Health Information Exchange Community Meeting at Partnership HealthPlan of California on 11/2/11

These notes were taken during the meeting by Peter Mathews, MD, of Kaiser Permanente and have been somewhat edited by Lyman Dennis based on a recording of the meeting.

Remarks by Lyman Dennis, Organizer and Facilitator

The objective of this meeting is to hear from participating organizations about what each is each doing now with respect to Health Information Exchange and what it plans to do. Considering sources of HIE services is not a topic for today's meeting.

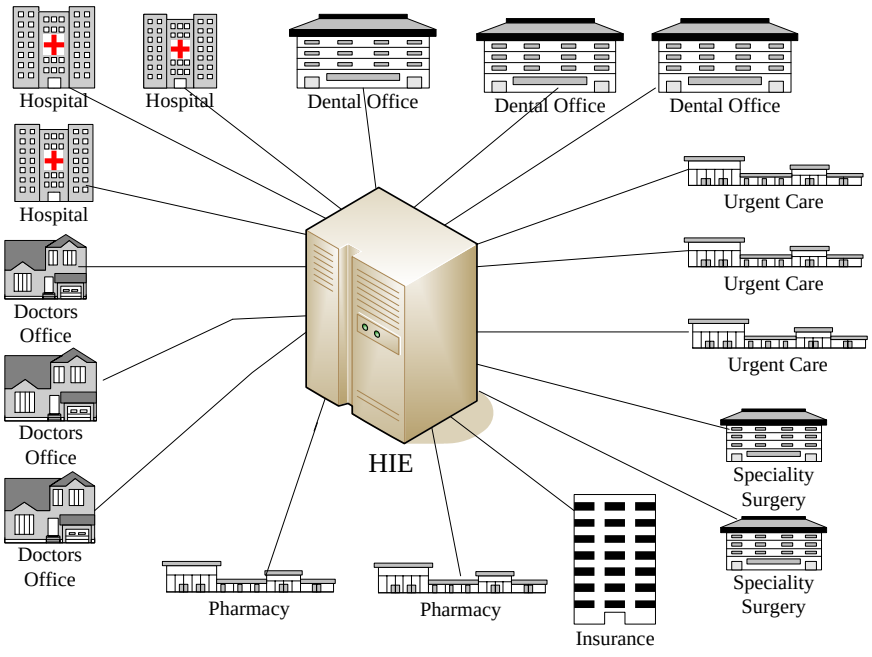
Partnership HealthPlan of California (PHC) graciously provided the venue and the food. This is a community meeting, not a PHC meeting.

What is HIE? HIE is the exchange of clinical and administrative information among *unaffiliated providers.* The emphasis on "unaffiliated providers" is the focus of the Office of the National Coordinator for Health Information Technology ("ONC").
Push data is the simplest and typically first exchange -- point-to-point transfer of data called "clinical messaging". An example is a reference laboratory sending lab results electronically to the EHR of the ordering provider.

Options for HIE:

- Direct provider-to-provider exchange
- Provider to central HIE; HIE to relevant providers

There are between 200 and 500 provider organizations in the 3 counties. The diagram below is a schematic of the situation.



Connecting each provider to every other provider would not be a spider web design. It would be a solid fabric many layers deep. Each interface has a cost at each end: $5k to $50k for a "gateway" to the sending or receiving system and a month or so of programmer time to configure each interface (at each end). The point-to-point interface approach is not financially feasible or logistically workable approach for a community.

A hospital (for example) might send 5 or 6 major transactions to the HIE and the HIE might have links to every provider and service organization in the community. This is workable as has been shown in many communities across the US.

Some of the key players in HIE include:

- Cal eConnect, the State designated entity, Laura Landry, Interim CEO

- Active HIEs (examples)
    - Santa Cruz HIE
    - Redwood MedNet
    - Orange county partnership… (OCPRHIO)

- Vertical HIEs (examples)
    - Kaiser
    - VA
    - John Muir
    - Sutter Health
    - CHW
    - Partenrship Health plan of California

- HIEs in Development (examples)
    - Health Share Bay Area
    - Inland Empire HIE

A key driver of EHR implementation is the meaningful use incentives available to providers under ARRA (the American Recovery and Reinvestment Act of 2009).

Stage 1

- EHR implementation
- Basic exchange
- Limited number of clinical measures

Stage 1 essentially requires an attestation that data can be exchanged (Medi-Cal) or 90 days of exchange (Medicare).

Stage 2 and 3

- Electronic med admin
- Record patient communication preferences
- etc

Stages 2 and 3 require regular use of exchange and some additional elements of data to be exchanged. They take HIE to the status of a production process.

HIMSS Analytics has identified 8 stages of EHR (including HIE) implementation:

US EMR Adoption Model[SM]

Stage	Cumulative Capabilities	2011 Q2	2011 Q3
Stage 7	Complete EMR; CCD transactions to share data; Data warehousing; Data continuity with ED, ambulatory, OP	1.1%	1.1%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	4.0%	4.4%
Stage 5	Closed loop medication administration	6.1%	7.1%
Stage 4	CPOE, Clinical Decision Support (clinical protocols)	12.3%	13.2%
Stage 3	Nursing/clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	46.3%	46.1%
Stage 2	CDR, Controlled Medical Vocabulary, CDS, may have Document Imaging; HIE capable	13.7%	12.6%
Stage 1	Ancillaries - Lab, Rad, Pharmacy - All Installed	6.6%	5.9%
Stage 0	All Three Ancillaries Not Installed	10.0%	9.6%
Data from HIMSS Analytics[TM] Database © 2011		N = 5,310	N = 5,299

As of August 2011, there are 50 hospitals in the world that have reached level 7. One is in Germany and one is in South Korea. Thirteen in the US are not Kaiser hospitals. Thirty-five are Kaiser hospitals. Research by Blackford Middleton and others at Partners National Healthcare and the National Quality Forum has shown that hospitals at level 7 are more cost-effective and the quality of care is higher. Patients in California have noticed that Kaiser is an effective provider and rewarded it with market share to the extent that UCSF has announced in print several times that “its ambition is to become Kaiser light.” We can exchange data to improve quality, to cut costs and to hold or increase market share. Organizations that choose to do the minimum to achieve ARRA incentives for meaningful use are likely to be marginalized in the long run. The public votes for care not necessarily with reports on level 7 achievement but based on a clear evidence that providers have all their records and do use that data to manage their care effectively.

Remarks by Laura Landry, Interim CEO, Cal eConnect

Cal eConnect, the State Designated Entity for HIE, has been given the responsibility with its grant to assist all providers in California to reach the point of being able to exchange health information electronically.

