NHII 2004 – GOVERNANCE TRACK BACKGROUND PAPER

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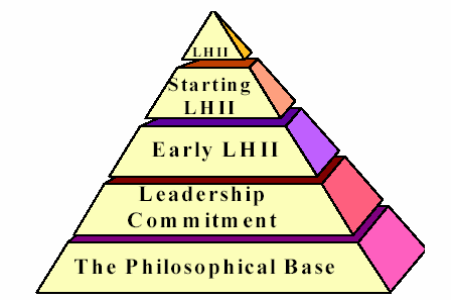
Governance of an LHII is defined here to mean the structures and processes that must be created to enable an organization to conduct its main fiduciary duties: decision-making on development and allocation of resources and oversight of the disposition of those resources.

Among the most difficult issues that nascent local health information initiatives confront relate to governance. These difficulties stem from the inherent complexity of the issues at hand (e.g., collaboration among competing organizations) combined with the lack of a base of experience in collaborating among enterprises, either locally or nationally, from which to draw upon. For many communities contemplating the creation of a local health information initiative, governance could pose a serious hurdle.

The Governance Track will structure the discussion of issues relevant to formulating, starting and operating a local health information exchange (HIE) entity (referred to throughout this paper as an LHII). This paper presents some of the key governance questions that LHII aspirants are likely to confront. The breakout groups will be particularly important in this regard precisely because there are many LHII experiments underway or nearly underway across the country, but there is so little documented experience in this area to-date. This background paper lays some groundwork for that exchange by highlighting: 1) the current state of thinking about and experience with LHII governance; 2) the importance of governance to LHII creation and sustainability; 3) key drivers of governance design; and 4) a recommendation framework to launch the breakout discussions.

CURRENT STATE OF THINKING

While there was no NHII 2003 governance track on which to build for 2004, a useful launching point is the work conducted for HHS by Nancy M. Lorenzi entitled "Strategies for Creating Successful Local Health Information Infrastructure Initiatives." The Lorenzi paper distills success strategies from detailed examination of two case studies (Santa Barbara and Indianapolis), provides useful checklists to enable communities to identify the key ingredients for a successful LHII launch, and depicts the stages of LHII development as follows:



Philosophical Base. This is the first phase of LHII development and describes formation of the vision growing out of the base of a community's experience in cross-institutional collaboration. Formation of an LHII is, by most accounts, more of a political process than a technology process. The ability of LHII initiators to forge consensus through collaboration will depend on the local community's experience with prior attempts at cross-institutional collaboration as well as local health care enterprises' cultural attitudes towards risk taking and loss of power and control.

Leadership commitment. The second phase of LHII development begins when an organization or individual begins to spearhead and coordinate the overall effort – in short, when a person or organization becomes directly accountable for LHII creation. This is the stage in which the LHII vision begins to get translated into a set of value propositions that motivate a core group of community/institutional leaders.

Early LHII. In the third phase of Lorenzi's progression, the LHII vision starts to become reality with the creation of a governance structure to formally endorse the vision and to set a strategy for accomplishing it.

The Lorenzi paper lays out a roadmap to guide communities through the first two phases of the pyramid. The goal of this paper is to pick up where Lorenzi left off and 1) identify the key drivers of governance choice, and 2) create a framework to facilitate other LHIIs' efforts to tackle important governance issues.

IMPORTANCE OF GOVERNANCE TO LHII CREATION AND SUSTAINABILITY

As noted earlier, we define "governance" as the structures and processes that must be created to enable an organization to conduct its essential fiduciary duties: decision-making on the development and allocation of resources and oversight of the disposition of those resources. This definition obviously covers a wide range of structures, activities, and processes, and our aim is to focus on the issues that seem to be most important for decision-makers contemplating launching their own LHII.

It's important to note at the outset that, while governance is important to any organization, it is particularly important to the creation and sustainability of LHIIs. Because most LHIIs will be cross-institutional, few will have a foundation of trust to ground them or an organizing body or principle to guide them. A key challenge,

therefore, is establishing a framework that builds on areas of agreement among stakeholders, but at the same time allows stakeholder autonomy in areas in which no agreement exists, *without magnifying those differences.* An enabling governance structure and process will meet the overwhelming need to create a neutral and trusted forum that strengthens consensus-building – by generating, affirming, and nurturing areas of agreement, by damping tendencies towards escalating conflict, and by identifying, isolating, and resolving areas of disagreement.

