HIE Community Meeting
5/2/2012
Santa Rosa Memorial Hospital, Santa Rosa

Participants:*

Name	Title	Organization
Paul Alcala	CIO	NorthBay Healthcare
Bob Andrews	Director, Ambulatory Information Systems	Sutter Health
Elisa Ashton	Clinical Faculty, UCSF, CHHS, Dignity Health	Calif Health & Human Services
Ellen Bauer	Division Director, Public Health	Sonoma County Health Services
Trayce Beards	PPA	Sonoma County Health Services
Bill Beighe	CIO	Santa Cruz HIE
Stephan Betz	HIE Coordinator	Solano County
Juel Bortolussi	Project Manager	St Joseph Health System
Scott Christman	Dir, HIE & Meaningful Use	Adventist Health
Lyman Dennis	Principal	El Dorado Health Consulting
Daymon Doss	Executive Director, No CA Health Care Authority	Petaluma Health Care District
Maryann Eckhout	Executive Director	Napa Solano County Medical Society
Mark Elson	Chief of Policy and Program	Cal eConnect
Kathy Ficco	Executive Director	St Joseph Health System
Justin Graham, MD, MS	CMIO	NorthBay Healthcare
Jim Hauenstein	CIO	Enloe Medical Center
Frank Hayes	IT Manager	Clinic Ole
Don Hitchcock, MD	Physician	Queen of the Valley
Alice Hughey	Assistant Director	Napa County Health & Human Svcs
Charles Kennedy	IS Site Leader	Sutter Health Support Services
Craig Lindquist, MD, PhD	Medical Director, HHS Clinics	Marin Health & Human Services
Richard Loos	Consultant	Executive Healthcare Consulting, LLC
Marty Malin	Interim Manager, MHSA	Solano County Health & Human Services
Peter Mathews, MD	Pediatrics	Kaiser Permanente
Cynthia Melody	Executive Director	Sonoma County Medical Assn
Melinda Miers	Team Lead, Physician Connectivity	Adventist Health
Bob Moore, MD	CMO	Partnership HealthPlan
Todd Morgan	IT Director	Partnership HealthPlan
Suzanne Ness	Regional VP	Hosp Council N & Cent CA
Steven Nord	Administrator	Paradise Medical Group
Rachel Olmedo	Grants Specialist	Cal eConnect
Evan Rayner	CEO	Healdsburg District Hospital

Jayleen Richards	Prop 10 Project Manager	Solano County HSS
Will Ross	Project Manager	Redwood MedNet
Rita Samartino	Systems Analyst	Yolo County Health Department
Paul Sampedro	Health Information Exchange Program	S. Joseph Health System
Anna Shields	Exe Dir Clinical Informatics Services & Info Systems	St Joseph Health System
Joel Sklar	CMO	Marin General Hospital
Lori Sklar	CEO	Redwood Community Health Network
Alan Stadelhofer	Support Services -- West Bay Region	Sutter Health
Anthony Stever	Consultant	AWS Consulting Services
Mark Street	IT Director, Chiropractor	Alliance Medical Center
Carl Thomas	Interim Executive Director	Solano Coalition for Better Health
Jennifer Williams, MD	Power User Physician	Sutter Med Group of the Redwoods
Tim Wilson	Epidemiologist	Yolo County Health Department
John Wise	Manager, Department of Information Systems	Sonoma County Dept Health Svcs
Yolanda Ybarra	Organizer	Health Alliance Northern California

***Several of the above were not marked checked in but we saw some of them so all have been counted as present.

Notes:

Acknowledgement: Peter Mathews graciously provided his excellent notes from the meeting which form the core of these notes.

Slides. Slides from the presentation are available on the same page as these notes.

Introductions

(In order of seating)

Lori Sklar, Executive Director, Redwood Community Health Network

Jennifer Williams, MD, Family Practice, Sutter Medical Group
We use Epic.