We have an unsustainable health care system. The costs are too high. We need to put tools in place to manage costs and improve the quality of care so we can take care of patients in the way they deserve.

What will Cal eConnect do for you? Cal eConnect will support national, regional and local efforts so that health information can flow.

There are real barriers that keep us from being able to exchange health information. The job of Cal eConnect is to be the State leadership with respect to HIE.

What needs to happen from stakeholder bodies?

What is important to stakeholders today? We need a single data use agreement for the organizations desiring to share data in California so that if your organization signs the data use agreement, it is the same agreement that other organizations have and will sign – not necessarily because you will exchange data with everybody but because the cost of developing these data use agreements is extraordinary. For four community based operational HIEs in the State of California, we've spent at least $500,000 to get individual data use agreements signed. That cost is unsustainable.

We need to focus on what is necessary to sustain grant funding Office of the National Coordinator in the State:

- Every provider needs to have the ability to ePrescribe
- Every provider needs to be able to receive structured lab results electronically
- Ever provider needs to be able to share patient care summaries

Why? Because if we can move that data electronically, when someone shows up for care, the provider has the information needed to make the most appropriate decisions -- decisions that the provider wouldn't be able to make correctly without that data.

What might we do as the next stage? Some examples may include

- Disease management,
- Population health management, and
- Innovations in R&D.

Until we achieve the minimal requirements supported by meaningful use, we are not ready to plan what we might do in the future. Meaningful use is the minimal bar.

We may further enable data sharing through federal Direct program and the federal Connect program but emphasizing the importance of and reliance upon local health information exchanges. Exchange of patient information is primarily local.

It is great that I live in Long Beach and if I come to the Bay Area that Kaiser can exchange my information but I am not a member of Kaiser. In two years or so, my data should be available through Health Share Bay Area when I visit here. In an emergency, the system should be able to access my information with full knowledge of my healthcare history.

Quite frankly, we need a bigger team. With the amount of funding received by Cal eConnect, $38 million dollars, we can't buy enough staff to set up health information exchange in California. So, we have to rely on local HIE's to be able to multiply the workforce and be able to accomplish this.

Office of National Coordinator and the California Health and Human Services agency have three priorities:

1. **Establish a trust environment.** This includes the legal framework, the agreed-upon definitions, the rules of the road that say "here is my information and you are allowed to move it under these cirumstances in this way in order to take care of the patient or accomplish a public health goal or other allowable purposes. Each organization can rely on other organizations meeting a minimum set of security requirements, minimum policies for security and privacy, so if you pass data, you know the data will be protected by receiving provider.

2. **Robust support for ancillary services.** Public health, community pharmacies, community diagnostic labs get connected, get providers connected. Who do we have to connect them to? public health, community pharmacies, community diagnostic labs. Our job is to make the connectivity happen.

3. **Report on, coordinate and monitor the HIE landscape.** In order to be effective, Cal eConnect and healthcare needs to move to a performance improvement model. We need to know where you are today, put incremental improvements in place and measure progress, and continuously improve again. This is similar to the Toyota Lean processes.

The holy grail of HIE is a SUSTAINABILITY – a financially viable model that allows people to recover their investment for what they put out in technology. This allows them to have a financially viable model so they can sustain what their activity requires – interfaces that need to be maintained, workforce that needs to be sustained, etc. HIE is not inexpensive. How do we help California create sustainable health information? We have created a framework based on

- governance,
- technical assistance, and
- coordination.

What we are doing her tonight is supporting your conversation now and we want to be able to support you as you move forward from what is health information exchange to operating and participating actively in health information exchange.

Remarks by Dave Minch, HIPAA/HIE Project Manager, John Muir Health

In addition to my role at John Muir, I have been active at the state level. I co-chaired the Security Committee of California Privacy and Security Advisory Board at the state level. , the state privacy and security advisory board. The Governor actually disbanded the Privacy and Security Advisory Board but retained the committee which continues to meet and work.

I am going to speak about interoperability. One of the key barriers that has inhibited health information exchange since Bill Beighe started his exchange (Santa Cruz HIE) in the 1990s to the current day. The Regional Extension Centers in each state are out there encouraging the adoption of electronic health records and if we don't do something about interoperability, the participating provider will create point-to-point interfaces from every single EHR to every single HIE in the state which will cost hundreds of millions of dollars in that process. To deal with this concern, we created something called the States and Vendors EHR/HIE Interoperability Project. This was begun at the last HIMSS (Health Information Management and Systems Society, the international professional organization for health information technology) meeting in February with the idea of creating a set of interoperable specifications drawing on existing standards and driving them toward a defined set of specifications that vendors and states can agree on and push to implement consistently. By leveraging the participating states and vendors, we have between one-third and one-half of the US population represented in this project. Now at the tail end of this project, we are encouraging other vendors and states to participate.

The participants are as follows:

Vendors	States
Allscripts	California
eClinical Works	New York
eMD's	Maryland
Greenway	Massachusetts
McKesson	New Jersey
NextGen	Ohio
Sage	Oregon
Siemens	Delaware
Cerner joined late	Colorado
Epic chose not to participate	

California and New York are driving the process. Delaware and Colorado are participating in listen mode. We have memoranda of understanding that have been signed by all of these states.

The vendors who were initially missing were Epic and Cerner. Center has since agreed to participate. Epic is the only one that believes they can conquer the world all by themselves

In addition, we have three HIE vendors. In meetings where you are doing technical deep dives, it becomes very difficult to manage if you have a large number of parties desiring to give their opinion and then actually work out the details of cooperation. Medicity and Axolotl have the lion's share of HIE services in the country and InterSystems supplies a lot of middleware that HIE vendors can use

HIE Vendors
Medicity
Axolotl
InterSystems

Medicity and Axolotl have the lions share of HIE services in the country. Inter systems supplies a lot of middleware use by HIE vendors.

We have had request from other states to join in the next round of interoperability specifications that we prepare.

Between May and August, 2011, we went through the Continuity of Care Document (the C32) developed by HITSP (the Health Information Technology Standards Panel) and literally drove that down area by area and field by field into the meta data for those documents so now have a very specific implementation that has been agreed to by all of the participating states and vendors. When we completed this work, we took it to the Office of the National Coordinator and began joint meetings with the Office of National Coordinator to resolve any differences between the documents the project produced and the Standards and Interoperability Framework ("S&I Framework") documents.

We are jointly announcing with States Group and ONC the availability of the specifications for virtually anyone to use on our website. We are opening the results up to all states and all vendors. We hope that the Regional Extension Centers in each state will endorse these exact specifications in their contracts so that everyone is using them.