A well-structured governance framework will set in motion the vision-strategy-organization process to align the LHII with the vision laid out by its stakeholders. A key learning from organizational governance models generally and the LHIIs already in existence is that form should follow function: An LHII can hope to meet its vision only if there is a practical strategy for achieving that vision and an organization put in place to execute that strategy. The governance structure is thus the codification of the LHII's vision – in short, it should be tailored to accomplish the goals laid out by its stakeholders.

In the context of health information exchange facilitated through an intermediary organization, emerging LHII organizations must consider what is to be governed, who will benefit from the work of the LHII organization, and how the organization is chartered to pursue the health information exchange. Basically, they must answer the question, "governance of what and for what purpose?"

This paper assumes that LHIIs, will be chartered as corporate entities, most likely non-profit entities. In short, the process should:

- codify the vision of the LHII's founders – since form should follow function;
- align the LHII's strategies with its chartered mission;
- clarify how the LHII strategies align with member strategies;
- create a trusted forum for collective development of a strategy to achieve the vision; and
- establish an organization to implement the initial strategy and refine the vision and strategy over time.

KEY DRIVERS THAT SHAPE GOVERNANCE

Three key decision levers will be the primary means available for an LHII to shape the governance of the organization going forward: board structure and composition, legal entity model, and operating model.

Board structure and composition

One of the earliest and most critical decisions to be faced by an LHII will involve who should be on the Board and who should lead it. This is a critical question because its

answer will likely be the first concrete decision made by the organizers of the LHII. The key questions that will be confronted from the outset will be:

- Organization/interest representation – which organizations need to be on the Board?
- Individual representation – what level of individual will represent each organization (CEO, CIO, other)?
- Leadership – who will lead the Board, particularly in the early stages?

Organization interest/representation. Deciding which organizations need to be represented on the Board reflects the LHII's past and its future, in that the Board will be selected from those stakeholders who are already involved in the LHII creation, as well as those who are not yet involved but will be critical to the LHII's vision in the future. Frequently, tension exists between two opposing goals: pursuing a broad coalition to ensure stability of the LHII going forward, on the one hand, and the need to get organized as quickly as possible to launch the LHII, on the other.

As a practical matter, one strategy for managing this tension is for the Board to comprise the fewest number of organizations required to launch the activity in a reasonable period of time. Obviously, influential/key organizations within the community bring respect and proven business practices and relationships that are probably necessary to making a LHII succeed in the long run. In the short run, however, having a discrete, self-standing LHII organization will motivate other organizations to decide whether they will be a part of it; by providing a concrete decision point, it will give an imperative to action to organizations that might be struggling with the decision to join. The existence of a legal entity also enables fund-raising because it gives contributors a much clearer understanding of what their money will be used for. Finally, launching the organization is a sign of success and signals the evolution from broad concept to reality, thus enhancing the future marketability of the LHII.

Who is not on the Board can be as important a question as who is. There will be some organizations that may not be represented on the Board at the outset purely for expediency, in which case bringing them in is simply about communicating with them and ensuring that the structure of the organization is flexible enough to allow their easy entry. The LHII organizers' decision to exclude some organizations for reasons other than expediency should reflect the LHII's vision, and the consequences of their exclusion should be carefully considered.

The principal issues regarding who to include and who not to include usually revolve around trust among stakeholders, and thus, are often along the main fault lines of the adversarial relationships that existing in health care delivery, namely, horizontal (market competitors, such as hospital systems, who occupy the same place in the value chain) or vertical (transactional rivals, such as payers and providers, or hospitals and physicians).

