

# HIEPI Business & Technical Operations Workgroup Meeting

<b>Meeting Owners</b>	Bill Baggeroer (WG Lead) Tim Andrews (WG Facilitator)
<b>Minutes Authors</b>	Diana Quaynor (WG Business Analyst)
<b>Version</b>	1

<b>Date</b>	7/6/10
<b>Time</b>	1 p.m. – 3 p.m. / ET
<b>Location</b>	(877) 449-6558

## AGENDA

Topic “Casting the Net Widely”	Led By	Start	End
OPENING REMARKS – introductions, stated purpose of meeting, ground rules, administrative/logistical reminders	Bill	1:00 PM	1:15 PM
Reiteration of vision, overall approach & final deliverable	Tim	1:15 PM	1:30 PM
Walk-through of use cases mapped to HIE building blocks	Tim	1:30 PM	2:00 PM
Walk-through of use case prioritization	Tim	2:00 PM	2:30 PM
Presentation on technical infrastructure packages for HIE building blocks	Tim/Bill	2:30 PM	2:50 PM
CLOSING REMARKS	Tim/Bill	2:50 PM	3:00 PM

## ATTENDEES

Name	In Attendance (Y or N)	Name	In Attendance (Y or N)
Bill Baggeroer (NH Lead)	Y	Mary Hunt, PA-C, MHS	Y
Carol Roosa	Y	Patricia Witthaus	N
David Briden	Y	Peter Malloy	Y
Diana Quaynor (BA)	Y	Sandy Pardus	Y
Doris Lotz	Y	Scott Maclean	N
Fred Kelsey	Y	Shawn Tester	N
Heidi Johnson	Y	Theresa Pare-Curtis	N
Hillary St Pierre	N	Tim Andrews (Facilitator)	Y
Kerri Coons	Y	Trinidad Tellez	N
Lorraine Nichols	N	Wendy Angelo, MD	N
Marcella Bobinsky	Y		
Mary Beth Eldredge	Y		
Mary Brunette, MD	N		

## GUESTS

Name	In Attendance (Y or N)
Mark Belanger (PM)	Y
Micky Tripathi (Program Lead)	Y

\* Via telephone

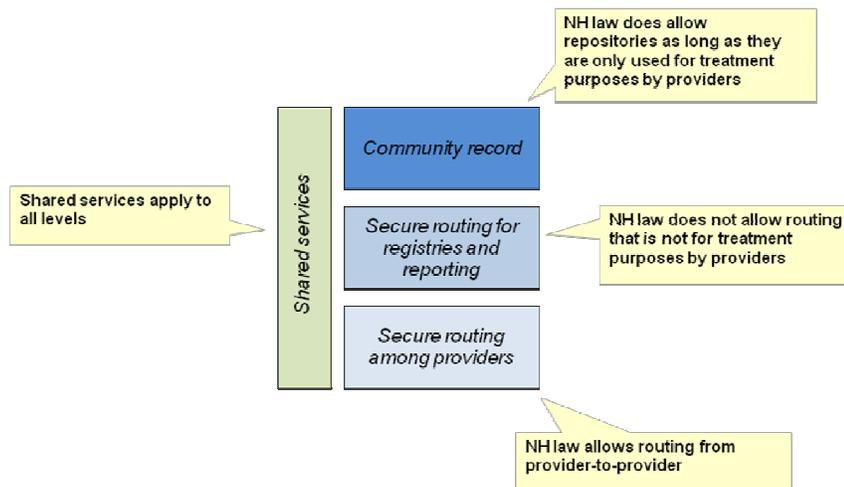
## MEETING HANDOUTS

1. <<HIEPI Teleconf Presentation Biz Ops – 6 Jul 10.pdf>>
2. <<HIEPI\_Strategic and Operational Plan Strawman 062210 v0.pdf>>

## MEETING SUMMARY

### Item

1. Opening remarks - "Considering alternatives and narrowing options" phase
  - a. The plan is to discuss the back end work which is setting up technical operations and the front-end work, which are the requirements. The core of the meeting is to get through the transactions discussed last week, review modified list and review/comment/react to a set of priorities set up by the facilities.
  - b. Goal for today is to take a closer look at the building blocks and technical infrastructure & take a very brief look at the skeleton draft SOP.
  - c. We are trying to incorporate comments/notes received from WG members into our documents and material that we produce, etc. Encouragement for more input.
2. Discussion of transaction mapping to HIE building blocks
  - a. Before moving to transaction mapping to HIE, there needs to be a brief review of what the group saw last week.  
Building Block Refinements
    - i. Secure routing - basic routing capabilities amongst providers generalized across the state
    - ii. Secure routing for registries & reporting - an expansion to include other entities, such as public health
    - iii. Shared services – catch all for higher level value-added services
    - iv. Community Record – cross institutional record matching. Ability to get all information about a particular patient where ever they reside.