In October, we developed specifications for Push for the Direct messaging framework with provider directory services for interoperability between health information exchanges.

Privacy and Security

This is a huge subject area. There are two agencies of interest:

- CalOHII and
- Cal eConnect

http://www.ohi.ca.gov/calohi/ This is a compendium of work since 2008. This includes a complete set of security specifications. They are in the process of taking those guidelines and driving them down to recommended steps for provider organizations based on the size of the organization.

These are two committees looking at policy from the Cal eConnect side:

- Privacy committee focused on consent and use of data, http://www.ohi.ca.gov/calohi/eHealthPolicy/PrivacySteeringTeam.aspx

- Security committee focused on securing the data, http://www.ohi.ca.gov/calohi/eHealthPolicy/SecuritySteeringTeam.aspx

The privacy side focuses a lot on consent. We all agree that data can be used for purposes of treatment. A greyer area is secondary uses of data and use of data for operations.

http://www.caleconnect.org/?page id=525

The link above shows page 525 for the Policy Advisory Group. The same link with the page 527 reaches the page for the Technology Advisory Group.

Dough Hayward, Executive Director, Solano Coalition for Better Health

Paul Alcala, CIO, NorthBay Healthcare

NorthBay is 98% electronic in all of its lines of business: hospitals, home health, imaging centers, and a primary care physician network. We started with single EMR to serve all our enterprises. The physician at home or in his/her office can look at anything about the patient in the entire spectrum of care: hospital, home health, imaging and primary care. We just attested Stage 1 today (11/2/11). We are putting in private HIE. We are at the beginning of sending information to affiliated physicians who are not part of our organization. We send them patient demographics, documentation, transcriptions and lab results in our own private network. Our plan is to see how HIE services evolve in our region and potentially participate. Right now, there is not an HIE out there serving our region.

Lynn Denham Martin, Professor of Nursing, Solano Community College

I teach registered nurses how to use informatics in EMRs. I am here as an interested member of the faculty.

Elisa Ashton, California Health and Human Services

We are the HIE grantee of the Office of the National Coordinator which provides grant support to Cal eConnect. We are working to help Medi-Cal be successful in getting its providers to meaningful use through EHR adoption and HIE.

Dan Glaze, HIT Program Manager, California Health and Human Services

I report to the Deputy Secretary for Health Information Technology and help with communication and coordination of all activities between the different agencies with respect to health IT.

Marty Malin, Interim Mental Health Services Act Coordinator, Solano County Mental Health and Substance Abuse

We are currently planning for impending implementation of the Avatar system. We have an HIE activity ongoing in which I am not involved but which is to get our Avatar system to talk to our NextGen ambulatory clinic system. We have had some contact with ERs in the community to determine if they would use our data.

Robert Sullens, Project Manager for EHR program for the Solano County Mental Health Department.

We hope to go to board of supervisors with the contract by end of month and begin implementation immediately thereafter. We are purchasing NetSmart for both behavioral health and substance abuse. We did not purchase either a custom interface or their Connect product because of the ongoing interest in the County in tying into Redwood MedNet for HIE services.

Tom Bartee, District Director, Assemblymember Michael Allen

I am here to absorb whatever information I can pick up. Perhaps, we may be of some assistance with legislation. We are looking for new ideas for the next session which would be introduced in January.

Randy Snowden, Director Napa County Health and Human Services Agency

My colleague, Alex Hughey, will explain what we are up to.

Alex Hughey, Assistant Director, Napa County Health and Human Services Agency

We are looking at four items in this area.

- As a CMSP (County Medical Services Program) county, we will be participating in the CMSP low income health program
- We are interested in positioning ourselves to qualify for additional federal reimbursement for services that the CMSP program does not decide to provide.
- Looking for an interoperability solution for our local Federally Qualified Health Center, Clinic Ole, which recently opened a clinic on our Health and Human Services campus as part of our integration of services. We would like to have eClinicalWorks, which Clinic Ole uses, talk to Anasazi, a behavioral health system.
- We are an integrated health and social services agency and we would like to be able to include social services. We also screen clients for homelessness, housing needs, and related situations.

We would like any discussion of interoperability to take these four factors into account for us.

Tracy Krumpen, Staff, Senator Lois Wolk

I am pleased to be here and to hear about what is happening. Our doors are certainly open. Please let us know of anything we can do to be of assistance.

Don Hitchcock, MD, Medical Director, Clinical Information Systems, Queen of the Valley Hospital

Locally, we are pretty much though with our implementation of the electronic medical record. We have implemented Computerized Physician Order Entry. We just started bar code scanning this week. We pretty much through with implementation except for physician documentation which we are leaving for the last because physicians will love that so much. The hospital is ready for meaningful use stage 1 and will be starting our demonstration period very soon. Physicians can access the EHR data remotely through Citrix servers. We have just gotten iPads and iPhones on board for data access from anywhere. Physicians at California Veterans Home can also access data this way as they send many patients to Queen of the Valley.

HIE among organizations is a St Joseph Health System initiative. St Josephs has implemented four interfaces with MediTech. It is a challenge in Napa with more than a dozen different vendor products in physician offices. Currently, the system plan is to try to use a product form Forward Advantage to interface to these different provider

systems. We are also moving data into Microsoft Amalga which feeds the Microsoft Health Vault so patients can have a personal health record so that this data can be accessed remotely by providers if the patient has consented to this. Queen of the Valley is not part of HIE yet. Our consultant has talked with Cal eConnect and will Redwood MedNet and discussions are ongoing. Hopefully, once the St Joseph Health System connections are all made, St Joseph will be able to connect to statewide HIE.

Andrew Benware, Staff, Assemblymember Mariko Yamada

I am staff to Assemblymember Mariko Yamada and am pleased to be able to participate in this meeting. (Remainder not audible.)

Rayna Caplan, Research and Evaluation Manager, Cal eConnect

I work with our expansion grantees and look to get a better picture of the HIE activity statewide so can understand those efforts at the ground level.

Liz Gibboney, Deputy Executive Director, Partnership HealthPlan of California

Sokkim Lynn, Senior Program Manager, Cal EConnect

My work is focused on the ONC HIE. Much of my work is focused on ePrescribing. Those of you who have worked with ePrescribing know that it is not the low hanging fruit that we all hoped it would be. Right now we are in the process of finalizing the gap analysis which will help inform our strategies for next year and ongoing.

Rebecca Kriz, Senior Manager, Grant Programs, Cal eConnect

I run the grant programs and the Community of Practice program where we invite anyone involved in HIE to participate.

