



## **Establishing Governance: Focus on Sustainability and Community Inclusion**

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*“An effective governance structure provides the necessary framework for making the many decisions that define and guide the RHIO effort. Because participants come together for different business reasons, it is not surprising that governance models also differ. Someday the industry may arrive at a common roadmap for defining tax treatment, legal identity, organizational structure, charters for the board of directors, and inclusion of stakeholders. But until then, each RHIO must determine which solution best fits its circumstances.”<sup>1</sup>*

The long-term sustainability of a community-based health information exchange (HIE) requires a well-articulated governance structure capable of harnessing leadership and moving the initiative into an operational reality. The structure should be simple, yet effective and adaptable, and consistent with the overriding mission and purpose for establishing the HIE.<sup>2</sup>

The model structure provides an ongoing forum for the potentially competitive constituents of the governing body. An effective governance structure will be able to carry the HIE forward through the inclusion of representatives from all areas of the community. Industry learning indicates that communities will be well-served to pursue governance structures that are both inclusive and neutral.

A successful governance structure will also incorporate the business model upon which the HIE is based and lessons learned from other community-based information exchanges, which can provide a retrospective view of the past to avoid repeating mistakes in the future.

### **Linking to the Financial Model**

The most effective governance structures tend to be those that are tied to the business and financial models under which the HIE intends to operate.

Typically, business model selection is based upon a range of variables, including tax status and incentives, governance and control factors, and whether the HIEs are focused more on coordination, solution development or infrastructure implementation. For instance, while some HIEs exist specifically to foster the sharing of clinical data, others are focused on providing services such as electronic prescribing or results reporting.

“It is expected that each community will explore the different types of HIE business models and pick the one(s) that offers them maximum benefit and return—especially the greatest chance of early sustainability.”<sup>3</sup>

<sup>1</sup> First Consulting Group, *Overcoming Ten Non-Technical Challenges of RHIOs* (Oct. 2006).

<sup>2</sup> First Consulting Group 2006.

<sup>3</sup> Deloitte Center for Health Solutions, *Health Information Exchange (HIE) Business Models: The Path to Sustainable Financial Success* (2006).

Four general categories of business models have emerged:

- **Not-for-profit:** Tax-exempt status can help reduce funding challenges and provide special tax credits. However, it also requires operating under strict conflict of interest rules, can create issues with access to capital, limits lobbying activities and carries heightened executive compensation scrutiny.<sup>4,5</sup>
- **Public utility:** Created and maintained with the assistance of federal or state funds, and provided with direction by the government.<sup>6</sup>
- **Physician/payer collaborative:** Created for/by certain physicians and payers within a geographic region. These can be either for- or not-for-profit; the key is the collaboration between and mutual benefits for participating payers and physicians.<sup>7</sup>
- **For-profit:** Created with private funding and having firm return on investment (ROI) targets, for-profit initiatives seek to achieve financial benefits from their transactions and typically have solid start-up funding.<sup>8</sup>

Additionally, HIE initiatives typically rely on a combination of three types of revenue sources. The business model can both impact and be impacted by the revenue source, as variations in income classification often depend upon legal and accountancy advice, statutes and regulations, form of incorporation, and IRS determination:

- **Contributed income:** Cash or in-kind resources such as grants from governments and private philanthropy, as well as in-kind grants such as facility usage. In fact, 84 percent of revenue in start-up HIEs falls within this category.<sup>9</sup>
- **Earned income:** Payments received for services or privileges, such as transaction fees and membership/subscription fees representing volume-based pricing and flat pricing, respectively. Transaction fees make up 8 percent of total income in production HIEs, while membership fees accounted for 28 percent of total income.<sup>10</sup>
- **Loans, other repayable assets and investor proceeds:** Cash and in-kind resources that were loaned and must in some way be repaid or that were received from investors in exchange for equity ownership of the organization. Investor proceeds in exchange for equity are not available to 501(c)(3) tax-exempt organizations. However, not-for-profit organizations may participate in for-profit enterprises that, subject to very specific and detailed limitations, may partner with investors.<sup>11</sup>

The earned income model, particularly in the form of a combination of membership and transaction fees like the one employed by the Utah Health Information Network (UHIN), appears to hold the most promise for long-term financial sustainability. Founded in 1993, UHIN has been self-sustaining from its inception by charging a membership fee to providers and transaction fees to payers. This has allowed UHIN to cover all operational costs for its administrative data exchange and positioned it to expand services to include the electronic exchange of clinical information through a secure Internet gateway.<sup>12</sup>

In many ways, it is the funding model that plays the greatest role in determining the most effective governance structure. For example, if the HIE is funded through grants and/or stakeholder contributions,

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<sup>4</sup> Deloitte Center for Health Solutions 2006.