- b. WG leads talk across with workgroup co-chairs quite a lot and encourage that group members do the same with their constituents and stakeholders to get as much information and input as possible.
  - i. Slide 8: We are trying to address what's legal to do in New Hampshire.
    - Shared services was moved to the side as it applies at all levels.
    - Secure Routing falls under current law for provider-to-provider.
    - Registries and reporting appear to be a problem
    - Community record has to be between providers and for treatment purposes only. We have to either get a different interpretation of the current law or be constrained by it. This helps us try to refine our priority list.

*Question: Did legal team address the consent issue?*

*Answer: Ingoing assumption is that there is an opt-out consent provision they touched on that. The law says it is opt-out or according to applicable law. Does HIPAA constitute "applicable law"?*

*Q: Clarification of the law was requested with regards to HIPAA. What is opt-out consent?*

*A: You don't need consent prior to exchanging the patient information, but you have to provide the patient the ability to say they don't want their information exchanged. If they say they don't want their information exchanged, then the provider is prevented from exchanging it. Default in an opt-out model, you can exchange information until a patient tells you otherwise. Minimal law in HIPAA says for TPO, research & marketing, etc. is not included. For standard clinical practice, HIPAA has a more restrictive law.*

*Comment – clinicians interpret the law conservatively and do not exchange information without a release, which is current practice in NH.*

*Comment – there are other NH laws that have a higher threshold for sharing than HIPAA or national law which complicates things in NH.*

- i. Legal WG has focused efforts on determining what treatment means and the terms of exchange. They will be focusing on consent and carve-outs.*

*Comment – part of the reason that Community Viewer is on top of the hierarchy is so attractive from a provider perspective is because of the multiple interpretations of the consent laws. Retrieving a patient's information in the exchange without having to navigate through another institution's interpretation is what makes it attractive.*

*Facilitator's comment – yes, from a governance perspective, having a uniform state-wide consent is part of what this whole process is about. You need to have that before you can even put a community record in place.*

- ii. Opt-out is much easier than opt-in, but we still have to address minor/substance abuse & emergency consent scenarios.
- c. Slide 9: This includes all that was discussed in this and other workgroups. We reviewed the proposed additions to the Use cases.
  - i. Add: Chart review by Public Health for case investigation
  - ii. Add: Creation of Radiation Exposure Registry (from our group)
  - iii. Add: Public health labs
  - iv. Add: Patient summary request from provider to provider
  - v. Add: Laboratory decision support for revenue cycle management (big topic in our group)
  - vi. Health Information Exchange Planning and Implementation Project
  - vii. Add: Commercial imaging centers and laboratories to use cases
  - viii. Add: Public health alerts as per Stage 2 MU recommendations
  - ix. Add: Medication history from other clinical sources (not just from pharmacy)
  - x. Add: Quality measure delivery from ambulatory physicians to CMS and/or plans (already had hospitals, just needed to add ambulatory physicians)

We also had modifications that were discussed.

- xii. Modify: Discharge instructions to patient (instead of discharge summary)
  - *Q: In the public health system there are clinicians that aren't seen as PCPs and this may be the case for Medicaid where there may be more than one key clinicians. In such cases, is there a place for more than one provider to sign up to get notification?*  
*A: It's a good point that comes up for labs and images as well where there should be multiple providers that get notified. We can think about it as a requirement. \*NEW USE CASE. We may want to think about it in terms of consent as well as consider privacy and security issues.*
- xiii. Modify: ADT transactions from hospital to referring physician to PCP (instead of just discharge summaries; includes ED visits, which we talked about in our group as well.) We don't want to send every internal transaction, e.g. to do a transfer transaction to report to the HIE every time a patient is moved from one unit to another? Maybe, maybe not; it is unclear. Clarification from Micky – the only thing they added were notifications for ED visit summaries. We have a proposed strawman that does the first level of filtering.