Bill Beighe, CIO, Pacific Medical Group of Santa Cruz County, Santa Cruz HIE

Alice Hughey, Assistant Director, Napa County Health and Human services

Yolanda Ybarra, Organizer, Shasta Collaborative, Redding California

Anne Shields, Executive Director Clinical Informatics, St Joseph Health System

Tim Wilson, Epidemiologist, Yolo County Health Department

Joe Sklar, MD, CMO, Marin general

Lisa Ashton, Clinical Faculty UCSF, Statewide HIE Cooperative Grant, Dignity Health

Laura Landry, CEO, Cal eConnect

Suzanne Ness, Regional VP, Hospital Council of Northern and Central California

Anthony Stever, Consultant, AWS Consulting Services. Consulting with Redwood MedNet.

John Wise, Manager, Department of Information Systems, Sonoma County Department of Health Services. We are connecting public health laboratory through Redwood MedNet

Maryanne Eckhout, Napa Solano County Medical Society

Cynthia Melody, Executive Director, Sonoma County Medical Association

Will Ross, Project Manager, Redwood MedNet

Richard Loos, Consultant

Carl Thomas, Executive Director, Solano Coalition for Better health

Stephan Betz, Assistant Director for Operations, Solano County. Have implemented an EHR for mental health and primary care. They are working with Redwood MedNet to connect them.

Scott Christman, Director HIE & Meaningful Use, Adventist Health. One hospital in implementing an ambulatory EMR in the fall.

Mark Street, IT Director and Chiropractor, Alliance Medical Center, Healdsburg. Using an Epic EHR and exchanging labs and imaging.

Bob Andrews, Director Ambulatory Information Systems, Sutter Pacific Medical Foundation. They are live on Epic.

Robert Moore, MD, CMO, Partnership HealthPlan of California. They are seeking improved quality of care with greater exchange.

Todd Morgan, CIO, Partnership HealthPlan of California. Here to indicate support for data exchange.

Craig Lindquist, MD, PhD, Medical Director, Health and Human Services Clinic, Marin Health & Human Services.

Charlie Kennedy, IS Site Director, Sutter Medical Center, Santa Rosa. His role is to get information back to community physicians from the hospital setting.

Steve Murphy, Research in Action, Organizational Development

Peter Mathews, MD, Adult Primary Care, Kaiser Permanente

Mark Elson, PhD, Chief Program Officer, Cal eConnect

Frank Hayes, IT Manager, Clinic Ole

Trayce Beards, PPA, Sonoma County Department of Health Services. Here to help support collaboration and create a system out of this fragmented non-system.

Paul Alcala, CIO, NorthBay Healthcare. Connectivity is good for the patient, good for our workflow and streamlines processes.

Marty Malin, Interim Manager, MHSA, Solano County Health and Human Services.

Overview of St Joseph's Health System

Kathy Ficco, Executive Director, Community Health
Anna L. Shields, Executive Director, Clinical Informatics Services & Information Systems
Paul Sampedro, HIE Program Director

Connection to Redwood MedNet. Plan to connect to Marin Sonoma.

Receiving laboratory results now. Orders in development. Transcriptions of radiology reports and micro pathology upcoming.

SJHS uses Meditech in the inpatient setting and connects to eClinicalWorks, Allscripts and other ambulatory systems. A core advantage is having a Sybase translator between ordering systems. SJHS uses Forward Advantage, a contractor, for point-to-point connections.

SJHS connects with the North Coast HIE in Humboldt for bidirectional exchange using Redwood MedNet. They expect to be able to meet or exceed meaningful use

requirements. Vendors are providing hub and scope solutions. SJHS is bringing in vendors and allowing them to deploy proven leading-edge solutions (vs bleeding edge innovation).

Background

Lyman Dennis, Organizer. The purpose of this organization is to acquire, not build, HIE services. We will be able to acquire HIE services more intelligently if we develop a plan among providers and counties and make sure it makes sense. Goals are to limit duplication between different systems and avoid silos that do not communicate with the whole. Our plan is to contract for services. We are not all at the same place at this point but we are communicating. The organization we are setting up should be a good candidate for grants, in part because we are not doing the same thing as are pure HIEs.

The Need for a Local Organization

Lori Sklar, Executive Director, Redwood Community Health Network
Robert Moore, MD, CMO, Partnership HealthPlan of California

In this session, Lori Sklar and Robert Moore, MD, explained the "vision paper" for the organization. The content of the paper is at http://regionalhie.wikispaces.com/Vision+Statement.

