

HIEPI Business & Technical Operations Workgroup Meeting

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

Date	7/20/10
Time	9 a.m. – 11 a.m. / ET
Location	(877) 449-6558

AGENDA

Topic “Converging on solutions”	Led By	Start	End
OPENING REMARKS, review of work to date, review of initial consensus areas	Bill/Tim	9:00 AM	9:30 AM
Converging on Solutions –Generating content for the strategic and operational plans	Tim	9:30 AM	10:45 AM
WRAP UP & next steps	Tim/Bill	10:45 AM	11:00 AM

ATTENDEES

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

GUESTS

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

* Via telephone

MEETING HANDOUTS

1. <<HIEPI Biz Ops Phase 3 Discussion Document 07-20-10.pdf>>

MEETING SUMMARY

Item

1. Opening remarks, review of work to date, review of initial consensus areas.
 - a. Essentially, we go from simple complex, with the idea that the more complex capabilities take more time and are costly. In the tactical arena, the ONC PIN has a big emphasis on lab. Therefore, for providers to be able to meet meaningful use, they must be able to receive labs electronically, ideally in a structured format, in a standard industry protocol; HL7version

2.5.1. Although in some areas of NH area hospitals are already doing this, in the vast majority of the state is not doing this. Phase 1 infrastructure is to allow a standard framework.

Comments: There were several comments challenging the value of phase 1, which does not offer value-add capabilities such as MPI and RLS.

- *There was a concern that there is no system in place for a providing matching; the ways systems they had generally worked, was through a patient-matching process to get integrated into the database. Therefore, without the ability for patient-matching, there is fear that it will not work.*
- *Some systems can support the provider address matching method that we are proposing—with some manual patient matching intervention—while others cannot.*
- *Most of them have systems that have some level of fail-out error queues, but it's one thing if it's going to be a few weeks to months error queue that gets significantly better vs. a scenario where it's going to be a year or two to have a 20% fail-out rate, which would require an FTE to match.*
- *Not having an MPI may be so painful that it is not something they would want to pursue.*

Response: This was an issue we went through because of our inability to expose PHI, but we can address that issue by taking what we suggested in the infrastructure section – a uniform addressing scheme from provider to provider and take the existing interfaces for the hospitals and map them into a standard interface, so that we can use standard addressing scheme from provider to provider across the state. The HIE backbone would use that addressing scheme to route messages to appropriate system. Then the system would do what it does that and translate that to internal coordinates in order to get it to the right EMR.

- *This issue is split between our group and the infrastructure group and will require further discussion as this is something different than what was agreed to in previous meetings, but it is better that it come up now, rather than later.*
- *Probabilistic matching across systems based on demographics is still a grind to get it going based on systems using different demographics.*
- *It is hard to answer a question about how painful it will be to leave out the MPI in phase 1.*

Leader Comment: Phase 1 essentially replaces the fax process of sending labs to providers. This comes back to the request for "1a" to cover value add items that we want to track separately, but are unable to put into phase 1 because of financial constraints.

Response: There is no doubt this is a high value item, but not only are there financial constraints, there is a significant effort to instantiate this. We need to have a discussion, especially with the Infrastructure group about all the different options for issuing a MPI.

Comment: If we will be approaching the hospitals for funding, we need to show value-add, but phase 1 has no value add in WG member's system and she can think of at least 4 other systems that will also not show any value add from this. We have to make sure we're not setting up a system nobody uses because there's no value add—or only north country uses it.

Leader Comment: Phase 1 does have some value, but we need to be clear about who is receiving value and determine whether that's enough to pay for. Another request would be to number the use cases for ease of reference, and group in phase 1,2,3. We all need to remember that even though we represent different entities, we need to pick what's the best solution for the state of NH.

Comment: Where are we with the environmental scan that can help with determining the best solution based on the survey and the real situation. Are we spending something on a real value add or are we just talking about doing something just to say we're doing something just to get the funding.

Leader comment: Bill will find out within a day or two.

Response: there are clearly some questions at the basic level that need to be sorted out. That cannot be done during this meeting, but perhaps we can articulate what we would have to know to understand what we're doing well enough to know whether we really need a change of course here. There's definitely been a change in sentiment, but we need to be very specific about it.

