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## RHIOs — Struggling to Bloom

By Elizabeth S. Roop

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*Industry leaders react to a recent Harvard University study that raised eyebrows when it presented less-than-flattering data on the health of RHIOs.*

With each new study examining the status of regional health information organizations (RHIOs) and health information exchanges (HIEs), the debate over their future reignites as supporters and detractors dissect each statistic and interpretation in the hopes of finally answering the question that dogs the information exchange movement: Can RHIOs and HIEs survive?

The latest round of discussion came in response to the Harvard University study "The State of Regional Health Information Organizations: Current Activities and Financing" that appeared in the January/February issue of *Health Affairs*. Researchers found that nearly one in four known RHIOs in January 2006 had failed by early 2007, according to the study.

Among the 138 so-called survivors, 20 were considered functioning. Of those, 15 were exchanging clinical data across a broad range of patient populations, and 13 were collecting user fees. Although data on profitability was not collected, the authors determined that only 12 of the RHIOs were self-sustaining because eight were receiving moderate or substantial grant funding.

### The Quest for Sustainability

"It is interesting because that report came out and so many people looked at it as a negative report," says Leigh C. Burchell, director of the Center for Community Health Leadership. "I actually saw some pretty positive things in it, in that there are 20 functioning health information exchanges across the country, 12 of which have been deemed by an objective third party as sustainable. They have something going. They have come up with a business plan that works for them."

The center, which was launched by Misys Healthcare Systems in 2006, provides practical guidance to RHIOs and HIEs as they work toward facilitating the exchange of clinical information within their communities. Part of that involves identifying effective business models and revenue sources, as well as offering guidance on how to eliminate intraexchange competition and other obstacles to ensure interoperability at the local, state, regional, and, ultimately, national levels.

One of the greatest challenges RHIOs have faced has been the development of sustainable business models that enable the initiative to wean off government funding and generate sufficient operational revenues as quickly as possible.

"Everyone can see the writing on the wall," says Burchell. "Whether it's two years from now or five years or 10 years, those grants now focused on health information exchange are going to be focused elsewhere. You have to know how you're going to pay for this. There are clearly models out there that are working. Now it's a matter of making those models more visible so others can implement them."

While business models differ from organization to organization, there are some common elements, including sources of seed money and earned income, data types, and functionality.

In the Harvard study, 13 of the 20 RHIOs identified time and/or in-kind resources as a moderate or substantial funding source during the planning stages. One half also identified one-time financial contributions, grants, and contracts as important sources.

Once the initiatives began actively exchanging data, 13 identified subscription- or transaction-based fees as moderate or substantial sources of support. Nine also identified time or in-kind contributions, eight identified grants, and seven identified one-time financial contributions as other important forms of financial support.



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Forty-five percent stated that they received no grant funding at all, while 20% received grants in all stages. Six RHIOs reported receiving grants and other forms of financial support once they were exchanging data.

In terms of the functionality and data offered by the RHIOs, the most common (90%) was viewing or delivery of test results, while 50% offered clinical documentation and consultation/referrals. Five offered electronic medical record (EMR) licenses, with the initiative acting as the middleman between vendors and participants. Three RHIOs offered a single data exchange functionality, and nine offered five to nine different functionalities.

Revenue streams, service offerings, and stakeholders as sources of revenues were broken down further in the second annual "Sustainable RHIO Funding and the Emerging Business Model: The 2007 Survey of Regional Health Information Organization Finance" released in September by the Healthcare IT Transition Group.

What it found was that of 38 RHIOs examined, the majority, at all stages of development, rely heavily on contributed income, including grants and gifts from the government, other stakeholders, and private philanthropy outside the direct stakeholder community.

In the start-up phase, contributed income represented 84% of fiscal 2007 budgets. That dropped to 56% in the transition phase, reflecting the establishment of earned revenue operations, and declined to 34% in the production phase, when the full commercial potential of operations was achieved.

Other earned revenue sources included the following:

- Membership fees were 7% in the start-up phase, 12% in the transition phase, and 28% in the production phase.
- Transaction fees were 0% in the start-up phase, 4% in the transition phase, and 8% in the production phase.

The survey also noted a significant difference from the previous year in the earned income sources. Focusing on membership fees, RHIOs in the start-up phase reported the following declines by source:

- providers: from 29% to 6%;
- vendors: from 26% to 0%;
- health plans: from 24% to 6%; and
- governments: from 11% to 3%.

Though not as dramatic, RHIOs in the transition period reported a similar pattern, particularly among providers as revenue sources.

The change was attributed to a shifting revenue model that saw an overall delay in the rollout of RHIO services and a greater focus on services that are valued higher by noninstitutional providers such as independent physicians and physician groups. Among the most notable were the transfer of inpatient episode records, enrollment/eligibility information, eligibility screening, claims submission, immunization registry, physician EMR implementation assistance, and personal health records (PHRs) or patient Web portals.

