

HIEPI Governance Workgroup Summit #2 Meeting Summary

Meeting Owners	Frank Nachman, WG Lead Micky Tripathi, WG Facilitator
Minutes Author	Jackie Baldaro, WG Business Analyst
Version	1

Date	7/7/2010
Time	1pm-5pm
Location	NH State Hospital, 2 nd floor, Batchelder Conf. room, Concord, NH

AGENDA

Summit #2 Considering Alternatives & Narrowing Options	Led By	Start	End
Opening remarks - "Considering alternatives and narrowing options" phase	Micky Tripathi	1:00 PM	1:30 PM
Discussion of transaction mapping to HIE building blocks	Micky Tripathi	1:30 PM	2:45 PM
<i>Break</i>			
Discussion of prioritization	Micky Tripathi	3:00pm	4:00pm
Review of initial technical infrastructure packages and business/technical operations approaches	Micky Tripathi	4:00pm	4:50pm
Wrap up & next steps	Micky Tripathi	4:50pm	5:00 PM

ATTENDEES

Name	In Attendance (Y or N)	Name	In Attendance (Y or N)
Cindy Rosenwald	Y	Kelly Clark	Y*
Deanne Morrison	Y	Kirsten Platte	Y
Denise Purington	Y	Lisa Bujno	Y*
Dick LaFleur, MD	Y	Maggie Hassan	Y
Janet Monahan	Y	Mary Beth Eldredge	Y
Kathy Bizzaro	Y	Susan Taylor	Y*
Frank Nachman, WG Lead	Y	Jackie Baldaro, WG Business Analyst	Y
Micky Tripathi, WG Facilitator	Y	Vanessa Santarelli	N

GUESTS

Name	In Attendance (Y or N)
Mark Belanger, MAeHC	Y
Scott Kolbe, NH Medical Society	Y
Rebecca Hoizdahl, Intern	Y

* Via telephone

MEETING SUMMARY

The meeting began with a recap discussion and summarization of what was accomplished in Summit #1, a high level review of the project timeline and a brief cross-workgroup summarization of the efforts over the past week. Slide 5 provided a recap of the HIE building blocks and the increasing complexities as one "moves up" each level. Slide 6 provided detail to a preliminary categorization of use cases to HIE building blocks for the work group to digest and results in a slight refinement of the building block structure on slide 8 which illustrates Shared Services as aligning across each building block.

Work completed across the domain groups resulted in additional proposed use cases as presented on slide 9. The group was reminded that these are not final and are not intended as recommendations to NH priorities but more a catalogue of currently meaningful use cases to be considered. The group was reminded of the goal of "casting a wide net" to allow for the complete cataloging of current use cases in a meaningful way ultimately allowing for some, or a number of them, to fall as off the list as non-priorities.

Opening remarks concluded with a brief discussion of the rest of the agenda for the afternoon and where we are with the workgroups ending with a description of where the Governance Work Group currently stands. A few comments arose when the group was asked their agreement to the status recap thus far...

Comment: I disagree with one piece, the vendors are also promoting efforts to move forward based about meaningful use, < there's> more of a vendor strategy also.

Response: Vendors are not in a position to promote agreeing to secure exchange between say, Elliot hospital and say Lowell General.

Comment: The Frame work is self contained but many have exchanged information across states. The governance can be the model that secures the contact but not necessarily have the technology.

Comment: When we get to the straw man, we have done some thinking that they do not get anything out of phase 1 so we have ideas to change that.

Response: Let's discuss that, again this is "casting a wide net" and we may find that most of these are done or nearly done and we may ultimately focus on the next phase or different elements.

Comment: Need to understand priorities and financing before we talk about the governance; seems premature.

Response: In an ideal world, you are correct; we are moving in parallel putting down a strategic plan to allow us to move forward, gain funds and then refine the model. There are some basic Core principles that we can come to agreement on is all we are suggesting.

Comment: I don't think the statute says that no one else can have access to "de-identified information"; it doesn't lock out other uses.

Response: It is a HIPAA definition of what specifically is needed to be removed and de-identified.

Comment: If you look at immunization registries- it's a protected health registry- only providers for treatment purposes can look at it and still wouldn't get the statistics needed for public health use.