The small amount of evidence that exists to date shows that the vertical fault lines appear to be more prominent than the horizontal ones (i.e., it seems more common to leave out a

whole category of organization, such as payers, than to exclude individual companies within the same category). This may reflect the fact that horizontal players may feel that they have more control over how any shared information gets used because they don't have routine interactions with their competitors, and thus, there is less likelihood that the shared information will affect their core business processes. For example, vertical rivals (such as payers and providers) have ongoing and frequent interaction as part of the negotiated transactions they conduct for business. For these organizations there may be greater concern about how shared information will be used to gain advantage in those transactions.

Individual representation. Selecting individuals to become part of the Board structure is a function of the vision of the LHII and the organizers' assumptions about the role of the Board. It seems clear that the greater the degree of sharing of clinical information among the LHII participants, the closer the LHII is to bumping up against the strategic imperatives of the individual stakeholder organizations, and thus, the more likely that the collaboration will require senior-level (e.g., CEO) representation. There is a time trajectory to this as well – as LHIIs expand into deeper levels of data sharing with a broader set of players, they may find the need to "elevate" their Board representation.

The level will also be dictated by how "activist" the LHII's organizer envision the Board to be. For example, will it be (1) a working-level, "roll-up-the-sleeves" type of board with working sub-committees or (2) will it be involved more in agenda setting, oversight, and strategic guidance? As a practical matter, the former will be more difficult to manage with high-level Board members who are more accustomed to delegation and who may have tighter time constraints.

Who leads? Leadership for the organization will be critically affected by the founding organizations. It will also be tempered by the criticality of any individual organizations and their organizational/individual need for control or tight monitoring. The choice will also reflect individual personalities and will depend on individuals' reputations for collaboration in the community and among peers. Finally, and not to be underestimated, it will also reflect their ability/willingness to commit the time required to launch the activity.

Legal entity model

The second major lever of governance is the organization model adopted by the LHII. Turning the LHII from a movement into a viable organization will require the creation of a legal entity to implement the strategic plan, manage the activities of launching and sustaining the LHII's activities, and monitoring the execution of the organization against the strategic plan.

Legal entity structure. There is large variation in legal entity structure exhibited by even the small number of LHIIs that exist today. While each of them is unique in its specifics, three general archetypes can be distilled: (1) a centralized, divisional model, (2) a

holding company model, and (3) a federation or association model. The following schematic (Figure 1) highlights some of the main features of each of these models and their advantages and disadvantages, and provides some examples of prototype LHII organizations that exhibit some of these features.

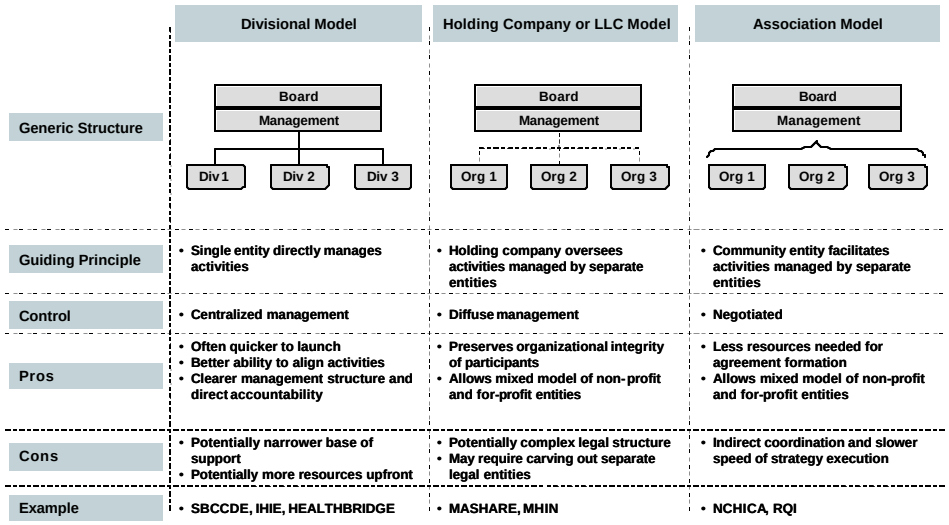


Figure 1: Comparison of Organizational Models[1]

The centralized/divisional model is one in which products/services/projects are developed and executed from within a single organization through a single management structure. In this model, formal collaboration occurs mostly at the Board level. By contrast, both the holding company or limited liability company (LLC) and association models lean more toward executing projects by coordinating the activities of separate organizations, and thus, have formal collaboration meshed more integrally into their operations. The LLC and association models differ most visibly by the fact that the LLC owns the organizations operating within it, whereas the association model does not. While these archetypes clearly oversimplify not only the variation that exists among LHIIs today but also the variation in possibilities, the framework highlights some of the main considerations faced by nascent LHIIs.