<sup>5</sup> William S. Bernstein and James R. Schwartz, *Governance and Regulatory Issues*, Presentation to the CalRHIO Governance Committee, Oakland, CA 19 July 2005.

<sup>6</sup> Deloitte Center for Health Solutions 2006.

<sup>7</sup> Deloitte Center for Health Solutions 2006.

<sup>8</sup> Deloitte Center for Health Solutions 2006.

<sup>9</sup> Michael Christopher and Martin Jensen, *Sustainable RHIO Funding and the Emerging Business Model: The 2007 Survey of Regional Health Information Organization Finance* (Sept. 2007).

<sup>10</sup> Christopher and Jensen 2007.

<sup>11</sup> Michael Christopher, *RHIO Financial Models*, 17 April 2006, 14 Sept. 2007 <[http://www.informatics-review.com/wiki/index.php/RHIO\\_Financial\\_Models](http://www.informatics-review.com/wiki/index.php/RHIO_Financial_Models)>.

<sup>12</sup> Avalere Health LLC, *Evolution of State Health Information Exchange: A Study of Vision, Strategy, and Progress*, Jan. 2006, 6 Sept. 2007 <[http://www.avalerehealth.net/research/docs/State\\_based\\_Health\\_Information\\_Exchange\\_Final\\_Report.pdf](http://www.avalerehealth.net/research/docs/State_based_Health_Information_Exchange_Final_Report.pdf)>.

the best approach may be to establish a governance structure in which the HIE is steered by classes of stakeholders designated by their level of involvement, possibly with different levels of voting rights based upon their contributions.

Alternatively, if the HIE is funded through transaction or subscription fees, a public utility model that provides governance for public accountability of private businesses may be the most appropriate structure. However, if financing is coming from private investment, a board of directors is often the best governing model to follow.<sup>13</sup>

By mapping the governance structure to the business model, the final governing body will incorporate the strengths of each stakeholder organization and provide the appropriate level of consideration to each group's incentives for participating in the HIE.

## An Inclusive, Neutral Structure

In addition to relating back to the business and financial models that will drive the HIE, the governance structure should be inclusive of key stakeholders, yet still maintain a high level of neutrality. An inclusive, neutral governing body is better able to maintain a clear focus on shared community goals while avoiding or mitigating potential conflicts among stakeholders.

This is important, as HIEs are typically made up of diverse organizations that must come to agreement on critical—and potentially divisive—issues such as protocols for patient identification and data transfer, data standards, rules for authentication, and access and data maintenance. “One of the critical success factors for a governance structure is to involve the key stakeholders in a forum that develops a neutral environment of win-win for all.”<sup>14</sup>

Three popular options for the governance model are all-inclusive membership, classes of membership and independent/self-perpetuating.

Under the **all-inclusive model**, each participating provider and other interested parties, such as payers, self-funded employers, regional health authorities and public health agencies, are invited to join. In some instances, membership on the governing board is limited to those who make a financial investment as part of their commitment.

The classes of **membership model** has categories of interested participants divided into “classes,” which then select one or two representatives for the governing board. The initial class representatives can be selected by the Executive Steering Committee (see Chapter Three of the *Best Practices for Community Health Information Exchange*) or by members of each individual class. This model is ideal to support fee-based membership as a source of funding. However, differences among membership groups may impede decision making progress.

Finally, the **self-perpetuating model** typically starts with the Executive Steering Committee selecting the initial board members. Terms may be staggered and subjected to limits, and a nominating committee would be responsible for proposing board candidates on an ongoing basis. The advantage of this model is that it is large enough to be representative of all stakeholders but is still manageable. The drawback is that the limited size often necessitates other means of ensuring inclusive participation.<sup>15</sup>

Whichever governance model is determined to be the best fit for the individual HIE, special attention must be paid to ensure it is *truly* inclusive. For example, a special emphasis should be placed on including physicians who represent multiple types of medical specialties. This is important not only because physician adoption of the HIE is critical to its long-term success, but because physicians control the longitudinal patient record, which is the cornerstone of the HIE and the fundamental future of healthcare.

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<sup>13</sup> Deloitte Center for Health Solutions 2006.

<sup>14</sup> Healthlink, *Regional Health Information Organization (RHIO): Frequently Asked Questions* (Sept. 2005).

<sup>15</sup> Bernstein and Schwartz 2005.

The responsibility of physician representatives as part of the governance structure should be to inform, advise, watch behavior change and track medical compliance—all of which relate back to the success of the initiative.

