIO Steering Committee, under Dr. Secrest's direction. DCMS, Tarrant County Medical Society, and the Dallas-Fort Worth Hospital Council were the principles. In April 2007, just as the steering committee was preparing to transform itself into a nonprofit organization, TCMS withdrew from the project due to financial reasons. This withdrawal ended the second attempt to form a regional health information exchange, as it was deemed that without a true regional effort, the exchange would fail.

In early 2008, unwilling to let the issue die and believing that physicians must take a lead role in creating an exchange, DCMS formed a RHIO Strike Team, led by Kevin Magee, MD. This effort was short-lived because of a lack of consensus between the DFWHC and DCMS about the need for an independent nonprofit. The Strike Team disbanded.

DFWHC and DCMS subsequently went on their own paths toward establishing a regional exchange. DFWHC sought a Beacon Grant but was not successful because the application was not seen to include enough stakeholders.

In March of 2008, DCMS created its HIE 5 Committee. The committee experienced the most momentum of any effort to date, collecting significant financial contributions from area hospitals and hiring a consultant to write a business plan for the region. The final business plan was shared with the funding hospitals. Despite their initial buy-in, the hospitals declined to act on the plan, saying that they wanted to seek initial funding from outside sources.

DCMS next sought to use Project Access Dallas as the focal point of the renewed effort to create an exchange, now called an HIE by those in Washington. (RHIO was a tainted name by now due to so many failures across the country.) In mid-2009, DCMS made a final attempt to secure funding for a physician-led HIE by requesting that private hospital systems that were partners in PAD financially underwrite the project. This request was denied.

Until this point, the failed HIE experience in North Texas seemed to derive from a deficiency in at least one of four separate, but critical, components: an effective governance structure, financing, full participation of all regional partners, and involvement of all four primary stakeholder groups (physicians, hospitals, payers, and industry).

In May 2009 the landscape changed. In the midst of congressional hearings about health system reform, the concept of the Accountable Care Organization was introduced. Using the ACO model as a

starting point of discussion, representatives from the four stakeholder groups formed a steering committee and discussed how to address the high cost of health care in North Texas. Part of the motivation was to explore the potential of gain-sharing models and the possibilities materializing in the emerging world of capitation. DCMS' Michael Darrouzet was named chairman of this committee. It soon will become apparent to all involved that the success of the HIE largely was a result of Michael's keen insight, relentless nurturing and skillful stewardship of the process.

Having learned from failed HIE attempts, the steering committee agreed to an organizational structure with a solid and effective governance system based on each stakeholder group having equal representation on the board. This relationship is unique in healthcare delivery models and will be key to the success of the entity. In April 2010 the steering committee agreed to form the North Texas Accountable Healthcare Partnership as a 501(c)3 nonprofit corporation in order to apply for federal/state HIE grant funds that were allocated to Texas from federal stimulus funds. Here, three of the four elements for a successful HIE project appeared to have been met: full stakeholder participation, effective governance and an adequate start-up funding source (the feds). The regional component was satisfied by the federal requirements for application for the funding. The feds defined the counties and regions that would have to work as partners if they wanted to apply for the federal grants.

On Sept. 30, 2010, the NTAHP was formed. Mr. Darrouzet was "promoted" from chairman of the steering committee to chairman of the NTAHP board, and Bryan White, former DCMS director of socioeconomics, was selected as the executive director of the HIE.

The Partnership chose diabetes and congestive heart failure as the two chronic illnesses for which to develop "shared savings models." For many months, the four workgroups met and planned "shared savings" strategies including Metrics, Care Coordination, Common Plan Designs, and Rewards.

In November 2011 the Centers for Medicare and Medicaid Services and the state approved an amendment to the state grant award, opening funding to NTAHP totaling more than $4.9 million over the next 3 years, contingent on meeting performance goals. The NTAHP grant tied for top grant applications in the nation. I was added to the board as a DCMS representative.

In March 2012 Orion Health was chosen as the HIE vendor for North Texas. This is the same vendor that the State of Massachusetts recently chose for its statewide Medicaid program. That same month Joe Lastinger accepted the position as CEO of the Partnership, and John Flores, MD, Denton County Medical Society; Matt Weyenberg, MD, Collin-Fannin CMS; and Jim Cox, MD, and Sandra Parker, MD, Tarrant CMS; were added to the board.

The North Texas HIE will go "live" this fall. I have seen a demonstration of the HIE and I am very excited. The Partnership HIE also will offer the opportunity to subscribe to an on-line EMR service for a nominal fee that will satisfy CMS meaningful use requirements. This particularly will be valuable to solo or small group practices for which the economies of scale for a traditional EMR are challenging.

Although the HIE has come very far and the benefits seem obvious, obstacles remain to be addressed. A major risk to the long-term success of the HIE will be the financial sustainability of the project after the federal grant monies expire. Money makes the world go round, and this is true for an HIE. However, the money saved from the reduction of unnecessary hospitalizations and redundant testing could be considerable and dwarf the cost to run the Partnership. The four stakeholder groups need to realize a financial reward for participating monetarily in the NTAHP investment. Only if all four partners participate in the reward for the risk taken can a true win-win dynamic materialize and financial sustainability be secured.

Preserving the hospital participation in the project also could present a challenge. Some private hospital systems may view the North Texas Regional NTAHP HIE as a threat to their nascent HIE efforts. However, the full potential of an HIE will not be realized unless it functions across all hospital systems. If we have an HIE system that is just a patchwork of compartmentalized information exchanges, the sweeping promise and extensive benefits of a comprehensive global HIE will be minimized. Some

hospital systems may also view the Partnership HIE as a threat to their individual competitive strategies, and the siloization of their patient base and physicians. An intersystem HIE of this magnitude will break down some barriers between hospital systems that otherwise would limit the outflow of physician referrals and patients (affectionately termed “leakage”), but the overriding consideration should be the net clinical benefit to the whole healthcare delivery system derived from the enhanced integrated care and cost containment. If all stakeholders maintain the primacy of the patient in this project, the NTAHP will be a stunning success. The huge winners will be all the patients in North Texas. Just as the connectivity of the telegraph and telephone linking all cities, towns and communities in America was a dramatic, transformative moment in our history, so, too, will be the NTAHP HIE linking all the physician and hospital providers in North Texas.

“Can you hear me now?”