Lori Sklar
Redwood Community Health Network (RCHN) represents 10 community health centers in Marin, Sonoma, Yolo and Napa Counties. We support their implementation of the eClinicalWorks EHR (eCW). We host eCW and train CHCs in using it. RCHN takes care of a significant amount of the safety net population of these counties.

We are here for a very important reason today. Lyman and I had a conversation about the vision for this organization. Lyman drafted a statement based on that. Dr Moore edited it to be viewed by providers who may not have an HIE background. I think this is a really great document.

We have been mandated by law and regulation to exchange information. The only questions are who we will exchange data with and how will we do it.

- We know data exchange is good for the patient.
- We know it's good for the government and will reduce costs.
- We know it's good for the providers.

How do we get everybody's information there?

Why a regional, integrated HIE?

- That is how we exchange data and get it at the point of care to the people who need it.
- It's better patient care.
- It's cost savings.
- It allows a patient to have a continuum of care.
- It allows organizations to save money on interfaces.

With meaningful use Stage 2 and Stage 3, we need to exchange information. Many details are not defined. A regional HIE organization is one means to that end.

With an ACO, the ACO needs to have all of the participating providers connected. This is the future of health care.

No legislation exists telling us HOW to do this in detail. Groups all know we have to do something. CMS will give us some funding but we have to figure out the structure ourselves.

Cal eConnect is here to help us. There are legalities of data exchange. There is opt-in; there is opt-out. Cal eConnect won't connect a statewide HIE for us. All of the people in this county are deciding what we will do. Look at lessons learned in the East Bay and San Francisco. They have already gone through a series of bumps and have lessons-learned. This process is not about the technology. It's about stakeholders being there and agreeing we need to do this and then doing it in the most efficient way.

How regional is it? Is it Solano? How big is too big?

Bob Moore, MD

What are the advantages of regional approach?

- Coordination
- Economies of scale
- Building on existing partnerships and collaboration

Mission

- To improve quality of patient care and cost-effectiveness of care.
- To connect providers within the region so that
    - The right data is available for
    - The right patient at
    - The right time in
    - The right place (the point of care).

Initial goal

- Develop an integrated plan for accomplishing data exchange.

Structure

- Community Meetings
- Coordinating Committee (governance)

One client

- Wanted read-only record
- Wanted the ability to annotate that record in ED

Health Share Bay Area

- Getting people to agree to work on principal
- Serves as the foundation to begin doing the tough work that lies ahead

Stage 2 Meaningful Use

Elisa Ashton
Clinical Faculty UCSF
California Department of Health and Human Services
Dignity Health

Medicare and Medicaid EHR Incentive Programs
Proposed Rule for Stage 2 Meaningful Use

2/2012 ONC put out Proposed Rule for 60 day comment period. Comments closed 5/7/12.

What the next stage of meaningful use will look like:

- Progression from capturing data and core functionality of EHR

and building on that.

- In Stage 2, use the technology for quality improvement and
- Moving more toward HIE.

Goal in Stage 3 of using everything we built in Stage 1 and Stage 2 to improve health outcomes.

New clinical quality measure reporting mechanisms

Timeline:
Stage 2 Final Rule, Summer 2012
10/1/2013 1/1/14 Proposed Stage 2 start dates for Hospitals and Eligible Providers, respectively.

2013 for Hospitals 2014 for Eligible Professionals

2 year increments to meet each stage
In 2015, penalties come into play for Medicare reimbursement.

MU and Implementation

Is it meaningful to collect the required information?

CPOE

- CPOE 30% of medical orders in Stage 1
- CPOE 55% in Stage 2

ePrescribing

- Today only 10% of prescriptions in California are delivered electronically.
- For Stage 2, requiring 55% is quite a lot.

Clinical Quality Measures

- Exchange of key clinical info
- 2 measures on transitions of care

Stage 2 requires a summary of care for more than 65% of transitions and 10% need to be with an unaffiliated organization.

- 10% of transitions of care to different providers in different organizations.
- 10% of transition of care between different vendor EHRs.

HIE is the methodology to get us where we need to do with meaningful use.

Improved health, improved quality and lower cost at end of day. We can't get there without exchange.

In Stage 1, we showed we could do the kinds of exchange.
In Stage 2, the emphasis is on using exchange in a production environment.