Example provided: You get a fax back from Concord hospital for lab results. Somebody looks at that and keys it into the system. What we are proposing is to have that sent electronically, print it out & key it in.

Response: Correction—last week we were talking about structure and unstructured documents, but what we're really talking about is a way to get the lab results electronically all the way to the provider system. Non-structured is an option, but for providers to qualify for meaningful use, the final rule states that 40% of labs need to get to the provider system in a structured format.

Comment: Yes, that's what was being discussed last week and we said if we could get this data in a structured format, it would show real value—this is something that we can't lose.

- b. (Slides 5 & 6) Strawman Phasing: The facilitator then went through previously discussed phased infrastructure, with each phase adding more value, with legislation to support its implementation.
- c. (Slide 7 & 8) Use Case Prioritization: The use cases listed in the first box are what we have set up for phase 1 and phase 2 use cases are listed below. Phase 3 use cases are on slide 8, where value added capabilities bring value directly. That was where we were at in terms of the basic prioritization.
- d. Initial consensus areas from each workgroup : we're just reviewing what's been going on in the other workgroups. It's important to understand that we're not doing this in isolation; we're trying to cross-pollinate to be as coherent as possible.
 - i. Governance WG
 - 1. Considering "Public Instrumentality" as organizational form modeled after NH Healthy Kids (independent 501(c)3 with explicit link to State government)- and independent private body that would be governing body for HIE activities. In the state that body has to have very good stakeholder inclusion in order to be credible and to provide the appropriate insight. This is an inclusive stakeholder governance body to undertake governance functions of policy setting, financial oversight and control, and operational oversight. It's not a financial or population-based representation; it's equal governance representation based on critical stakeholder groups identified. There's representation in each stakeholder group and those are representatives of that stakeholder group—not individuals representing their own individual agendas. Also mentioned in the slide was
 - ii. Finance WG
 - 1. The PIN (program information notice) came out last week and made a strong emphasis on sustainability, with a reminder that these grants are one-time only. The federal grant to be treated as one-time startup investment with no expectation for ongoing operational revenue. They want to work on an incremental process and try as early as possible to build a self-sustaining organization. They are thinking of this as a steady-state entity that has both cost and revenues and try to match those revenues & cost to make sure that you have a reasonable operating function. Here the funding could be from state, federal, community, contribution from stakeholder, revenue from services; at the end of the day, you have revenues coming in and cost going out and you want to make sure there's a match to keep it going.

Q: has the goal of sustainability been specified?

A: the dates we are working with are from congress and it's important to be as specific as possible, but there's an understanding that given the short timeframe, it would be difficult to exact the number, but a process has to be detailed for getting to the endpoint.

Leader Comment: Great question & great answer. One thing we should keep in mind is that after we submit our plan, begins stage 2 that begins in the fall to refine the plan; this is a 2-phased process.

Q: Has the finance WG thought to look into the NH charitable foundations about financial contributions?

A: Bill knew it had been discussed, but didn't know to what level.

Comment: concern raised was that we don't build something that we can't sustain.
 - iii. Business & Technical Ops WG – we might be at a different point than we thought we were at the beginning of the conversation. This needs further discussion.
 - iv. Legal & Policy WG
 - 1. Their primary concerns have been focused on the 4As: Audit, Authorization, Authentication, Access, and Contracts considerations for phase 1 health information transactions (transactions that are within current NH State and Federal law)
 - 2. Identifying areas where the HIE could improve privacy and security of health information exchange over current practice
 - 3. Identifying areas where public health reporting is both required by NH law and prohibited from the HIE
 - v. Public Health WG
 - 1. There is a PH WG and they are working on the legal ramifications of trying to take advantage of the HIE (while recognizing that exchange of public health information using the HIE is currently prohibited by NH State law).