[1] SBCCDE – Santa Barbara County Care Data Exchange ; IHIE – Indianapolis Health Information Exchange; MA-SHARE – Massachusetts SHARE (Simplifying Healthcare Among Regional Entities); MHIN - Michiana Health Information Network; NCHICA – The North Carolina Healthcare Information and Communications Alliance: RQI – Rhode Island Quality Institute

Operating model

The final level of governance involves the model for operating, that is, doing the work. Just as the models for legal structure range from centralized to de-centralized, the operational approaches range from developing the in-house capability to sub-contract or conduct projects internally, to using the existing capability of stakeholders or collaborators, to contracting an entire function or project to a vendor. Generally, organizations following the first approach most closely include IHIE, SBCCDE, and Healthbridge, whereas MA-SHARE, RQI, and NCHICA seem to be more closely following the second approach, and MHIN takes the third.

While these elements – board composition, legal entity model, and operating model – represent individual decision points, they are in practice not independent of each other. The critical link between all of them is the interplay between the vision and strategy, on the one hand, and the selected organization model, on the other. This connection is exhibited in Figure 2.

Variation in vision/strategy is measured in the "reach," or number and type of stakeholders behind the LHII, and the "richness," or depth of interaction contemplated in the exchange model. LHII organizations that have a wider array of organizations or organization types but a lower level of sharing of clinical information seem to have more of a "coordinator" function, whereas those with more far-reaching sharing initiatives tend toward more centralized operating models.

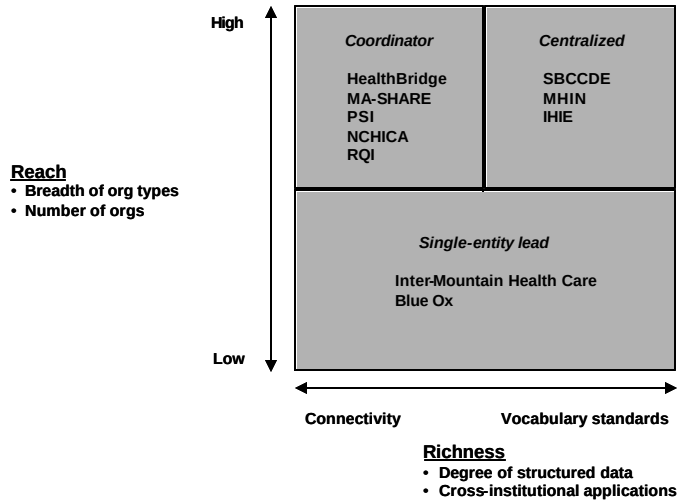


Figure 2. Comparing Organization Membership (Reach} vs. Degree/Complexity of Data Exchanged (Richness)

RECOMMENDATION FRAMEWORK

LHII formation, start-up and operation are the concern of DHHS, as well as that of the many communities that will plan one. These recommendations focus on methods for gathering experience, sharing information and informational artifacts, and conveying the collective wisdom gained from experience of operational LHIIs. Through a coordination of DHHS agency grants/contracts and DHHS office activities, innovation can be sponsored, field experience can be assessed, and vetted knowledge and best practices can be made widely accessible.

Support needs to come in the form of an authoritative resource center and program for offering assistance in regional or local forums. LHII leaders will need access to an array of information that helps them to conceive, plan, initiate and operate a local health information exchange. Establishing a governance structure and accompanying processes are essential to LHII success.

A **resource center** that builds a library of key lessons learned and best practices, and offers informational artifacts relevant to governance will accelerate the rate of new LHII formation.