Greg Baldwin, MD, Medical Director, La Clinica Vallejo, one of 25 sites of La Clinica de la Raza out of Alameda

La Clinica is associated with CHCN (Community Health Center Network) which is a fiduciary agency which works with eight different community organizations in Alameda and surrounding counties. CHCN was involved in investigating and selecting the HER that La Clinica will be using. which is NextGen. The practice management portion of the system will go live January 3. We expect to be the first go-live for the appointment side of the system. With respect to HIE, we are taking a wait-and-see attitude to see how Health Share Bay Area moves forward.

Fernando Cortez, Chief Information Officer, La Clinica de la Raza

Jack Horn, CEO, Partnership HealthPlan of California

We have a very limited health information exchange for our members which pulls in pulls in claims information for our 200,000 members and also pulls in pharmacy information and lab results. It is not highly used. It is used more as a reference but not regularly used. We have tried to promote it to emergency room and the providers get excited about being able to see the data but the providers get overcome by events. There are so many demands on their time and they don't routinely use this niche system. Where we want to go longer term is to be able to aggregate information back from the various electronic health records. We have a quality bonus system and it may be in the interest of providers and primary care physicians who work with us to allow us to pull information from EHRs to help meet the quality goals. This would save the providers a lot of time in submitting data demonstrating attaining quality goals. With respect to HIE, we see ourselves being in more of a supporting role as we are just one of many players. If we can facilitate, or help, or be involved in some kind of larger effort, we would love to do that. We don't see ourselves as being the leader in that activity. I applaud Lyman and all of you for stepping up to start by taking a bite of this elephant. We will see what can happen over time.

Frank Hayes, IT Manager, Community Health Clinica Ole

As Alice Hughey from Napa County just mentioned, we just opened a clinic at the County of Napa and we are trying to figure out a way to share patient information over there. We have a real need.

Robyn Wiedner, Director of EHR and Special Projects, Planned Parenthood, Shasta Pacific

We have 20 centers, from Chico to San Francisco. We recently had a significant expansion into San Francisco, Mendocino and Marin counties. We are in the process of our EHR rollout with NextGen. We have 6 health centers live as of yesterday (11/1/11) and 14 more to go. We are going live on ePrescribing next month. One all sites are live, we will be able to focus more on health information exchange. We would love to be good partners on that issue.

Robert Moore, MD, Chief Medical Officer, Partnership HealthPlan of California

Jack Horn has covered our planned efforts.

Michael Hogarth, MD, Faculty, UC Davis

I am an Internist by training but I teach in Informatics. I know many of you and have worked with Will Ross at Redwood MedNet. I am wearing my UC Davis hat. We have been taken over by Epic. Four out of five academic medical centers in the UC System will be using Epic. UC Davis is one of the most advanced in our system. We are at level 6, gained last year. We are the 164th level 6 hospital in the US. We are targeting level 7 for next year. Unfortunately, UC San Diego beat us to level 7. Nevertheless, we will beat UCSF and that is all that counts.

For the last several years, under contract, I have worked with State Department of Public Health to develop and now operate electronic death registration system in California which is the most successful one in the country with 99.8% of all death certificates in the state electronic. That is by far the highest of any state.

I am used to taking Luddites and transitioning them to electronic system users. If you think doctors are conservative, you should meet funeral directors. Many of them have said that they would never get rid of their typewriters. They have all done that.

I love rural medicine and the HIE concept is very attractive in that kind of environment.

From a UC Davis perspective, we are waiting to see what happens. We are a big system. I wish we exchanged more data with our physicians in the community but we are so busy with our own implementation. We have connected with Sutter. We have access to each other's records and we have done so for about 4000 patients. I actually used that system when I was treating a patient and it was very worthwhile for the patient. It saved them a couple of procedures and improved the care. One of the challenges is how to measure that success? Some folks will say that HIE is a lot of money spent for nothing and we have seen that in the press. One of the challenges out here now for many of us is to determine how to put a metric on the benefit.

Marylou Fracisco, Instructor, Computer Science and Business, Solano College

I am here to learn. We are interested in being able to develop programs to train individuals to support in the kind of work you do.

John Urrutia, Professor of Computer Science at Solano College

My objective is provide you with people who can help you in the technical support area -- people who can handle systems, modify these systems, update them, and keep things running smoothly.

Lori Sklar, CEO, Redwood Community Health Network

We serve nine community clinics in the four counties surrounding Solano County – Napa, Marin, Yolo and Sonoma. We are completely implemented with our EHR thanks to Robert Moore, MD, our former Chief Medical Officer. We are about to implement a private eExchange system. eClinicalWorks sells product called EHX. We will be building that effective in January to store all of our own clinical records. While that product can serve as an HIE product, we will use it as our own portal for sharing with other providers outside our network. We will be able to create a spoke to any provider that wishes to talk to us. We expect to have that completely implemented by the end of next year, with all the clinics online. It is a big challenge as we have to look into all the legal arrangements – op-in, op-out. We are just getting involved with that now. We will initially focus on the local market of our nine clinics. We also work with 16 clinics, some of which chose other EHRs. We wish to be able to speak to the non-eCW clinics as well, including Napa County for Clinic Ole because RCHN hosts the environment for all the clinics. We are trying to set up one easy way to do this rather than interfaces to all the different sites. So we are actually on the forefront of some of this.

Kathy Ficco, Executive Director, St Joseph Health System, Sonoma County

Our first foray into HIE was through the implementation of a personal health record for vulnerable populations called MiVIA. That got me acquainted with Laura Landry and Will Ross. Dr. Hitchcock told you a bit about what St Joseph Health System is doing. Our vision is to connect not only to St Joseph Health Systems physicians but also to physicians we collaborate with in the community as well as local hospitals in the region and community health centers as well. We are in collaboration with Will Ross, Redwood MedNet to serve as an HIE network. We use Amalga as our data warehouse. Our phsyican groups use Allscripts MyWay. What we are really excited about in the future is the patient engagement part. We plan to use the HealthVault as the vehicle for transferring patient information to the consumer on their request. If the patient already has a personal health record like MiVIA, that will be the vehicle for transferring the data. We are interested in collaborating and connecting and partnering.

Dave Minch, HIPAA/HIE Project Manager, John Muir Health

We started our HIE back in 2005 2006. We built a small-self-developed system to distribute lab results. We contracted with RelayHealth about two years later. We presently distribute hospital results to four other partner hospitals in the East Bay area and to several hundred physicians both in our own IPA and our own primary care network and outside that network to quite a range of physicians in the Contra Costa area. For about two years, I have been working beginning with meetings like this to try to get true health information exchange going in Alameda / Contra Costa areas. About a year ago, we merged our efforts with the San Francisco group doing the same thing and we are now called Health Share Bay Area.