Also, because healthcare workflow is a multidomain challenge, the governance structure should include representatives from all domains, which are most often defined as:

- Clinical, which includes physicians, nurses, ancillary service providers and other allied health professionals
- Technical, representing IT professionals and medical device experts
- Operations, including clinical and technical support and help desks
- Administration, which encompasses workflow, admissions and IT management
- Financial, which incorporates reimbursement and funding

Other key representatives to consider include patients, employers and payers, as well as individuals who bring specific expertise to the structure, such as government agencies, health information management professionals, health law attorneys and privacy experts.<sup>16</sup>

Ultimately, the governance model should be populated with representatives who are capable of making the decisions necessary to ensure the HIE is able to adapt to “changing market dynamics and... overcome new obstacles as they provide more and varied services to their customers.”<sup>17</sup>

## Creating Structure

Once the formal governance model has been determined, a hierarchy of committees, subcommittees and advisory groups should be established under the direction of the Executive Steering Committee defined in Chapter Three of the *Best Practices for Community Health Information Exchange*.

Typical standing committees include Audit, Business/Finance, Governance/Nominating, Compensation and Operations, which are charged with overseeing specific functions required to keep the HIE moving forward toward long-term success.<sup>18</sup>

Many HIEs also establish a separate Community Advisory Board, which encompasses the Outreach Committee defined in Chapter Three but expands its outreach responsibilities to include engagement of the public at large. It is also responsible for development of a decision-making process that aligns incentives and ensures adherence to the strategic roadmap from the clinical, financial and social perspectives by addressing the needs of those organizations that tend to provide the most financial support for the least immediate benefit.

For example, hospitals pay for electronic health records that sometimes offer limited value and, in many cases, no continuity of care, and have low physician usage levels after implementation. In this case, patients stand to be the real benefactors of the technology investment, but they make little or no contribution to the HIE. “This creates an imbalance between those who pay for the system and those who benefit. In order to keep incentives in line, the remaining stakeholders, such as providers and payers, can find ways to pass on some of the operating costs in the form of fees or surcharges.”<sup>19</sup>

It is the responsibility of the Community Advisory Board to identify ways to balance out these inequities to ensure all stakeholders will realize benefits in the long term.

Another key subcommittee is a physician advisory group that is specifically focused on clinical issues, such as what type of data should be shared. This is critical to ensuring physician adoption of the HIE and

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<sup>16</sup> Robin Blair, *RHIO Nation, Health Management Technology*, Feb. 2006.

<sup>17</sup> Deloitte Center for Health Solutions 2006.

<sup>18</sup> Bernstein and Schwartz 2005.

<sup>19</sup> First Consulting Group 2006.

helping patients feel comfortable that the clinical issues related to data exchange have been thoroughly discussed and vetted. Other committees to consider include a regulatory committee to manage issues pertaining to Stark and anti-kickback laws, antitrust laws, and privacy and security laws, as well as quality/oversight, public relations and marketing, incentives, and consumer participation/patient advocacy<sup>20,21</sup>

## Keeping Focus on the End Game

Ultimately, the responsibility for achieving the 'end game' of the HIE lies with the governing body. As such, it must fully represent all facets of the community, and it must be structured in a way that allows the HIE to achieve community and stakeholder goals, as well as widespread provider adoption. Without that, its efforts have "been reduced to an academic exercise."

If an HIE "is to ever break out of the 'demonstration project' box, it must be *inclusive*. If it's a 'community project,' then it needs to involve the whole community or at least be structured so that everyone in the community can participate if they elect. If the vast majority of providers in the community are unable to participate in a RHIO, then they will take no ownership of it."<sup>22</sup>

A very real risk that should be recognized and considered is the natural tendency for the largest organizations that are investing the most in the project to inadvertently develop a structure that offers only proprietary interoperability. In this case, the vast majority of providers in the ambulatory environment who deliver the bulk of patient care in the community are left out. A clear contingency plan to help avoid this problem is to include healthcare professionals from organizations of all sizes and financial contribution to the program in the initial design.

Success requires a community-based governance model that represents every facet of the healthcare community and strikes a balance between benefits and contributions while remaining neutral to prevent politicization at any stage of development.

### About the Center for Community Health Leadership

The Center for Community Health Leadership, launched by Misys Healthcare Systems in June 2006, facilitates the development of health information pathways by helping to build connected, prepared and responsible communities. These communities will improve the quality of care delivered to its patients and reduce costs in everyday care administration, as well as in crisis situations such as epidemics and natural disasters. The Center strives to transform the healthcare system within the selected communities via grants of Misys<sup>®</sup> software and contributions of hardware and services from industry partners. For more information on the Center for Community Health Leadership, visit [www.misyscenter.com](http://www.misyscenter.com).

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<sup>20</sup> Bernstein and Schwartz 2005.

<sup>21</sup> Heather B. Hayes, *RHIO confidential: Experts offer advice for creating a foolproof privacy and security plan for sharing patient information*, *Government Health IT*, 10 Sept. 2007.

<sup>22</sup> ProviderLink Incorporated, *Designing RHIO's that Work: Five Pillars for Broad Provider Adoption* (July 2005).

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