ACTION ITEM: <the Work Group suggested and agreed to adding the nuance of de-identified data to the building block slide>

Further discussion of Slide 9 continued with discussion of the other Workgroup suggestions for additional use cases understanding that in prioritization some of these may fall out and may not be allowed under NH law. A suggestion was made to "do it blind for now" and then will add another cut for legal considerations and restraints.

Q: Have we tried to define what is allowable for HIE on a point-to-point basis?

Response: As long as it doesn't pass through an HIE entity, you are not unlawful.

Comment: < *This is* > not consistent with what's going on in the state, to me that is not sound legislature.

Response: There was no opposition anywhere to the HIE proposed law.

Response: Any large single data base that can be hacked raises a level of concern, when we look at what we can regarding privacy – understanding who's reacting to what and where can we coupled the votes.

The Work Group discussion continued with further explanation and a re-statement that slide 9 took a first pass on prioritization to give folks something to react to and that it is not intended to suggest these are *the* priorities.

Comment: It should be noted that MU stage 1 does not need this to meet MU.

Q: Do we know how many MDs will meet MU <in the state of NH>?

A: Not many, many do not even have EMRs

Comment: statewide challenge will be to get those tied in to be able to meet Stage 1

Comment: certainly correct there is nothing in MU that says you have to do HIE.

Q: Incentive funds are tied to Medicare & Medicaid?

A: Yes.

Comment: Most will qualify for the Medicare cap, 75% of annual Medicare billings.

Comment: When we talked to Vermont- they gave us inexpensive options to get those who can't afford to get up on some technology.

Comment: Most of those are on CHAN?

Comment: An article in NY times- they can only meet 12 of the 48 steps to qualify- all or none, 25 hospital, providers 23; this not so much about technology but change that will happen to the workflow to do these things and changing the whole way we care for our population. We have to not only collect but to do something with it. A very challenging but a very good set of objectives.

Comment: This needs to be a broader scope for the providers.

Comment: A lot of things will change because of this, pricing models etc...

Comment: This will change how we build things, and stop building things that people do not use.

Comment: Beyond that it's about the disincentives, not just the 5 Million...

Comment: It is important that we don't tie these 2 things together; you don't need HIE to achieve MU.

Reponse: MU is telling *<the>* hospitals & MDs that you need to do these things, then you have certification for vendors that they need to do these sets of things- there is no requirement that says you as a hospital have to do exchange "this way" to meet MU.

Comment: Many of us will welcome the point to point stuff going away; I can't afford to do all that stuff.

Response: I agree, you still have the problem with vendor to vendor.

Comment: *<WG member name>* has lead us into prioritization with – the big bang for the buck is those environments where most of the people travel between and the inability to exchange within your community (e.g. nursing homes, behavioral care etc... and public health reporting. There is always a ying and a yang here. Each time we have a different model for public health reporting we could have a lot of savings if it was standardized.

Comment: Concord community exchanges well, we need to reach out and exchange with the smaller communities for example Weeks, Springfield, New London and so on...

Q: How well does it work transferring data?

A: Right not pretty well; again it's the vendor, once the standard for CCD documents is in place they will be able to exchange.

When you start to talk about security /privacy < >

A: When you look at MU, weak stage 1 requirements- need to make one exchange, stage 2 may be broader.

Comment: The idea is yes to being broader.

Q: People will be happier if it doesn't go with Central data base?

A: Yes that's fair to say, unless we get some standardization

Comment: There is a desire not to have a central repository- the challenge in the state is how do we protect the privacy of patients and still get some sort of HIE.

Comment: The idea is if you're on vacation *<elsewhere in the state>* and need care that your information is available.

Comment: eRx example, the question is for HIE how much is how do I reach out for the information as opposed to having right there within the record.

Comment: It's about getting the public to understand that this is about making their care better- for the healthy population they may not get this?

Comment: Another example is Nursing home visits & med lists- lots of opportunity to use this daily & very frequently.

Comment: Residents that go south for the vacation- a patient portal will let me log in and see what my kid's have- patient portals have been under discussed.

Response: The CCD will allow an upload, and theoretically have a pretty complete record

The Work Group continued with a discussion of slide 15 and "Phasing Process". Slide 15 describes the process the domain groups had taken to put activities into phase. Essentially, Phase 1, 2, 3 are a "top of the pile to the bottom of the pile" graphical explanation.