The authors conclude that a greater emphasis on services valued by physicians coupled with fewer physicians reported as sources of earned revenues—from 25% in 2006 to 3% in 2007 for start-up stage RHIOs and 47% to 26% for transition stage RHIOs—indicates a shift toward a "zero entry cost" model as a strategy for inciting providers to participate in RHIOs to achieve the critical mass needed for long-term sustainability.

"If you're trying to build operational sustainability, having revenues from providing services is a great way to do it. The problem is when you try to squeeze revenues out before you reach critical mass," says Martin Jensen, chief operating officer and chief analyst with the Healthcare IT Transition Group and coauthor of the study. "You have to build the network before you can extract value from it. A lot of the things RHIOs are doing are taxing the people who are the early participants."

#### **Achieving Critical Mass**

Achieving critical mass is an issue that continues to plague even well-established RHIOs. The blame typically lies with revenue models requiring up-front investments and a lack of early involvement by the ambulatory care sector.

The revenue model in question is the reliance on membership or subscription fees that require any participant to pay, regardless of any other in-kind or resource contributions they may have made. Jensen uses the example of a physician who invests in an EMR, widespread adoption of which is integral to the success of a RHIO.

"They have already invested a whole bunch into that RHIO even before they've paid a dollar's worth of membership fees," says Jensen, who advocates a scalable pricing model based on volume of use. "You can't be penalizing the people that you need to make this fly. You'll never get enough rowers on the boat to get away from the dock."

That is not to say physicians should get a free ride nor should they be provided with direct financial incentives. In fact, some say paying for participation is little more than a bandage on the deeper issues affecting long-term RHIO success, including low EMR adoption rates and a lack of perceived value by the ambulatory care sector.

"It is an easy suggestion to just pay people to use it, but that doesn't work. We should not create a system that the only reason people are using it is because they're paid to do so. ... It will create a false sense of adoption," says Dave Levin, vice president of marketing for MEDSEEK, which currently provides a Web-based platform for information exchange to the North Carolina Health Network.

Levin says that physicians are enthusiastic about technology but reluctant to adopt EMRs because "the vendor community has given them too many examples of bad technology. It's not that they are afraid; it's that we just haven't done a good enough job of showing them the value. Sometimes you need that early seed incentive."

Providing that incentive is where many believe the government and other organizations can have the greatest impact on RHIO sustainability by helping physicians cover the costs of implementing the EMRs and other systems critical to the success of any data exchange. It will also help position them for looming changes in reimbursement that will mandate EMR use.

"There are likely going to be more of the 'stick' types of incentives coming down the road, whether that is pay for performance, quality reporting requirements, or any of the other things doctors are watching with a pretty wary eye," says Burchell. "If there are positive financial incentives out there via grant programs from [the Centers for Medicare & Medicaid Services], individual states, or organizations like the center take advantage of those because they are not going to be there forever, and the other side of the incentive train is coming."

The Center for Community Health Leadership, for example, is awarding \$10 million in Misys software to select communities as a way to encourage physician adoption of EMRs. In addition to software, the grants provide access to at-cost implementation services and deeply discounted hardware from partners such as Dell, Intel, Fujitsu, and Lenovo.

The recipients are not RHIOs but community physicians, hospitals, home care agencies, independent technology hosting centers, and other organizations committed to forming a collective community to benefit patients. A key focus is finding ways to help physician practices, which hold 80% to 90% of patient data, implement the electronic systems necessary to participate in data exchange initiatives.

It also sets the stage for the ambulatory care sector to play a much greater role in the design and development of RHIOs and HIEs. Burchell says it's a sector that has been excluded to the detriment of many initiatives' ability to create a comprehensive, interoperable data exchange.

She says physicians should be at the table from day one because "ultimately, they are the ones with the patients, the ones who will be sharing data, and the ones who should be at the hub of this. It really is quite shocking. If you look at the board formation of some of the RHIOs out there, there is not a single physician. That doesn't make sense. If the center has one driving message, it is to invite the clinicians from your community to participate. If you determine a path and try to force someone down it, they are much less likely to go along with you and be supportive."

#### **Putting Technology in Its Place**

Although widespread EMR adoption and interoperability are critical to the long-term survival of any RHIO, too many initiatives make the mistake of looking at technology first and then designing their operations around what they like rather than what they need.

It is an approach that can doom any RHIO by failing to address the specific needs of the community and by underestimating the stakeholders' competitive nature. It also can defeat the objective of achieving true interoperability.

"Why develop technology for something that isn't going to be sustainable?" asks Andrew J. Hurd, chairman and CEO of CareFx, which works with RHIOs such as the Louisiana Rural Health Information Exchange to facilitate data exchange between disparate systems and applications. "There needs to be a model there that is self-sustaining. It is then—and only then—that you will have the proper incentives in place for people to utilize and be focused on delivering a real RHIO architecture."

Hurd points to the "politics of data" as a primary stumbling block for many RHIOs, particularly those that fail to understand the delicate balance many stakeholders must strike between the good of the community and the need to sustain their individual institutions and organizations. "If there is one thing that is a significant block and that creates a lot of consternation, it would be that," he says.