The focus on is on push transactions in Stage 2. EHRs have limited capacity for exchange at this point in time. As we move toward Stage 3, the robustness of HIM will also improve. ONC is trying to create a program that drives the technology. We are going toward more robust information exchange for better health care of the patient.

Santa Cruz HIE

Bill Beighe, CIO

Physicians' Medical Group of Santa Cruz County and Santa Cruz HIE

Board of Cal eConnect
Board of CalHIPSO

Lyman: Bill Beighe runs the longest standing and most successful HIE in California.

Bill: History of how the Santa Cruz HIE developed

Good to hear talk that interfaces are important once HIE organizations get up and running. The biggest challenge in terms of cost, complexity and time-to-build is interfaces.

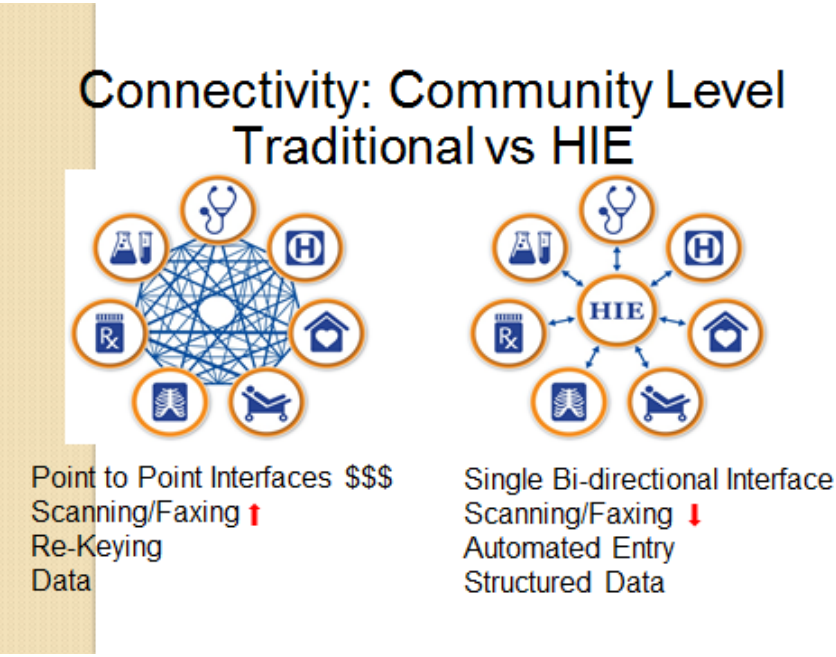
A key goal is to help drive down the cost and standardize interfaces.
There is an Interface-cost WIKI. One can get to it through the Cal eConnect website.

The first partners have signed up to make interfaces available at affordable price.
There will be a demonstration on July 18th, the day before the July 19th Redwood MedNet Symposium. The goal is to make interfaces part of the core vendor offerings as part of their EHR package.

PMG & Santa Cruz

- 300 providers
- Started 21 years ago
- Initially, most doctors worked in 3-4 physician practices.
- The IPA (PMG) brought fax machines for all of the doctors as the first step to electronic exchange.

Sutter/PAMF has a large presence



Structured data can trigger a health maintenance alert.

We see HIE as being the key for bending the cost curve of health care.

How will we be able to enable promote and encourage HIE?

SCHIE
Santa Cruz Health Information Exchange

Population: 270,000 people in county.
Operational in 1996.

- We have 95% of the population in the master patient index.
- 130,000 bidirectional exchange clinical documents per month.
- 367 active MD using the exchange
- 2 hospitals
- 5 radiology centers
- County Health Services and jail
- Web-based EMR lite has 900 users per month
- 9 connected EMR's (4 certified)
- 7 labs connected
- County Health on EPIC system
- Behavioral health doctors can get to the community data (but not vice versa)

Organizing began in 1995

- Led by the medical group (PMGSCC) and partners with
- Dominican Hospital (now Dignity Health)\
- UniLab (now Quest Diagnostics)

Required $1.2 million in start-up funds

Needed operational fund so they set up subscriptions.
All of stakeholders pay in: labs, hospitals, physician groups all pay something to exchange data.