Bill Beighe, CIO, Physicians Medical Group of Santa Cruz

We started organizing and operating the Santa Cruz HIE in 1995. There were three partners at that time: the IPA I work for (PMG Santa Cruz), Catholic Healthcare West and Unilab, which was bought by Quest Diagnostics. We started at a time when there was no grant money and put up about $1 million total to get the HIE off the ground. We are a true multi-stakeholder community. We operate only in Santa Cruz County. We just serve Santa Cruz County physicians. We have about 70% of health care in Santa Cruz County running through the exchange. Both full-service hospitals are completely connected. We believe that the secrets to success are

- local support and
- local engagement

These build trust. We also have a really rich set of data to exchange.

Just about anything that you can image, we have been able to add to the health information exchange starting with laboratory, radiology, transcription but also discharge summaries and ED reports. We have jail in. We have behavioral health in in a separate area that can only be accessed by that specialty but they have access to physical health information. We have the surgery centers. The initial system was web-based. In the mid -2000s, we began adding EHR connections. We now have nine different EHRs connected. We have three certified EHRs. We helped the physicians get these implemented. We have 50 doctors that are going to be attesting to meaningful use this year and another few hundred next year.

Will Ross, Project Manager, Redwood MedNet

Redwood MedNet formed in 2004 by a steering committee drawn from facilities that were under-resourced and were unable to rely on an enterprise data processing department. We incorporated in 2005. We began moving lab results from a critical access hospital to an FQHC in 2008. In 2009 we added radiology. Last year, we added ePrescribing. This year we added immunization reporting. We are now pushing results to CAIR (the California Immunization Registry) from community clinics and primary care practices. Next year, we have a lot of interfaces on our plans. We have about 30 interfaces now. We expect to have 100 by the end of next year. We interface with seven different EHRs now. We expect that to go up. We have 20 sites participating now in HIE. We expect that to be 40 by the end of next year. As Kathy mentioned, I was in 3 hour meeting at Santa Rosa memorial where we are lining out about a dozen interfaces to be built over the next three to six months to put some kick into St. Joseph's efforts to interoperate. What we do is live in the network and build services like those Bill Beighe was describing and Dave and Arieh Rosenbaum will be describing. We are here to help anybody get connected.

Peter Mathews, MD, Physician/Informaticist, Kaiser Permanente

I am a physician with Kaiser who has been involved with informatics for about 20 years. We implemented a full inpatient-outpatient Epic-based EMR about four years ago pretty much across the country. It has taken four years to pull the benefits out and operationally change things. We just went live with the ability to get records from other Kaiser regions in my area two or three weeks ago from other Kaiser Epic clients like from Washington DC, Georgia and California. I can view only a complete medical record from the other regions on demand, which is pretty powerful. The system is view only because each region has different ordering systems.

Speaking as a physician, once you have these systems in, it changes how you practice medicine. For example, I may preorder studies before the patient goes to the orthopedist to make the process more efficient. We do a tremendous amount of online and phone care because you have available the full electronic medical record. It really changes how you deliver care. I used to go to the hospital to provide care at night. Now I do all of that over the phone. I can do a much better job and do it more efficiently. We probably get 30 emails a day from patients. As you get further out this curve, it really redefines how you can deliver care. About half of it is figuring out how to use these tools which probably takes a couple of years or even longer. Once the tools are in for all your providers, it set up very valuable enriched learning. I have talked with the Kaiser national people about when we are ready to move to the next level. We are all interconnected to ourselves now. I do not know the Kaiser policy with respect to sharing outside of Kaiser but I am happy to be of help of if I can.

Charla Parker, CEO, Western Clinicians Network

WCN is a regional professional association for the Medical and Dental Directors of community clinics. We are just completing a capacity survey to identify gaps in provide availability for 2014. High on the list was the inability to receive information between primary care, specialty medicine and hospitals. This is identfied as high learning need. I am here to listen, help develop education and training programs for clinical leaders. Our survey was validated by a survey conducted by the California Primary Care Association and the Medical Group Management Association. If you don't involve the physician leaders up front in planning, it will definitely prolong the successful implementation. Our role to train the clinical leaders to be champions of change – to accept and not resist change.

Arieh Rosenbaum, MD, Chair, Health Share Bay Area and Hospitalist and Director of Medical Informatics, Cal Pacific Medical Center

In May 2009, we sat in a meeting just like this with the California eHealth Collaborative (CAeHC), with a bunch of really enthusiastic people ready to do health information exchange. It has been a little over two years. We have accomplished so much. We have gone through the technology due diligence. But more importantly, we've done a lot of trust building in the community and that has been the key part of the process. We

are at the point now where we are just about to select a vendor. We are just about to have participants sign MoUs. We hope to launch exchange in May 2012.

What started out as a San Francisco exchange is now a San Francisco and East Bay exchange. We have merged the two efforts. It's been great collaborative effort. It's truly a community effort. That is what this is all about. I am really excited about this and here to answer any questions.

Susan Elliott, Clinic Administrator, Touro University Medical Center

We have some upcoming potential changes that are still in the pipeline. We may potentially merge with Solano County. Any efforts in this area will be put on hold until we know what we are doing.

Craig Veracruz, CIO for the West Bay Region, Sutter Health
I am here representing my colleague for the Sacramento Sierra region and Sutter CMIO, Dr Sundeep Desai. I am privileged to be able to work with Dr. Arieh Rosenbaum in a number of roles including Health Share Bay Area. At Sutter Health, we are largely through with implementations in our medical foundations and we are moving down path of hospitals. Our Central Valley region and our Costal regions are the furthest along of our five regions. UC Davis connecting with Sutter using Care Everywhere version 2.0 is very successful. With the five regions, there is no one strategy for HIE. Within Sutter, a lot of the approach depends on the medical market within which you live. "All care is local" applies here.

In Sac Sierra Region, there is a lot going on. A similar group is forming in the Sacramento area.

In my West Bay region, Arieh spoke about Health Share Bay Area. We look at this as very important initiative and are doing as much as we can to support that trust-building. We are ready to sign those MoUs and to commit dollars to start construction so we can prove this thing. It will be wonderful. It's not an EPIC OR Community HIE. It's a both/and strategy. Dr. Mathews of Kaiser mentioned the power of transforming care. This is integral to what we are doing in our West Bay regions and another hat I have as Chief Process Officer and that is to bring the Toyota Management System into our region. We have been doing it for 3 years. We are starting to actually sit up. We want to crawl but we are hopeful when we look three or four year down the path that the management system with a true methodology for improving care delivery processes merges with this great technological effort of community HIE and we start to extend beyond our walls to our partners and use a more seamless information flow to truly do good by our communities. That is the whole connection point to this effort in the East Bay region to do our part in bending the cost curve.