The inevitable result of trying to retrofit the business model to technology is loss of stakeholder support and the inability to achieve critical mass—not to mention the financial disaster created when the technology can't stand the test of time.

"Any complex, sophisticated system that is prone to rapid change and growth requires a solution that is going to be flexible and adaptable," says Hurd, who advocates a federated model for data sharing across information exchanges. "There are a lot of board meetings between the time you sign up for a big database-type solution and the time it's built and delivered. There are a lot of things that change. Having a system flexible enough to adapt to that is pretty important. You're building something here not for a 90-day period but, ideally, something that is sustainable for decades."

Defining the community-based goals and objectives for the RHIO, as well as identifying the kinds of information to be shared, how to share it, and how to pay for it, are critical to the initiative's success and the technology that will drive it.

As such, vendors should be willing to contribute to the planning process in an advisory capacity with the end goal being to help the RHIO match technology to problem rather than the other way around.

"Vendors have a very unique and important place, but without a strong governance body, vendors tend to drive the process because of their experience," says Levin. "While the local community and governance may not have that broad experience, they have the local knowledge and the understanding of the local problems. Where RHIOs and all technology projects go wrong is when they don't have that balance, where the technology drives the solution vs. the problem driving the solution."

#### **Collaboration, Consensus**

In the final analysis, industry leaders say the answer to the question of whether RHIOs can survive is yes—as long as the leadership takes the time to understand what it needs to accomplish, why, and how.

That requires bringing together all community stakeholders to define specific problems and solutions. It also requires achieving a consensus on the value each stakeholder group can expect to derive from their participation and how that value will be measured.

Finally, starting small can help work out the kinks. It will also demonstrate viability and inject a level of accountability that can motivate new stakeholders to toss their support into the ring.

"Start small with something that is doable and let that be your proof of success. Let yours be the health information exchange that justifies further investment, further effort, and further resources," says Burchell. "People want accountability, particularly in this instance where often you are collaborating with people who really don't owe you anything. Rather, it is just a desire for communal benefit that is driving them."

— Elizabeth S. Roop is a Tampa, Fla.-based freelance writer specializing in healthcare and HIT.

#### **A Nonprofit Model**

Not everyone agrees that total independence is the best model for regional health information organizations (RHIOs) and health information exchanges. In fact, some say a case can be made for a nonprofit business model that consists of a grant-supported capital base on which an infrastructure is built for earnings to sustain operations.

According to the Healthcare IT Transition Group in "Sustainable RHIO Funding and the Emerging Business Model," the Community Support Organization (CSO) model is preeminent, despite insistence by RHIO leadership that the opposite is true. It is also best suited to the public constituency nature of the RHIO mission and the most effective and efficient means for rapid expansion in an emerging market.

"When people say 'sustainable business model,' they equate that to commercial profitability, but you're missing a really big sector of the economy," says Martin Jensen, chief operating officer and chief analyst with the Healthcare IT Transition Group, who admits that his organization has an "against-the-grain interpretation" of what's going on.

"There is a business model for nonprofit; it's just not in the purview of the people who are looking at the problem. They have a commercial hammer, and they're trying to hit a community service nail," he says. "A nonprofit organization does not need to achieve profitability. It needs to reach sustainability, which can include an ongoing source of revenue from donated funds, goods, and services."

Under the CSO model, income is subsidized to a significant degree through ongoing fund-raising operations, while earned income is often part of the mix. In the rare instances that there is a surplus of capital, it typically goes into an endowment. Should financial "rescue" be necessary, fund-raising efforts are stepped up or, in the worst-case scenario, the endowment is depleted, programs are dropped, or facilities are closed.

The survey's authors point to several findings to support their CSO model, starting with RHIOs' continued reliance on grants for the majority of their revenues. Between 80% and 90% at all stages of development continue to anticipate the need for ongoing grant incomes. In fact, the survey found that 60% of RHIOs considered to be fully operational stated they still anticipate the need for grants.

The survey also found that the majority of RHIOs continue to be established as nonprofit, 501(c)3 entities, while a smaller group is utilizing the 501(c)4 form, better known as the social welfare organization.

These findings indicate that RHIO organizers recognize the need for contributed income, the advantages of tax exemption, and the value of donated leadership hours from community leaders. It also points to the vision of most RHIOs, which the authors define as creating a truly interoperable health exchange that extends value to the community beyond what participating stakeholders might be willing to do individually.

The challenge is one of execution. Most RHIOs have overlooked several primary sources of financial support, such as local and regional private foundations and other philanthropic organizations. It is a challenge that can be overcome by expanding the initiative's leadership to include business and community leaders, employers, banks, etc.

"One of the things that we see is there is sort of a 'deer in the headlights' phenomenon from the RHIO leadership [when faced with fund raising] because they already have so much on their plate," says Jensen. "The fact is, if you reach out to the right people, your burden gets lighter because they've already done what you're trying to figure out on your own. They already know the people you need to talk to next."

— ESR



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