In 2001 things took off.
Web-based EHR interface became available.
County Health System joined. They had primary care doctors. They wanted to be able to refer to specialists and get the specialists' notes.

SCHIE moved from independent physicians and a couple of hospitals to a multi-stakeholder HIE.

In the 2000's, SCHIE built interfaces to more EHR's. McKesson Practice Partner was the #1 EMR in our community.

SCHIE is open to any provider in Santa Cruz County who is a health care stakeholder.

600% growth in data exchange over the past 6 years.
1.4 million page view summaries last month.

Started ePrescribing in 2005 through Surescripts.

Substantial focus on transitions of care. 3400 transitions of care per month currently.
Electronic Referral form with clinical data attached sent on to another doctor.

28,000 electronic lab results per month.

2 years ago, put in longitudinal patient record.
Data needs to follow the patient and needs to be available wherever and whenever the patient is present. The notion that this data is provider property, that providers will not share it and that providers will hold it for competitive reasons is WRONG. We need to get over that. We need to focus on what is in the best interest of the patient.

What is in best interest of HIE?

- To have a lot of data

If you don't have a lot of data, there is not much reason to go there and use it.

We follow the data trails:

- Lab
- Rad
- ADT
- Chart notes
- Referrals

- Hospital – dictations, Op reports, ED, H&P, etc.

As an example, we asked providers, “Who do you need to obtain data from?” They said, “endoscopy centers.” We asked, “How can we get your reports out electronically?”

More data trails:
- Patient summary (print and CCD)
- EHR / EHR interface (McKesson Practice Partner and 8 others)
- Problems, allergies, immunizations, consent
- Provider to provider secure communication
- Community MPI (master patient index)
- Virtual health record

Data are used by the diabetes education center -- lab results, e.g., hemoglobin a1c results.

Discharge summaries are one of the biggest values in Santa Cruz
Why does this make a difference to you?
- Patient gets discharged from ED.
- Told to see doctor in 1 week.
- That's why we have push from ONC to share with unaffiliated providers.
- Talk to safety net clinic and make that data available.
- Don't just talk to your internal network.

CCD not just problem list and narrative in Stage 2.
- In Stage 2, it is the consolidated CDA (more data).
- It becomes a standard way of sharing progress notes, discharge summaries, etc.

EHR Prevalence
- Few providers had EMRs when we started.
- We had a web based EMR until most of our clients got their own EMRs.
- 74% of our primary care doctors have EHRs now. 65 doctors.
- 97% of providers in our county have an EHR.
- We support a lot of small physician offices.

Base Costs
- HIE costs $2.25 per patient per year.
- The labs pay. The hospitals pay. The providers pay.
- The SC HIE core infrastructure is hosted by Axolotl
- We have a help desk 8 am to 5 pm
- We make buyers buy their own interfaces. That is only the beginning for interfaces. Who will maintain the interfaces? It will probably be you.
- 2.5 FTE support the HIE

- We have 9 more staff who do EHR implementation and support, problem resolution, etc.

Other Costs. Some costs are not included.

- We run an opt-out consent model. A patient's data is in unless the patient asks for it to be out. Some states make the opposite assumption. A patient must sign something saying that he/she is affirmatively in or affirmatively out. That approach will cost more.
- We did 2 factor authentication testing and a pilot. We have not implemented it in production.
- Who knows what other heinous things the government has in mind?

Vendor Pricing for Interfaces

- Most of the vendors offer interfaces.
- Most have a reasonable price for interfaces.
- Some vendors have a totally unreasonable price.

What are pitfalls to avoid?

- IRS was waffling as to whether an HIE was a commercial entity or a not-for-profit. The Santa Cruz HIE is a for-profit. Organizing as a non-profit is on the right track.
- We had a collaboration effort of 25 people. I "practice medicine" in the daytime. We have a robust sharing of information via Lotus notes at night. (Bill is not a physician. He means that he works with providers in the daytime.)
- Our biggest mistake: We said, "Give us your data in any format. We don't care. Just give us your data." That led to a lot of matching problems with patients and some patients with sketchy demographics such as name, data of birth and nothing else. This made our MPI (master patient index) messy and caused difficulties in exchange. If I were starting today, I'd have demographic data standards. You cannot exchange data with us unless you agree to these standards.