Open Discussion

Privacy and security. We have offers of assistance with respect to legislation. Charla Parker asked if the rather strict set of California privacy and security requirements, going well beyond the federal requirements, might be something to consider for change. We all provide the best care we can to our patients. These laws and regulations should not get in the way of that.

Question. Is there one organization that speaks with a single voice for all the providers. Would WCN be such an organization? This might allow us to focus what we desire for the legislature.

Comment. We have an extremely close link to the legislature with Laura Landry here.

Laura Landry. Cal eConnect is the state HIE organization and we are actually spinning up a function to look at in a structured way what we can do without legislative change and what are the barriers that are created by the differences in law. We expect to have that in final form by June of 2012. We are starting on that right now. We also have two members on the Cal eConnect board, Terry Boughton and another who are staffers to the Assembly and Senate Health Committees and they are very interested in this as well. We would love to tie us into this and speak for all the constituents of California – not just the healthcare constituents but the consumer and patient advocates as well.

Tom Bartee. Assemblymember Allen is an attorney and former psychiatric nurse, which helps him at the Capitol. He has a genuine passion for healthcare so that is something we could easily embrace.

Will Ross. If you go to CalOHII web page now, there is open comment period on current draft regulations which opened 10/7 and closes 11/7. Anyone who wishes to submit comments to CalOHII re current draft regulations can do so now.

Laura Landry. There is also a public comment meeting at 9 am in Sacramento on Monday, 11/7.

Jack Horn. What would be some of the steps that might be taken by these counties to obtain HIE services? Could they join with other counties or combine existing HIE services or other solutions? Who could articulate what some of the choices are?

Laura Landry. There are many states that don't have health information exchange networks. You have five of people in this room tonight who have been doing this the longest sitting in this room. You should take advantage of the fact that you have Redwood MedNet, you have Health Share Bay Area, and you have Santa Cruz. They are close enough for you to reach out and tap at any time. They understand the scarcity of resources. They understand the real operational problems that you have to face as part of this. There are a lot of lessons learned.

First, you have to build trust. You have to have enough conversations with each other and you have to say things you don't want to say like here is what our economic interests are. Here is where we are headed. If you don't have that discussion openly you never get to next level. I know where everyone is coming from. Let's see if we can build a common conversation where we can compromise without putting economic interests at risk.

Second, I would reach out to the big three and ask "how can I learn from you?"

The California eHealth Collaborative has some material online about what it takes to build a health information exchange, but, honestly, you have people in your own communities who have been doing this. They can help you have the right kind of conversations. It's not about technology. It is really about how do you interact; how do you create the rules of the road; and how do you manage discussions where you are purchasing shared infrastructure for common purposes and you have your own purposes as well and how do you prioritize them. It is not an easy discussion but as long as you continue to have it in an open way, as a community, you will be much stronger community.

Will Ross. Recall what Bill Beighe was able to accomplish 2 decades ago by drawing together all the community partners. That is an era that has past. That opportunity does not present itself today because of the rise of private records and teams. The concept that I use and the Redwood MedNet has been using all along is that HIE looks more like the cell phone system than the land-line system. For example, I have AT&T and I can call you on Verizon even though you are on another network in the same building. We are not headed to a community where everybody is using the same system but where everybody uses their own productivity tools and can get to each other.

Peter Mathews. So do people feel that there is certain data that is the low-hanging fruit, e.g., problem list, allergy list, medication list, dictated ER and hospital discharge summaries? Is there a logical place to begin?

Dave Minch. It is surely ONC's interest that we be able to exchange lab results. At John Muir health, we clearly had a vision of trying to get information from our health system out to our physicians in our network and then we started exchanging information with Hill Physicians. The idea was that we wanted to push information out and we did that successfully and have been doing it for six years. But we came to the realization about four years ago and to action about two years ago that we weren't getting any info back. Discharge summaries were asked for a lot. But the data were not helping us with our EDs or trauma care. Our hospitalists had no idea when we were getting patients, especially from the safety net, we really did not have much information about the

patient. That was when we figured out that exchange has to be bidirectional. That required the community to come together. As Arieh mentioned, we started with a meeting like this. We set up a governance committee of 10 people, five from hospitals and five from Hill and from our IPA. We started talking about things we needed to put in place and what people we needed involved in it. Most of our meetings were over the telephone. Arieh got representative for San Francisco in a relatively small community to meet face-to-face a lot.

San Francisco and Contra Costa followed exactly the same path – it was sort of a race. We got together a year ago and looked at it and said, this is not either of our full-time jobs, this is something our bosses said, "Go do this and by-the-way, keep doing everything else."

At that time, San Francisco had developed more momentum than we had. It really helps if you have a close knit community and people sitting in room who really understand that vision.

The first meeting I had in San Francisco with CIOs and CEOs and everyone in that room had shared common vision. It was really amazing. I had my own committee doing the same thing and I think we had a lot of different pieces of a common vision. San Francisco had been able to achieve a melding of the ideas because the healthcare market in San Francisco is diffuse – not dominated by any one player, like any one health plan.

The organizations were in a similar situation and we were able to convince the two governance councils to throw in together and form Health Share Bay Area. It was a very positive step for both Alameda Contra Costa and San Francisco.

Craig Vercruysse. One of the strengths of the union was that the San Francisco Medical Society was at the table in the beginning, even before the initial forum they were a convening group. This gave us a corporate structure to operate in. They gave us the vehicle of their 5013C to form so we did not have that administrative overhead, they had connections that could be leveraged, and they had a community service foundation that conducted several educational events geared toward explaining what health information exchange is to help build momentum.

What we are trying to do is not to compete on technology. That is not our business. Our business is care for the community. We should not compete on this. We should compete on everything else. Let's work as fast as we can to commoditize information because, frankly, the only people that are winning in this game are vendors. Let's get together and drive the cost structure down in the interest of our community. Then we will compete on clinical care.

Bill Beighe. You need someone at the center to push. They don't need to be the owner. They need to have enough clinical clout and money to push. Someone has to put some money up somewhere.

Thinking about Peter's question about where is the low-hanging fruit, one you get the core organizational things set up and get the core basic infrastructure of what you will do, then go out and ask the users, "Where is your pain? What do you need?" and get beyond lab, rad and transcription. In Santa Cruz, we have 500 providers in 100 different care settings -- lots of 1,2 and 3 doctors groups so there is a lot of need to exchange data that would be going by fax or mail or some other way. So you go to the primary care physicians and ask what they need. So they say, "If I could send my diabetes referrals through my system here to them electronically, that would be great. You know what be even better, if the diabetes center could put treatment notes in so they would be part of the chart. We go over to the diabetes education center and ask, "Would you like to do this?" It's very much boots on the ground -- that sort of outreach.