2. Identification of information that could be gathered via the HIE in the future that is of high value to public health including elements required by the ONC (Immunization information, Biosurveillance, Reportable Conditions)
 3. Consensus on approach that provides minimal exposure of personal health information (PHI) – (For example public health may receive the number of H1N1.
 4. Initial consensus areas from each workgroup diagnoses for a given region and may go through an exception process to identify the provider and patient for follow-up action.
 5. Identifying areas where the HIE could improve privacy and security of public health information reporting over current practice as well as efficiency and cost of information gathering
 - a. Previously there were about 25 measures for providers to report on and 23 for hospitals, but one important change in the final rule was the loosening of those requirements to 15 for providers and 14 for hospitals, with an additional 10 that providers must select half. Additional info: those first 5 will contribute toward the provider's Stage One requirements, while the rest are deferred to Stage Two. Even then 1 public health item is mandatory.
 - i. Public health may be able to apply this to privacy and security because right now there's a lot of paper and faxing going on which can be aided by the use of the HIE.
 - vi. (Slide 12) Technical Infrastructure WG – their work is very closely aligned with ours. With the possible change, we will have to discuss the opportunities that the infrastructure can present for phase 1.
 - e. The facilitator showed an illustration of the emerging approach in phases 1 through 3 (p. 13 – 15).
 - i. (Slide 13) Phase 1: We the leadership and staff talk about the infrastructure on an almost daily basis, but slide 13 represents a visual representation of the statewide network as a backbone, with nodes set up to exchange data with it, with the idea that we're not connecting providers directly through their system, but indirectly through their hospital nodes.
 - ii. (Slide 14) Phase 2: Where we start adding value by allowing secure routing to other entities, such as public health and value add services, such as EMPI and a Record Locator Service.
 - iii. (Slide 15) Phase 3: where furthermore value is added by introducing registries and a merged medical record translated still by the hospital system nodes and transmitted to the appropriate provider systems.
2. Converging on Solutions –Generating content for the strategic and operational plans
- a. (Slide 18) The facilitator went through Business and Technical Operations requirements for our WG as outline from the FOA. For our group, they ask:
 - i. Implementation – To address how the state plans will develop HIE capacity, the Strategic Plan must include a strategy that specifies how the state intends to meet meaningful use HIE requirements established by the Secretary, leverage existing state and regional HIE capacity and leverage statewide shared services and directories.
 - ii. The implementation strategy described in the Strategic Plan shall describe the incremental approach for HIE services to reach all geographies and providers across the state.
 - iii. The implementation strategy shall identify if and when the state HIE infrastructure will participate in the NHIN.
 - iv. An additional question we thought to answer is "What capabilities will be needed to manage the projected business and infrastructure of the organization?"
 - b. (Slide 19) There is also an HIE Business & Summary guidelines were also pulled and described content requirements to include 1) Current HIE Capacities; 2) State-Level Shared Services; and 3) Standard operating procedures for the HIE, which are not required, but encouraged, detailing things such as how you become a node.
 - c. (Slide 20 & 21). Facilitator also ran through Operational Requirements for Phase 1, 2 and 3, which will be under discussion for the MPI/RLS issue raised earlier in the morning.
3. Wrap up and next steps
- a. Our next meeting & final summit is next Monday, July 26th at 9AM in Concord.
 - b. The issues raised today are substantial, and we may not have all the answers by August 31st, but it is important to remember that we are not closing this effort down at the end of August. We will freeze it solely for the purpose of writing the plan, but can come back later and say that we've had more time to think about it and propose changes.
 - c. Tim and Bill will circulate a message to this group and leadership of the other groups to discuss and hopefully reach resolution.

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	Follow-up required
6	WG member	Look into Surescripts fill rate issue	Tim	7/12/10	Follow-up required
7	WG member	Determine whether we can include Home health care/VNA in routing - for discharge example	Tim	7/12/10	Follow-up required
8	Bill	Number use cases for ease of reference & name phases that each use case falls into	Tim/Diana	7/26	

ISSUES IDENTIFIED

Issue #	Raised By	Issue Description	Assigned To	Due Date	Status/Remarks
1	Peter Malloy and others	Phase 1 does not present enough value-add without MPI for sustainable funding past phase 1. Tim & Bill will discuss with other WG leads.	Tim, Bill	7/26	

DECISIONS MADE

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