Key principles:

- Everyone pays.
- Need a business funding model going forward.

HIE Workplan

Paul Alcala
VP CIO NorthBay Health care

Paul reviewed HIE Critical Success Factors published by the National eHealth Collaborative last month:

Are we doing the right things?

Objectives & Vision

- Identify the community to be served
- Why do we need an HIE?
- Building of trust among key stakeholders
- Agree on guiding principles
- Obtain buy-in from stakeholders

A complete view of a longitudinal patient record is the holy grail. Many EHR's haven't got there yet. The process is evolutionary. We are all after the complete continuum of care. Point-to-point data transfers send elements of what is desired.

Do a market assessment in your community.

Market Assessment

- Market understanding
- Community readiness
- Inventory HIE relationships
- Referral relationships
- Patient flow

Then perform strategic development at a high level:

- What are our options?
- We don't want to build it. Let's tap into one.
- Let's define the nature of the desired service and then contract for the service.
- We want to avoid the build, avoid that cost and avoid that risk.
- What's the value proposition?
- What is the phasing of services? What do we want to have initially? What do we want to plan for over time?

Implementation

- Define the business model. You have to plan for sustainability. How many participants? Who are the stakeholders?
- Who will put up funding?
- What is the source of startup money to get the organization going?

We have a first draft of a workplan at http://regionalhie.wikispaces.com/Workplan. It addresses the 4 elements above and more. This workplan won't be executed for a dime. It will take resources to execute this plan.

The timeframe is over 1 1/2 years at best. This is not meant to be concrete but to be a guideline for us that we will adjust as we go.

Certain key elements need to be complete to get to implementation. We get the workplan from lessons learned from others. Key questions:

- Who is the community?
- Who are the stakeholders?
- How do we get participation?

I will close with a couple of comments. The HIE marketplace is in an immature stage of evolution. There is confusion in the marketplace. As in any new industry, there will be a shakeout. We might see 50 HIEs over time. Not all of them will survive but it will be a market-driven outcome. Stakeholders will stay with you if you meet their needs. Fiscal viability, service and performance will determine success.

The ACO market will be huge driver of the HIE marketplace. Who will align with these ACOs and who will meet the service needs of the ACOs will have huge influence on public and private HIEs.

Incubation of the HIE Entity

Partnership HealthPlan of California has offered to be the incubating organization for us. Our vision is to eventually be a not-for-profit organization as Bill Beighe suggests. For lack of a better term, we are calling it “an HIE” though we do not plan to replicate a Santa Cruz HIE model – a full-service HIE, but to contract for services.

Guest Speaker
Incubator Organization
Carl Thomas, Executive Director, Solano coalition for Better Health

The coalition is very committed to this process. We are a neutral party. We feel we can hear all of the stakeholder's concerns. We are here acting as the neutral Switzerland to help facilitate this process and move it along and work as the incubator.

Lyman Dennis pointed out that Jack Horn, CEO of Partnership HealthPlan of California, our other incubation offeror, is on the board of the Solano Coalition for Better Health and had voted for this offer as well. The PHC offer remains fully open should we desire to take that. The decision would be made by the Coordinating Committee, gradually growing to represent the eventual board (hospital systems, medical societies, public health departments, etc.).

Lyman. The Coalition is a 501c3 organization now. That would allow bidding on certain foundation grants that Partnership as a quasigovernmental not-for-profit might qualify for and might not, in some cases.

Carl. One of our interests is to tie together different parts of the health care system. Some aren't currently tied in to HIE. We don't have data from school systems now. We don't have data from the prison health system. Behavioral health is not tied in, though work is contemplated or in process. Rehabilitation and LTC are not linked. One of the nice features of the PHC offer is that PHC covers all of the counties of current interest.

Laura Landry, CEO, Cal eConnect

What I like is that I'm hearing conversations about Health Resource Planning in the community. HIE solves a logistical problem. You are talking about using scarce resources to solve problems of an over-stressed health care delivery system. You participants are setting the tone. What happens when a community gets together? Participants don't talk about HIE. They talk about community resource planning.