You repeat that approach over and over again. "What do you mean the surgery center is not sending data electronically?" Well, I will go talk with them. We find the doctor on the board of the surgery center and ask him to help us. That is how you get to the low-hanging fruit, beyond the basic infrastructure.

There are four to five things an HIE does but increasingly the value is interfacing and data transformation. We take data from some parties that are only able to send it in one way and we transform it. We cross-reference it between private identifiers and NPIs and vice versa. We deliver the data in a way that they cannot do or cannot do efficiently. We take data from a hospital transcription service where the doctor does not dictate the gender of the patient because the physician is an OB/Gyn with all female patients. We take that transcription in and match it against the master patient index and add the gender to the record and deliver it to the provider. Otherwise, the record ends in an exception queue that a human has to manage.

Laura Landry. If you want a real practical way to determine where to start, most or all of you have a **community health assessment.** If you line those up as we did in my community**,** you'll notice common themes that all of you are struggling with. Have someone gather all of the community health assessments from your hospitals, public health departments and community clinics and put them together and see what is common. That will be an indication of the low-hanging fruit.

You need two things:

- A need high availability of data, which means data moved electronically and
- A need for the data to move inside the community.

You have to put those two things together to get a win.

Robert Moore, MD. Lyman envisioned this geography as Napa Solano and Yolo which I think is a relic of the original Partnership HealthPlan service area.
Queen of the Valley is part of St Joseph Health System which has two hospitals in Sonoma, Clinic Ole and CommuniCare are part of RCHN which has a bunch of clinics in Sonoma which are live with the same system. So I don't see a reason not to include Sonoma County.

Unknown Female. I was at the initial meeting in Contra Costa County and now we are doing this in Sonoma County. Are we going to do the same thing all over again? Do we need to spend another two years to end up exactly where you are? Or do we say, let's look at their experience and say how do we just join with them? What is the value in doing our own thing?

Arieh Rosenbaum, MD. The value of having a community forum to talk about exchange will be greater if more participants join. The experience in San Francisco and Alameda Contra Costa is organization, various stages of readiness both technologically and priorities for health information exchange and it takes a lot of organization and a lot of time with decision makers. We had people at meetings but they were not necessarily the decision makers. They had to speak with the decision makers but the message was sometimes diluted. It took that time to galvanize some of the decision makers in the core oragnizations to get them to think about HIE, much less joining one or starting one up.

Thinking of Will's cell phone analogy above with AT&T calling Sprint, you will tend to call those people in your same geographic area. In order to get value from participants in a community, you need to have as many participants on board as possible. That's where the time needs to be spent.

An HIE needs to include natural trading partners. Joining an HIE that is not representative of the local geography may not be useful as normal trading partners are not included.

Unknown female. How do we take lessons learned from these three counties and start the process 10 steps ahead of where they started (the early HIEs in California) so we can and get somewhere faster?

Paul Alcala. The first thing is TRUST. Health care is delivered in zip code basis. We realize we are competitors. We all have different objectives, but care delivery is on zip code basis. Unless an organization comes together and develops a trust and vision that all can embrace, all you have is a technical efficiency structure.

You have to start with trust issues and the questions that you are afraid to ask. If we don't get beyond that, we are building on very soft sand. Once you have vision and trust, then you can ask how do you get there. We are right at the beginning. This is not a technology issue. Technology is the simplest issue. It is the trust; it is the vision.

There will be a lot of consolidation in the market when is it appropriate to consolidate. The HIE governance will make those decisions. When is an HIE too big? That is the governance decision. When you no longer trust your partners, then you know the HIE is too big.

Today there is 10 year history of this with a lot of failures. You want to learn from those failures and learn from the successes. Starting later is an advantage.

Laura Landry. Let me add some hope to that. Long Beach Network for Health started in October 2003 in waning days of Santa Barbara HIE, one that ultimately closed. We learned everything we could from them including how not to write data participation agreements. It took us two years to have right kind of community meetings and it took us five years to get to data sharing agreements.

Redwood MedNet had similar experience. It only took Health Share Bay Area and Alameda Contra Costa two years to not only have conversations, build trust, and recognizing their health care market was bigger than they thought it was, and get to the point of selecting a technology and getting ready to implement it along with the governance development. The time to get the work done to build an HIE in a community is going down and down and down.

Part of job of Cal eConnect and California eHealth Collaborative is that we don't want you to go through the pain we went through. If you let us, we will help you focus on the questions that will make the biggest difference. We will come have conversation with you. We will help you pull your meetings together and will help may you successful. It will not take you 5 years. You will really accelerate your process as you are working with people who have that experience. But, you still have to have the hard conversations yourself because we don't know happened 20 years ago that made this person upset with that person and they won't talk to each other.

Unknown female. What is the plan once the grants are gone? Will the grants always be there? What's the plan for sustainability?

Dave Minch. For Health Share Bay Area, with the exception of less than $100k in very small grants, we are basically starting with no grants. We are planning on making the HIE be sustainable from day one. When we turn the HIE on, we will be asking all of members to contribute to the operation of it. There will not be a tremendous amount of value in the beginning as there will not be much data there. As data builds over the first year, members will start to get value out of the HIE.

We are working with two vendors who became the finalists to explain to them that there is no world where someone will write a check for $2 million is no longer there. We may be the first ones to turn the pockets inside out and say we have no money but we want

to start a health share and we want you as a partner. Part of the partnership is we will start very lean and then we will grow it and as we grow it we will provide more services.

One of the most important things about HIE is that it is more than HIE. HIE is the beginning of it. All of the things you can do with that information and building a community record, when you start talking about disease management, you can only do disease management with a longitudinal record. The only way to have a longitudinal record as a community is to have an HIE that has that data. No one organization can have all of that information with possible exception of Kaiser. Even Kaiser doesn't provide all of the care to its members. Certain care is contracted. For example, John Muir does some of the oncology work for Kaiser patients. We are very anxious to exchange information with Kaiser. We want to get oncology information back into the record. When we get the patients, we want to be able to get the CCD. There's value there for everybody.

Peter Mathews. There are so many dropped balls. When a patient moves from acute care to other care. When there is a durable power of attorney. When ED record is missed. That specialty records go back to the primary care physician.

Laura Landry. You get to where you need to be by putting the patient at the center of it.

