

Hawaii Health Information Exchange Strategic Plan

DRAFT

Introduction to Strategic Plan

Overview

The Unique Nature of Hawaii and Hawaii Health Care

Hawaii is a unique place in many ways, not the least of which is its geography. The only island state within the nation, it is comprised of eight main island, seven of which are inhabited (Oahu, Maui, Hawaii, Kauai, Molokai, Lanai, and Ni'ihau.) Collectively they extend over 400 miles of ocean, creating land masses of approximately 7500 square miles, of which the island of Hawaii makes up approximately two-thirds. The inhabited islands are but the southern most reach of an archipelago over 2000 miles in length that extends from the island of Hawaii in the south almost to the international date line in the north west. Hawaii is also one of the most remote geographic areas in the world, illustrated by the air mile distances from Honolulu to San Francisco (), Honolulu to Washington, D.C. and Honolulu to Tokyo (). Hawaii is also one of the least densely populated states with but 188.6 persons per square mile. This combination of relative isolation, island separation, and the large number of sparsely populated rural areas makes healthcare delivery and accessibility an ongoing challenge.

With respect to health and healthcare matters Hawaii is distinctive in at least six important ways, each of which in some way helps to structure and define how healthcare is “done” in Hawaii.

First, up until the 1970s Hawaii was an environment dominated by a plantation economy, which then transformed rapidly into a tourism oriented economy. Many of the people inhabiting the islands to that point were tied in some ways to plantations, either directly or through historical family ties. Whatever its other faults, the plantation economy socialized people into a primary care oriented medical system, tendencies that have persisted in later decades.

Second, Hawaii alone among the fifty states from the mid-1970s onward had an employer mandate health insurance system, which while imperfect in providing healthcare for all, did provide healthcare coverage for most, and allowed Hawaii throughout the subsequent decades to have the small proportion of its population without health insurance coverage.

Third, quite unlike most states throughout much of the post war period the health care insurance environment was an effective duopoly, with the Hawaii Medical Services Association (HMSA) and Kaiser Permanente sharing the better part of 80 percent plus of the market (HMSA 60 percent plus; Kaiser approximately 20 percent). The remainder of the health insurance market was given over to smaller plans, some local and some national, which have flowed in and out of the overall market.

Fourth, again largely because of its plantation history, but also reflecting the fact that throughout the territorial period and into statehood many state agencies reflected their origins within the administrative structure of the Hawaiian kingdom, Hawaii developed a state hospital system, located until the 1990s with the state department of health and operated as a branch within it. One responsibility for this system was to ensure the existence of at least minimal hospital facilities on each island. Restructured in 199x as a public benefit corporation of the State of Hawaii and named the Hawaii Health Systems Corporation, HHSC currently operates fourteen facilities on four islands, ranging from comprehensive hospitals to long-term and veterans care facilities. The bulk of the remaining hospital system in the state is concentrated into three systems, the Queen's Medical Center, which operates Queens Hospital in urban Honolulu, Hawaii Pacific Health Corporation, which operates four hospitals, and Kaiser Permanente, which operates a comprehensive hospital on Oahu and multiple clinics on the neighbor islands. (Compete details of the entities that comprise the healthcare system are contained in the Environmental Scan.)

Historically, and for some of the reasons suggested above, the population of Hawaii is remarkably healthy and has enjoyed more than sufficient services, with one notable exception—the health of the native population and others of Polynesian ancestry, who lag behind other groups in the state's multi-ethnic population on almost all critical health and longevity indicators. The health and healthcare needs of this population stand at the center of public health and health care considerations, and have been recognized within the Native Hawaiian Health Care Act of 199x, which among other provisions establishes native Hawaiian health care clinics.

Finally, for a complex set of reasons having much to do with how federal formula generate reimbursement rates for Medicare, Hawaii has among the lowest rates in the country, a fact which takes on far more significance when viewed in light of the attendant fact that the state's cost of living (measured by the COLI) is the highest in the country, measured at 166.7 in the 4th quarter of 2009 with the next highest, Washington D.C. at 139. The simple but powerful implication for health care is that providers and service entities throughout the system are required to do relatively more with less as a structural fact of how costs and reimbursements face each other.

Each of these six factors has an impact on how healthcare information is generated, deployed, used, and exchanged (or not) within Hawaii. The burden of these

introductory remarks is that in many important ways, Hawaii as an environment is different in many respects from its sister states, and these differences are revealed in the multitude of ways that issues concerning health information exchange are raised and dealt with.

2.0 Environmental Scan

2.1 Overview

2.2 Assessment of Current HIE Activities

2.3 HIE Readiness

2.4 Human Capital

2.5 Collaboration Activities

3.0 HIE Development and Adoption

3.1 Overview

As indicated in the environmental scan the degree of electronic usage, storage and exchange of healthcare data is uneven—well developed in some areas and barely begun in others. The public-private conversation about healthcare data is of long-standing, stretching back at least to the Blue Ribbon Committee on Healthcare Costs, established by Governor Waihee in 1992. The underlying policy commitment for this endeavor, namely to create an entity that stood squarely within public-private policy space to become a demand-use facility for major hospital data that could be employed to assist both public policy and hospital users, created an attitude toward shared data within the state environment that has persisted. The result of that effort was the creation of the Hawaii Health Information Corporation which has created a broad data base organized around hospital data that is used extensively for various health reporting purposes, including supporting the most extensively used *Hawaii Health Trends*, published with the support of the HMSA.