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- d. Slide 10: We want to come to conclusion on this next Monday in Concord. Most of these transactions are what we went through last week, but they may be a little more spelled out.
- Consult note -- Summary of care record - Specialist PCP
  - eRX PCP or specialist Pharmacy
  - Hospital admission notification Hospital Referring physician and/or PCP
  - Hospital admission notification Hospital Referring Hospital
  - Hospital discharge summary Hospital Referring physician and/or PCP
  - Hospital discharge summary Hospital Hospital
  - Hospital discharge summary Hospital Other care settings
  - Hospital ED visit summary Hospital Referring physician and/or PCP
  - Images Hospital PCP or specialist
  - Images Imaging center PCP or specialist
  - Imaging order PCP or specialist Imaging center
  - Imaging reports Hospital PCP or specialist
  - Imaging reports Imaging center PCP or specialist
  - Key clinical information summary Hospital to Hospital
  - Key clinical information summary PCP or specialist Hospital
    - Sometimes you think you have what you need, but may find at the last minute that you do not have what you need.
  - Lab order PCP or specialist Hospital
  - Lab order PCP or specialist National lab
  - Lab results Hospital PCP or specialist
  - Lab results National lab PCP or specialist
  - Lab results Public health lab Hospital
  - Lab results Public health lab PCP or specialist
    - We talked about this last week and added some use cases.
  - Medication history Pharmacy Hospital
    - Last week we talked about the fill reporting from SureScripts was not great. We are looking into how we can improve fill information. We think it would be an important source of data, but it's very important for them to get it right.
  - Medication history Pharmacy PCP or specialist
  - Referral -- Summary of care record PCP Specialist
  - Referral -- Summary of care record PCP or specialist Hospital
  - Request for key clinical information Hospital to Hospital
  - Request for key clinical information Hospital PCP or specialist
    - The symmetric transactions simulate pulls for the request for *key clinical information summary* (a phrase that is used by ONC)

This first page shows secure routing for treatment purposes from provider to provider. Now on slide 11 we talk about expanding routing for claims and eligibility:

- Claims submission & eligibility checking - Hospital Health plan
- Claims submission & eligibility checking - CP or specialist Health plan
- Immunization record Hospital Public health
- Immunization record PCP or specialist Public health
- Laboratory ordering decision support Payers PCP or specialist and hospitals
- alerts Public health Hospital
- Public health alerts Public health PCP or specialist
- Quality measures Hospital CMS and/or NH Medicaid
  - Quality measures

- Quality measures PCP or specialist CMS and/or NH Medicaid
  - If there is a functioning HIE, it is of high value for sending
- Radiation exposure report Hospital Radiation exposure registry
- Radiation exposure report Imaging center Radiation exposure registry
- Reportable lab results Hospital Public health
  - Things like looking at reportable labs that can be
  - Q: Should this include National Lab Report? A: yes, but we need to check them against meaningful use as well.
- Syndromic surveillance data Hospital Public health
- Syndromic surveillance data PCP or specialist Public health
- Discharge instructions Hospital Patient
- Expanded secure routing General medical summary PCP or specialist Patient

Slide 12 – Community Record.

- Multiple sources Hospital
  - Requirements for stage 1 don't require PHR (Google & Microsoft), institutional PHR (e.g. payers, provider & employer PHRs). Question about what we want to do is
- We can create a central connection point to make clinical info available to allow patient access.
- Multiple sources PCP or specialist – general connection to PHRs
- Medication history Other clinical sources
- Medication history Other clinical sources
- Public health case investigation information
  - Public health case investigation information
  - Emergency response
- Expanded secure routing Post-visit summary

Slide 13 Group will have time to look at it & talk to their stakeholders about it.

- Terminology Service
- Format Conversions
- RLS
- MPI
- Certificate Authority – ability to encrypt & unencrypt data
- Subscription Management Directory & Address Resolution Service (e.g. Provider) – whether doing a push or pull
- Multi-factor Security Identity Proofing – how secure do you want to be – is there value in a shared service?
- Credential Provisioning Gateway (e.g. NHIN) – how do you get on, can you connect
- Health Information Exchange Planning and Implementation Project – consent policy. Lots of people don't have Consent Management
  - In terms of how we have to relate to it, we'll talk about it much more as we talk about technical and business operations for these systems
- Privacy Policy Enforcement – making sure you have enforcement so that privacy policies are followed
- Data Aggregation/Merging Other(s) – Community record—issues around consent. High value service, esp. with Public Health
 

*Comment: 90% being done vs. 10% - Approach to address prioritization. What's the expected value?*

*Comment: Building on what they already have is important.*

We may be getting really good data; we need to be flexible to learn more and more about what transactions provide to good clinical data.