1. The Small Business Administration offers an example of how this might be formulated. This resource center should provide:

    - reference materials from the academic peer-reviewed literature.
    - reference materials from the grey literature of functioning organizations, such as guidebooks and example documents (organizational charters, by laws, governance descriptions, etc.).
    - contact lists.
    - related conference and training opportunities that can serve accelerate diffusion of proven approaches.
    - financial support opportunities, such as updated and compiled list of AHRQ, HRSA, and CDC grants.

    To avoid wasted energy and confusion by local groups establishing LHIIs, the federal government should make these types of information readily accessible through one portal.

2. **Checklists and guides** that assist the design, launch, and maintenance of a LHII need to be created. These guides and checklists will assist formative organizations in addressing the host of requirements essential to starting and operating a new organization of this type. Checklists and guides should be developed to:

    - Provide an understanding how the organization's form relates to its function.

- Explain what questions they must answer (and those that can wait to be answered later) with the assistance of attorneys.
- Offer examples of how to establish a memorandum of understanding among participating entities.
- Show what provisions should be included in the by laws and articles of incorporation.
- Explain what form the high-level business plan should take, such that stakeholders understand how their interests will be served.
- Explain how to avoid creating showstoppers out of issues that can be resolved once the base of trust is formed.
- Manage when and how to present challenging, potentially show-stopping issues, such as data ownership, privacy, and intellectual property.
- Guide the LHII management in building trust among stakeholders, communicating, channeling information, resolving conflicts, and avoiding the "LHII as multi-lateral conflict sink" syndrome.

3. **Legal discussion / issue briefs and frequently asked questions (FAQs)** need to be developed around several key issues that bear heavily upon the governance of a LHII.

    - Anti-trust, the Stark Law provisions, and private inurement present legal challenges to the formation of an LHII and to its governance structure. For example, the Stark Phase II makes significant changes to the body of rules governing Stark law compliance. Thus, existing arrangements developed based on pre-Phase II interpretations create a compliance conundrum for individuals and organizations that are subject to the law. The costs associated with getting specific legal opinions on a case-by-case basis represent a barrier to forming and launching an LHII. We recommend that DHHS develop briefs that summarize point-in-time status of how relevant anti-trust, Stark, and private inurement rulings affect LHII operations. The point here is that LHII will flourish only if there is a consistent set of interpretations of legal rules as they pertain to the core issues of LHII governance and LHII member participation.
    - HIPAA is another set of key legal rules and regulations that presents as many opportunities as challenges. Legal issue briefs and FAQs explaining how HIPAA applies to LHII governance and operation will facilitate nascent LHIIs in addressing provider concerns.
    - Interstate sharing of information also raises legal questions that will confront many LHIIs, especially as they mature and as more LHIIs come into existence.
    - Telemedicine across state lines is a related issue because it challenges existing practices in state licensure.
    - Intellectual property issues within an LHII need to be anticipated. Issue briefs that explain where these issues will arise, present concepts as to

how intellectual property can be apportioned among stakeholders, and offer examples of practical experiences in dealing with intellectual property issues will help new LHIIs avoid significant legal fees and delays in forming an operating entity, while building trust among stakeholders.

Consistently updated issue briefs issued by DHHS on these subjects will improve understanding of the legal issues and will reduce variation in practice from locality to locality.

4. **Regional Workshops** targeted to organizations considering the formation of an LHII would assist their formation by informing many people at once, begin building a network of colleagues across regions, and be an avenue for receiving direct answers to questions. Such workshops would allow leading-edge LHIIs to share the benefits of their experience and would offer unique forums for knowledge exchange. In effect, these workshops would maximize the opportunity to examine different governance models and share relevant materials across regions, while minimizing travel and costs associated with attendance.

5. **Learning Communities** designed to foster collaboration and share learning have been proven to be an effective and efficient way for practitioners of emergent activities to share the tacit knowledge needed to solve problems in the context in which they occur. DHHS should sponsor the formation of communities of practice to that are charged with developing knowledge products, such as lessons learned. Products from the communities of practice should populate the resource center with the latest knowledge, as well as build a self-help network of trusted colleagues.