Will Ross. One of the problems with putting the patient at the center is that is raises the question of reducing your revenues because you were making money off of duplicate tests.

Oregon State HHS was interested in reducing duplicate tests. In the Portland metro area, they convened the five medical centers and did an 18 month study. For a net investment of $100,000 per medical center, they could lower the cost of Medicaid to the state by $1.5 million per year in Portland but it would lower revenue for each of the five medical centers. When the State offered the five medical centers the right to vote on the approach, the medical centers voted it down. It wasn't complete package that met needs of all of the players. It was strictly focused on reducing costs to Medicaid.

Paul Alcala. Those are exactly the types of conversations we have to have in order to get to answers to the question, "Why should I participate?" There are a lot more of those discussions than just that.

Laura Landry. If we take out all of the multiplication of effort and if we take out the fear of what we will get caught at, is there enough dollars to put back in the system to pay people for the outcomes we want to get, would you be able to create a new model of payment that would still reduce the cost?

Paul Alcala. Under health care reform, fee for service cost shifting will diminish and margins will get smaller. We will do a lot of what we are doing for 25% less revenue

starting in 2014. We will all live with thinner margins and will have to become more effective.

Laura Landry. The trust environment that you create here can be the nexus for those kinds of conversations. People were getting benefit out of these kinds of conversations at Long Beach way before we began use of technology. The participants realized that they had connections that they had not known about. It was the relationship building.

Paul Alcala. The advantage that we will have if we start today versus the pioneers of years ago is that the Government has already provided economic incentives for physicians and hospitals to get the EMR. Then you are enabled to do HIE.

Will Ross. Redwood MedNet was started by the Medical Society. There was a 4% adoption of EMR when we started. Now we are moving from 15% to 50%. That is a huge difference in the environment for having these conversations.

Dr. Mathews was talking about the dropped balls. In addition to reducing duplicate tests, you can determine when the handoff between two provider locations is not functioning. This is a benefit you can seek out.

Craig Vercruysse. Before you have trust you have to have belief. To have belief you have to have people like Dave Minch and Arieh Rosenbaum and Amy Berlin, the Co-chair of Health Share Bay Area and someone like Mary Lou Licwinko, the Director of the San Francisco Medical Society. Those four people are the reason Health Share Bay Area exists. It is not just a tack-on responsibility to them. It's a mission. The question is where did the fire start in the room? Laura and Bill, you can probably name the fire starters.

Bill Beighe. How we can accelerate this? The government in California is spending a lot of time in putting the guard rails up about what is permissible. The government needs not only to say, "Here are the guard rails." but also, "Here is where we are going." It is not about just setting the rules that you must work within, but how do we encourage health information exchange? With health care reform, I believe that HIE will support the core elements of health care reform and the financial crisis we have coming at us. The government in California and the federal government as well can help support this with regulations. Just leaving it to individual HIE organizations like ours is not enough.

Michael Hogarth. It would be a great advantage for a hospital that takes care of patients to know if a patient has died – the fact of death not the cause of death. I happen to run a system that knows who has passed away in California pretty quickly. They death registry has individual contacts for data delivery with every provider who has this. It is painful to contract with the State. There needs to be an easy pipeline for this kind of data to be made available. It's important not to send this person who died of cancer the next appointment. The fact that they died does not have privacy attached to

it. The cause of death might have privacy issues. This is something that the legislative side of the house might help remedy.

Unknown male. There is a need for a controlled substance repository to identify abuse, multiple prescriptions for narcotics and the like.

Unknown female. The Secretary of State has a repository of advanced directives but it cannot be accessed.

Unknown male. Another problem is the provision of excess care in the last six months of life.

Paul Alcala. Some HIE may make money by selling information. We want information for the good of patient care but we might also want it as a service for financial sustainability. Information is valuable and not just in health care but in many different ways.

Dave Minch. We grew up in era when information is power. The better intelligence you have the use of will get you farther and may give you an economic advantage. We have now transitioned to new era. We don't have enough information indivdiually to be effective anymore. We had that conversation. We built these repositories and we have great analytics, but I only see this much of the picture and the rest of this is somewhere else. We have to get over this concept that information is power and understand what can you do with it. We can compete in a lot of things but we shouldn't be trying to compete on hoarding information anymore because it doesn't do any of us any good.

Paul Alcala. You have to ask the question: are your values and vision and mission consistent with each other?

Bill Beighe. Regarding sustainability, our motto is everybody pays. Now, it is easy to make everybody pay when you have data there and everyone comes. For example, all seven local labs are there and the data is delivered to the HIE. It's easier to say that everybody pays when you have that reason to go there. The doctors pay, the labs pay, and the hospitals pay, and it is a subscription basis. When we started there were not grants. We had to figure it out from day one. We don't have any major employers. We purposely don't have any insurance companies because there are so many of them – the market is fragmented.

Paul Alcala. The only people really making margins now are the providers of the HIE systems – the vendors. They will promote you to become an HIE so you can buy services from them.

Michael Hogarth. As adoption goes up in a community, the use of point-to-point connections becomes less efficient and it becomes inevitable to have an HIE. Labs will eventually not interface with additional customers. Currently we have about 20%

adoption. Once you have 50% adoption -- I don't know what tipping point is where you get the network effect. With Bill Beighe's Santa Cruz HIE, he had the network effect early because partners came together and supplied data. When you are bootstrapping it, it will take a while. As adoption increases, it becomes more attractive. If I am a physician in community and I have EHR, it makes no sense to have lab fax me the results. I want the result interfaced to my EMR. That is 1.0 technology. With 2.0 technology, it is seamless. I don't want to have to have interfaces with five labs. At that stage, it is an obvious thing to have HIE. So HIE and adoption are really tightly coupled. I predict HIE will be part of business once we have certain level of adoption. I can't predict at what adoption level that will occur. Physicians will demand that labs be electronic. Looking at places like Santa Cruz as case studies are very important to determine at what point does the network effect make HIE a profitable sustainable enterprise?

HealthBridge in Cincinnati has 6000 MD and 18 hospitals. HealthBridge does not charge physicians because they have so many hospitals that pay. Taconic in New York has subscriptions. New York Public health has incredible reporting requirements. They became the connector between practices and the State. Hospitals paid $6000 per month to let them take care of connections and reporting.

Meeting Wrap-up

Lyman Dennis. We will plan for the next meeting. Will someone provide a meeting room and a meal for the group next time. Several volunteers. A number of individuals volunteered to be on a coordinating committee.

Laura Landry. Monday Community of Practice meeting in Sacramento. People developing community HIE will talk about model practices. There is more information on the Cal eConnect web site at caleconnect.org.