Understanding of the Problem/Rationale for the Collaborative

Over three decades, health care in the United States has transitioned from a care delivery model where a single medical practitioner served as the sole source of care to a care delivery model where large-scale institutions provide and pay for care. The complexity exhibited by our current care delivery model requires a myriad of Federal and state laws and regulations that are difficult to understand and navigate for large payors and providers. Health disparate and underserved* populations are further impacted as they rarely have the resources or tools to effectively understand and navigate the mix of federal, state and local entities that are engaged in providing health care for these groups.

In addition, significant disparities exist in our healthcare system, with respect to such key areas as insurance coverage, access, quality of treatment and outcomes. These disparities occur most frequently among racial/ethnic minorities and other medically underserved communities. Despite efforts to reform health care systems through structure, process and technology interventions, health disparities persist and gaps appear to be widening.

Numerous efforts to reform our nation’s health care system are being proposed and tested; yet little attention is being devoted to underserved communities. Reform efforts targeted toward disparities need to take advantage of advances in health information technology and best practices developed in states, counties and local communities in order to facilitate wholesale improvements and significantly increased access to care. Such efforts and others yet to be undertaken will help provide the requisite tools and technologies, if accompanied by culturally/linguistically appropriate outreach and educational initiatives; advocacy and public policy strategies; workforce development and training ventures; and concrete options for funding and sustainability. Such a comprehensive approach will be required to bring underserved populations into our national HIT framework, thus ensuring that the underserved will not be left behind. This need has never been more pressing.

The urgency of addressing the needs of underserved populations cannot be overstated. The fragmented nature of our nation’s health system has imposed special burdens on the most vulnerable areas and populations, already disadvantaged by socio-economic, historical and other societal barriers. If current trends in health disparities are not reversed, by 2050 nearly one in two Americans will be persons of color with higher levels of chronic diseases, shorter life spans, less health insurance and generally poorer health. (IOM, 2003) (Alliance for Health Reform, 2006).
To ensure that our nation’s underserved populations are not left behind as health information technologies are developed and employed, four entities have chosen to come together as conveners of the National Health IT Collaborative for the Underserved. These organizations are: the Department of Health and Human Services/Office of Minority Health (HHS/OMH); the Healthcare Information and Management Systems Society (HIMSS) Foundation’s Institute for e-Health Policy; Summit Health Institute for Research and Education, Inc. (SHIRE), and Apptis, Inc. These initial conveners will be joined by a consortium of Federal agencies and other key private sector and community-based stakeholders to mount a phased 18-month initiative. As a long-range goal, participants will work jointly to propose solutions to improve the quality of care increase access to care and care-related service; and reduce the cost of care among the underserved.

**Vision**

The National Health IT Collaborative for the Underserved envisions an interconnected public and private health system where all consumers have access to high quality, affordable care and to the information and technology resources required to maximize their access and effective use of health care services.

**Purpose**

The purpose of the Collaborative is to convene, study, experiment and propose solutions to help reduce and ultimately eliminate health disparities experienced by medically underserved areas and populations through the use of advances in health IT. We will incorporate a wealth of experience in both the public and private sectors to assess and propose new ideas to improve the health of those communities and populations that have historically had the worst health outcomes and the least access to care.

**Mission**

The mission of the Collaborative encompasses the following:

- Convene a diverse and multi-stakeholder group of community, public and private sector thought leaders to examine how to advance the availability of quality health services for all, including low income, racial/ethnic minority populations and other underserved populations, in a secure, timely, efficient, responsive and coordinated nation-wide system of care.

- Propose solutions that contribute to the coordination of preventive and primary care in both public and private sectors and which enhance the lives of all Americans, including those most vulnerable.

- Research and work to ensure that Federal, state, local and private efforts to develop and coordinate advances in information technology in the health arena
include revised or new federal and state legislation, regulations, funding, programs and initiatives for underserved communities.

Anticipated Outcomes

The National HIT Collaborative will convene and include leaders and subject matter experts in the following key areas: health information technology, education and outreach, advocacy and public policy, workforce development and training, and funding. These individuals will be leaders in their fields who have the capability to organize, motivate, build and sustain momentum necessary to produce by September 2009 outcomes or results, which may include the following:

- A compilation of models, strategies, practices and/or activities with proven effectiveness in informing and engaging the underserved in the use of HIT for health self-management and empowerment;
- New or revised Federal or state legislation or regulations or other model legislation that can be considered for adoption at Federal, state or local levels to advance the adoption and use of HIT by consumers and providers from underserved populations;
- Description of academic, in-service and other models, strategies, practices and/or activities resulting in the availability of health professionals and technical personnel in underserved communities who are HIT-literate and competent.
- A compendium of public and private funding options and written guidance for underserved communities seeking financial support for HIT/Health Information Exchange operations and sustainability.
- Recommendations for a structural framework to maintain an emphasis on HIT adoption in underserved communities, with such functions as providing for information exchange; conducting pilot programs; providing technical assistance and publication of community guidance documents. This framework must be consistent with other ongoing national and state-level efforts, such as those advanced by the American Health Information Community (AHIC) and AHIC 2.0; Certification Commission on HIT (CCHIT); Health Information Technology Standards Panel (HITSP); Health Information Security and Privacy Collaboration (HISPC); and other initiatives.

Process

1. The HIT-UP Collaborative was the brainchild of Ruth Perot (SHIRE), Mary Walker (Apptis) and Dave Roberts (HIMSS).

2. The conveners of the HIT Collaborative officially initiated their planning in March 2008, when Apptis, Inc. made available an Executive-in-Residence, Mary L. Walker, to work with HHS/OMH, Institute for e-Health Policy and SHIRE on a
national project of significance. Mary Walker works out of donated office space
in the Institute for e-Health Policy’s Arlington, Virginia office.