The development of the Hawaii Health Information Exchange (HawaiiHIE) as it is proceeding under funding from the America Reinvestment and Recovery Act (AARA) was anticipated with the creation of HawaiiHIE as a membership organization supported by major healthcare plans and providers in 2007. Hawaii HIE was transformed into a 501(c)(3) non-profit organization in November 2009, and provided status as a State Designated Entity (SDE) by executive order of the Governor of Hawaii.

A very useful pilot program, Ho'olamua, was developed through the collaboration of the Hawaii Primary Care Association for two of its major Oahu clinics (Kalihi-Palama Health Center and Kokua Kalihi Valley) and two of the major hospital systems, Queens Medical Center and Hawaii Pacific Health. The goal of the Ho'olamua project was to improve health care for vulnerable patient populations transition between CHCs and hospitals through the development and implementation of a master patient registry (MPR). The

lessons learned from the four years of this project inform this current plan inform its values and vision.

3.1 Vision

Hawaii's vision for the development of health information exchange is that public health and healthcare in the State of Hawaii will have been positively transformed by the exchange of critical health care information throughout the system of care and can be easily accessed, as appropriate, by all interested parties, including consumers and providers, with total confidence in the security and validity of the information.

3.1 Guiding Principles

In pursuit of this mission HawaiiHIE has adopted these guiding principles:

Inclusive. HHIE is committed to broad stakeholder engagement (statewide, urban/rural, large/small, consumers/providers/organizations) in shaping its services, establishes policies and procedures that assure fair representation and participation in decision-making, programs and services, and actively seeks to reduce barriers to improve the delivery of care for all stakeholders. Through this process stakeholders will be organized, their resources and needs inventories and relevant programs coordinated.

Quality. HHIE is committed to creating an open and respectful data sharing environment. Data integrity is the cornerstone that assures quality provider information and patient care, therefore HHIE will establish and maintain the highest quality control procedures and standardized metrics while still assuring easy access and functionality for users.

Transparency. HHIE maintains clear, open and constant two-way communications with its stakeholders, the public-at-large, and within HHIE itself.

Privacy. HHIE ensures consumers' privacy at all times by maintaining security on its products, engaging in regular system audits, and meeting all state and federal standards on privacy.

Sustainability. HHIE's own sustainability will be a direct result of providing quality services for its stakeholders, creating an outstanding value proposition, and investing in infrastructure that is flexible and useable for a long period of time.

Manageability: HHIE will gain optimal success by prioritizing its activities and making incremental progress, with "first steps first" its operational code. Once developed the technical infrastructure will succeed by keeping its design simple but effective.

Rules and Standards: Develop effective rules and governance models to facilitate the sharing of data, with a central, guiding principle being that of building trust among participants.

Use the Present to Achieve the Future: Make maximum use of “what already exists” throughout the health care community, building on existing capacity and making maximum use of integrated incremental steps.

3.2 Vision and Mission

Vision

Public health and healthcare in the State of Hawaii has been positively transformed by the exchange of critical health care information throughout the system of care and can be easily accessed, as appropriate, by all interested parties, including consumers and providers, with total confidence in the security and validity of the information.

(Note: One thought is to embellish this section with illustrative narratives, similar to the “use stories” Noam presented on May 4.

Mission

Hawaii Health Information Exchange facilitates the exchange of health information that enables quality health care statewide. To provide reliable health information when and where it is needed.

3.3 Goals & Objectives

Achieve the two year objectives established by ONR for each of the five domains.

Ensure full neighbor island participation in all aspects of HawaiiHIE development with special attention given to particular needs and circumstances of neighbor island communities.

Organize stakeholders in an effective manner, include them within the governance process, take inventory of resources and needs of individual stakeholders, and provide effective coordination of programs

Develop plans to build shared infrastructure (near term) that is sustainable (in long term)

Ensure eligible providers have connectivity to be “meaningful users.”

Forge cooperative relationship with relevant state agencies to enable maximum use of health care data at all levels, e.g. immunology registry.

Establish effective coordination leading to beneficial information exchange with all interested stakeholders. Engage independent physicians on all levels of information exchange, providing technical education and assistance.

Develop stakeholder agreements on data standards to be utilized at the state level. Ensure that standards and technical architecture are compatible with national standards as they are created.

(The next sections are to be completed over the coming weeks in May, and are closely linked to materials that will be included in section 2.0 Environmental Scan.)

3.4 State-level HIE and Regional Capacities

3.5 State-level Infrastructure Development

3.6 Implementation Roadmap

3.7 Coordination with other ARRA Programs