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N.C. HIE's 'crawl, walk, run approach' to successful exchange

By Beth Walsh Oct 17, 2012

The Coastal Connect HIE (CCHIE) of North Carolina committed to the walk, crawl, run approach during the process of its creation and expansion. Executive Director Yvonne Hughes shared the organization's experience during an Oct. 16 webinar presented by the National eHealth Collaborative.

CCHIE took a pragmatic approach to deployment, said Hughes. "Too much technology too quick will overwhelm providers. We learned that if we roll out too quickly, we will not get the utilization we were looking for." A slow, controlled approach worked better. They also were careful to follow up with connected organizations to ensure end-user adoption.

Hughes said market research was an important element of the HIE's success. "Putting a face with the name of the organization helped us establish early adopters." Once they assessed organizations' readiness and got the partners engaged, the HIE staff offered regional seminars and demonstrations. "We found that onsite visits and demonstrations helped them as well as helped us understand their workflows and needs." When it came time for rollout, people could "see our logo and colors and understand the organization and what it represents."

The HIE also conducted a needs assessment, asking providers in 12 counties to tell us what they thought about HIE, HITECH Act and EHRs. The majority (80 percent) of respondents were physicians themselves. However, while 73 percent said they were very willing to access patient data only 57 percent are willing to contribute patient data, clearly indicating "a barrier of trust to overcome."

The respondents listed their top three concerns as high cost (71 percent), maintain privacy of data (61 percent) and potential disruption to practice flow (48 percent).

"We heard loud and clear that the physicians did not expect to never have a data breach but they wanted to know our policy in dealing with it," said Hughes. "We made sure we addressed security during demonstrations."

A big question the HIE staff was always asked was the financial model for the HIE and the plan for sustaining it, Hughes said. The staff got a handle on the total cost of ownership so they could articulate that information back to members. CCHIE contracted with a consulting group to create a financial model. A good piece of advice Hughes received was to not look for grants to serve as start-up funding. They should only be used to offset one-time expenses. Also, participants should pay for the service from the very beginning. "If you give it to them for free to start, going back and charging fees is hard to do and hard to justify." CCHIE uses a "pay-to-play," subscription-based model.

The idea that "affordability equals sustainability has certainly proven true to us," Hughes said.

A recent $1.46 million Duke Endowment award will be used to connect safety-net organizations to the HIE and to conduct academic review with the help of a local college professor.

Hughes described the vendor selection proves as painful, long and arduous. CCHIE reviewed at least 18 different proposals, giving special consideration to the security model, quality reporting, application administration, messaging, patient registration and historic viewing. She said 16 physicians were involved in the process which helped them see that the technology was worth everyone's time.

Hughes recommended establishing committees early in the organizational process. "Getting buy in from CEOs, CFOs, CIOs and HIM is critical because these are the people who will be using the technology."

The thorough organizing and planning was required, she said, because the effort put high demands on financial and human resources. "We have a small staff so we depend on our member hospitals for their help with the rollout." The practices have a small window to install the technology and educate their staffs. "These are busy people and interrupting their workflow impacts the number of patients they can see. Having the process down to a science is important."

The value of an HIE needs to support providers ranging in sizes, said Anne Marie Robertson, CCHIE's director of operations. Before conducting a demonstration, CCHIE identified for a provider the value it would bring. For example, an OB/GYN practice with one physician and paper records now uses the HIE to access his own patient records as he deploys an EHR. For a large, multispecialty practice, the HIE delivers data right into patients' EHRs so "efficiency for their staff is taken one step further."

The partnering hospitals "have been very vocal in letting us know about value," said Robertson. For example, they like that the HIE is auditable and lets them track users and access. The HIE also helps the community to operate on one referral tool, allowing for consistency. The partners also can use the HIE for secure regional communications when patients must be transferred to medical centers outside of the immediate community.

Going forward, Robertson said CCHIE is looking at dashboards to help

track user adoption and support future adoption. They'd also like to audit access and report back to providers that they are keeping information secure. "We are young and the HIE is in its infancy," said Hughes. Currently, they can look at metrics such as A1c levels and smoking cessation efforts. "That helps us start to map out ways to provide preventive care measures to our providers."

Over time, the HIE will be able to track more data. Currently, more than 170 practices are connected the HIE has 952 unique user accounts.

All the work that has been accomplished to this point to establish the HIE "has been quite a learning curve but a very rewarding process as we connect disparate systems and connect the community for our patients," said Hughes.

Health Information Exchange [1]