Carl Thomas, Solano Coalition for Better Health, Background on SCBH

In 1988, in Solano County, many of the physicians would not accept Medi-Cal for services. Solano County Public Health, NorthBay Healthcare, Sutter Health, and Kaiser came together. The initial project was to form Partnership HealthPlan. Because of those relationships, we formed one of first three Child Health Initiatives in the state to improve health access for children.

Membership expanded from the first partners. The County became a partner. Community clinics were added: La Clinica and Community Medical Centers in Vacaville and Dixon. The base expanded to include Touro University and Solano College plus Napa Solano Medical Society. All of the players involved in delivery of healthcare services in Solano County are on our board and they agree to work in collaborative fashion. We have addressed several issues: impacted ED rooms in our counties, an oral health collaborative, HIV treatment, to name a few. We know that organizations compete on different levels. The partnership really works. People take off the hats of their individual organizations and they make decisions as a community.

Laura Landry, Cal eConnect

The notion of a neutral convener cannot be overstated. It is highly valuable. You can go right to the meat of the matter.

What do people who have different missions or different competitive interests do when they have a thing that links them together? If you put an organization with a history of resolving health bumps in a community in the middle of the process, it helps with trust. If you can link your wagon to someone already doing something very well, it brings a lot of value.

Lyman Dennis asked if there were other thoughts. He then indicated that comments might be made by email. Ldennis@eldoradohc.com.

Someone indicated that it would be nice to send out information on who is on the board of Solano Coalition for Better health. Carl Thomas indicated that the board is listed on the Coalition website www.solanocoalition.org .

Who also is on the Coordinating Committee? The current Coordinating Committee membership is listed at http://regionalhie.wikispaces.com/Coordinating+Committee.

Laura offered to provide an organizing web page. Since, Mark Elson of Cal eConnect suggested a wiki. The North Bay Regional HIE temporary "website" is at http://regionalhie.wikispaces.com/.

Dues Structure

Lyman Dennis

We have a need for some funds while we are organizing. Lyman is a volunteer for this project presently so we initially only need to cover organizing expenses.

Near-Term Needs (through ~July, 2012)

Item	Amount
Software for Incorporation, 501c3	$ 40
Filing fee for incorporation	30
Business & D&O Insurance	2,000
Legal review of documents	3,000
Website (startup)	10,000
Managing finances	2,000
General administration	2,000
Temp for registration	
Reproduction	
Misc	
Total	$ 19,070

We are probably talking about single year of dues. By the second year, participants should be paying a subscription for services.

The concept is that financially capable organizations pay more. The less affluent pay less. Everyone pays something.

The proposed dues structure is as follows:

Organization Type	Annual Dues
Hospital System	$5,000
HealthPlan	5,000
Public Health Department	3,000
Medical Association, Hospital Association, Clinic System, Other	1,000
Critical Access Hospital	1,000

When we have an MOU for the incubation (a decision between PHC or SCBH), we will ask as many organizations as are comfortable with the new approach, to sign the MOU.

Once we are incorporated as non-profit we will ask for the dues from all who plan to participate. The amount of the subscription is very small in comparison to the cost of making uncoordinated decisions about data exchange so one would not expect dues to be a barrier to participation.

The first step will be to file with the Secretary of State as a new corporation, indicating planned not-for-profit status. Then, we will file with the IRS as a not-for-profit for 501c3 status. The IRS has awarded not-for-profit status in as little as a few months and as long as several years. In the meantime, the organization will rely upon the incubation entity for its not-for-profit status. We will file tax returns as a 501c3 anticipating that designation, the normal practice.

Name of Community HIE Group

Suzanne Ness, Regional VP. Hospital Council of Northern & Central California

Lyman: Suzanne has been working her heart out helping with presentations, organization and naming.

Suzanne: My son does branding for a living. He has given us some guidance.

Goals

- Focus on the patient
- Improve health
- Collaborating care providers
- Increased healthcare access
- Reduce health care costs

Partners

- MDs
- Clinics
- Hospitals
- Home Health
- Nursing
- Rehab
- Public Health
- Schools

Descriptors

- Proactive
- Consultative
- Collaborative
- Relational

Considerations

- Memorable
- Easy to use

Samples

- Health Connect
- Health eNet
- Health Network
- Health eConnect
- Health Bridge
- Health Trust

Next Community Meeting

At Sutter Solano Medical Center in Vallejo, Tentatively August 1.