3. Slides 15 – 20: Discussion of prioritization
  - a. Legality: Adherence with NH State Law

- b. Difficulty: Technical, Business/Governance, Legal complexity
  - c. Demand: Stakeholder interest; federal/state requirements
  - d. Current market availability: Ability of stakeholders to procure service through existing – awaiting environmental scan.
  - e. Market health information exchange services. Every state HIE is thinking of building a provider directory for Medicaid. We put this in because it is real.
    - a. Environmental scan coming out in 4 pieces; informational data first, then the formal report will follow.
      - i. ASAP/immediate informational piece
      - ii. Preliminary results by July 31
      - iii. More complete by August 31<sup>st</sup>
      - iv. Final Environmental Scan November 30
  - f. Phase 1 prioritization
    - a. Top priorities- summary of information & getting it back, getting lab results delivered and sending lab across hospital systems is something that was mentioned in our group  
*Comment: this is assuming there will be something statewide that the HIE will allow the data to go system to system; bigger picture—not what is already in use.*  
*Comment: NEW USE CASE – Request + patient care record – this could be added in overall order use case.*
  - g. Phase 2 Strawman
    - a. Q: Does this include home health care.
    - b. A: For phase 2 it should.
  - h. Phase 3 - 2 reasons items are on this list
    - i. They are not legal right now
    - ii. It's being done very well by someone else (e.g. eRx), or it's incredibly challenging & complex (e.g. images, which has high value but also has high technical difficulty- underlying infrastructure problems that need to be solved).
    - b. We're going to be really tough about cutting this to be successful and build on top of it as we go along.
  - i. Operations discussion to include:
    - a. Need to have an overall program & project management
    - b. Vendor procurement strategies
    - c. When building a network, what is required technically and operationally?
4. Slides 21 – 25: We had a quick review of initial technical infrastructure packages and business/technical operations approaches, with a review of the infrastructure logic tree on slide 23.
- a. Community Record mapped to:
    - i. Merged medical record
    - ii. Clinical document repository & viewer
  - b. Expanded secure routing mapped to:
    - i. Secure routing to patients (e.g. PHR push)
    - ii. Secure routing among healthcare entities (e.g. DPH & health plans, immunization reports & reportable lab results)
  - c. Secure routing among providers mapped to:
    - i. Secure routing of clinical documents & information among providers
- With each building block mapped to the technical infrastructure, we were then able to look at a new HIE & infrastructure building blocks table to determine the level of complexity for each block. Secure routing was the simplest, with no persistent data or patient matching and only includes provider. Merged medical records on the other hand, was very complex with persistent data, patient-matching required and requirements for standardizing the message structure/format.
- Q: Is there merged medical records being done anywhere?*  
*A: Yes, IHIE - Indiana Health Information Exchange is doing it.*
5. Wrap-up and next steps– Request is to think

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- a. Each time we're getting into this in greater detail
  - b. Contact your constituents and stakeholders and talk to them about the building blocks, infrastructure components and prioritization.
  - c. On Monday we will try to reach some level of consensus & decision-making.

- ACTION ITEMS (FROM PREVIOUS MEETINGS AND NEW)

Item #	Raised By	Action Item Description / Comment	Assigned To	Due Date	Status/ Remarks
1	Tim	Think about critical and valued use cases for New Hampshire in terms of where we want to prioritize our activities.	All	6/28/10	Ongoing until 7/6
2	Mary Beth	Suggested Collaborative Tools: GoToMeeting and WebEx for T-Cons.	Bill	7/6/10	Agreed GoToMeeting provided.
3	Diana	Clarify/define some key terms, e.g. ER vs. ED, Mental Health vs. Behavioral Health	All	7/6/10	
4	Tim	Need a parallel set of Public Health use cases from the state perspective	All?	7/6/10	Completed
5	WG member	A request to look into providing cc: on messages so that delivery can be to multiple providers.	Tim	7/12/10	
6	WG member	Look into Surescripts fill rate issue	Tim	7/12/10	
7	WG member	Determine whether we can include Home health care/VNA in routing - for discharge example	Tim	7/12/10	

### ISSUES IDENTIFIED

Issue #	Raised By	Issue Description	Assigned To	Due Date	Status/Remarks
1		None			

### DECISIONS MADE

Decision #	Sponsor	Decision Description	Approved (Y or N)	Comments
1		None		