3. Initial activities of the conveners have included the conceptualization of the 18-
month HIT initiative; identification of other key players; provision of technical
and administrative support; location of initial funding resources; and defining the
parameters of the Collaborative’s launch on June 12th during National HIT Week
2008.

4. Initial conveners strategized, prioritized among key areas of focus, and selected
four specific workgroup topics; specified requirements for launching the HIT
initiative; identified prospective keynote speakers and panelists for the June 12
launch event; and clarified a process for the selection of workgroup leaders and
members.

5. Conveners contacted prospective presenters and participants for the June 12th
launch event and continue to secure funding for the initial phases of the effort
through September 2009.

6. The Collaborative leadership group will solicit volunteers and other forms of
support during the start-up phase of the initiative to provide administrative and
technical support for the functioning of four workgroups. Workgroups will be
headed by convener-designated leaders who will ensure that agreed-upon tasks
are completed by September 2009.

7. Workgroup members will be volunteers who will be recruited via a national
selection process similar to the process employed for AHIC 2.0. It is anticipated
that workgroups will have no more than 20 members, including the chair and co-
chair. Workgroup members will serve without compensation or other forms of
remuneration.

8. Initial workgroup updates will be reported at a special forum to be held in
conjunction with the HIMSS09 Annual Conference & Exhibition in Chicago in
April 2009. Final workgroup recommendations from the first phase of their work
will be discussed and published following a Collaborative event held in

**Leadership and Coordination**

The starting group will comprise representatives from each of the convening
organizations – HHS/OMH, Institute for e-Health Policy, SHIRE and Apptis – and will
be augmented by other selected organizations. In November 2008, eHealth Initiative
Foundation joined the Collaborative’s Management Committee. Led by Dr. Garth
Graham, Deputy Assistant Secretary for Minority Health, Department of Health and
Human Services, this taskforce will work to identify health leadership in both the public
and private sectors nationally, statewide and locally, and will work to expand their
contributions and those of their organizations to the Collaborative. This taskforce will set
up interchanges between leaders, soliciting their views on policy and procedures, and will
seek resources from these entities. The Leadership and Coordination Workgroup will also
ensure the smooth functioning of the four issue-focused workgroups, as well as the coordination and cross-fertilization of workgroup efforts.

**Collaborative Membership Categories**

Collaborative members will represent groups such as the following:

- Consumers
- Community health centers
- Health care providers
- Health care payers
- Underserved community advocates
- HIT-related and other private sector entities
- Quality and patient safety organizations
- Government and related programs
- Foundations and other funders
- Academic institutions
- Health information exchanges (state, regional, community-level)
- Other health and allied health organizations

**Key Workgroups/Scopes of Work**

**Workgroup #1: Education and Outreach.** This workgroup will identify and develop effective practices for communicating HIT benefits to diverse underserved populations. This effort should include identifying/creating and distributing culturally/linguistically appropriate materials to these communities. A focus of this workgroup will be on promoting opportunities to educate individuals on the value of HIT to improve health self-management and support consumer empowerment. (Chair: M. Christopher Gibbons, MD, and Co-Chair, Neil Calman, MD)

**Workgroup #2: Advocacy and Policy.** This workgroup will provide environmental scans – assessments of current federal HIT legislative/regulatory proposals/actions addressing underserved/rural populations. This group will also review state legislation/regulations for potential impact on these populations; identify components of model HIT legislation required to address needs of underserved/rural populations; and ascertain available legislative language that could be included in model legislation. These activities may culminate in the preparation of draft model legislation, which can be circulated for comment by stakeholder groups. Model legislation that has had the benefit of broad stakeholder review will be the workgroup’s final product. This final product will
then be available to any stakeholders who desire to transform health care for all communities in the United States. (Chair: Dave Roberts, Vice President, HIMSS)

**Workgroup #3: Workforce Training and Development.** This workgroup will study, develop and/or identify key strategies to train personnel from underserved communities; work with clinical staff to increase their capacity, knowledge and utilization of HIT tools and technologies; and help identify methodologies and processes for quick adoption of HIT tools by clinical and other health professional staff to accomplish quality improvement and cost savings. An additional task will be to promote the involvement of academic institutions to prepare individuals from underserved communities for HIT careers. (Chair: Brian P. Foley, MED, MHA, CPHQ, FACHE and Co-Chair, Jeffery Caballero, MSW)

**Workgroup #4: Finance and Sustainability** This workgroup will address such tasks as developing a clearinghouse for funding opportunities for underserved communities that are available through the industry and government; identifying and/or developing innovative ways for the private sector to invest and support HIT projects and programs in these communities; and developing tools to support communities to successfully access and acquire public and private funds. (Chair: Adam Welsh, Director and Senior Vice President, Apptis, Inc. and Co-Chair, Diane Pinakiewicz, MBA)

* The definition of underserved populations includes, but is not limited to, Medically Underserved Areas (MUA) and Medically Underserved Populations (MUP), the definitions of which are currently under review. MUA and MUPs are defined as areas or population groups with a quantifiable shortage of personal health services as defined using U.S. DHHS designation area criteria. MUA/MUP designations can qualify areas and population groups for benefits under the following programs: Community Health Centers and Federally Qualified Health Centers, Federally Qualified Health Centers Look-Alike Program, the Rural Health Clinic Act, and the Medically Underserved Community-State Matching Incentive Program.