The prioritization criteria included: a Legality screen to have adherence with current NH State Law; a level of difficulty screen to include a technical, business/governance and legal point of view; understanding if there is market demand; any federal/state requirements, and finally current market availability (ex. eRx, point to point exchange)

Q: We didn't take into consideration public/patient demand?

A: How should we represent this right now? How do we capture that?

Comment: We assume stakeholders involve the public

Q: Where is "willingness to pay"?

A: "Demand" means willingness to pay

Comment/Q: How can we describe a state HIE as benefit to public and others?

Comment: If you could show that it was more private & more secure & less costly, improved outcomes

Comment: The challenge of all of this is quantifying it.

Comment: The legal policy group is recommending certain changes in the law as a result of this. It is very unique to have legislators involved in this – this is very good!

Q: Do you know anything about the RI lawsuit for the civil liberties union?

A: Yes, we will have Ann Waldo < *from the Legal Work Group* > providing comment on it. Context is it is the development process; they did not have enough patient input.

The workgroup continued with a discussion of the proposed Straw man by describing the "end" of phase 1 concludes with things are legal; in terms of difficulty it is our sense that these are relatively easy understanding that one of the remaining things we need to gauge how much of the hospitals are already doing. Slide 16 provides the details of each use case in Phase 1. The workgroup entertained a discussion that considering they feel that much of phase 1 is already being accomplished by most hospitals systems perhaps a better use of the small amount of funds available would be best spent covering on a basic level or "floor" of activities, connecting a silo to silo model and the remaining funds spent on understanding & standardizing public health reporting to be able to save future monies spent on reporting to these activities for both the healthcare systems and the state.

Comment: There is cost involved with each hospital creating systems to report to each state dept based upon each < *Public Health* > department requirements; there is an opportunity to simplify the state reporting required by the state and standardize it.

Comment: All we are saying is that if you look at that aggregate cost there is an opportunity to use the 5 million to standardize some of that.

Comment: When you are looking at the dollars that need to be invested you look at the 80/20 rule, a lot of the sharing is done at the local service area level. For example the southern New Hampshire area hospitals- they have made moves forward to share some info.

Comment: I don't think that there is a lot of sharing within those systems.

The flip chart was utilized to illustrate networks connecting to state wide HIE and representing those outside of a particular network providing options to those in need. The group considered ways to think about spending the federal funding and performing an across the systems check to understand where exactly is each system is on that check list. The group paid particular attention to discussing was to spend the funding by giving a portion of the HIE dollars to fill in the existing gaps and secondly connecting of the hospital silos gap. Other options discussed included identifying a floor across the networks and fund that basic functionality across systems and tying in those not connected to a hospital to connect up to a statewide highway < *creating another silo* > perhaps under the medical society.

A preview of the survey to the hospitals that Kathy Bizzaro will be bringing to the state CIO meeting at the end of this week was introduced; the survey covers questions to understand the numbers of practices, if clinicians are employed/not employed, if they have an EMR, are they performing any data exchanges, and asking what types of information do they want to exchange with the goal of getting a first pass landscape view.

Comment: We should ask "can you do it now".

A: Agreed

Comment/Q: I am concerned about allowing the choice of doing labs or not, what is the standard of care in our conversation? At what point to we standardize this enough?

A: We would say ok, we are leveraging what you < *the hospital* > are already doing but what we want to have is a "floor" of what we are doing. A real world example is in Boston, Partners Healthcare has set up a proprietary system, BIDMC is doing the same thing. John Halamka, MD did a cost benefit analysis, using NEHEN vs. building it themselves and he ended up saying I am going to use the public infrastructure- it's cheaper.

Comment: Can't use HIE dollars to buy an EMR?

A: No.

The question was posed to the group to look at the first one, Consult Note- Specialist to PCP and asked how is this being accomplished currently?

A: From a Health center perspective- the specialist to PCP consult note is a huge gap.

Comment: The AHA summary data for IT is available to this group but currently does not have the level of detail that we are hoping to get with this survey we are doing.

ACTION ITEM: The Facilitator will add this to the list.

Break: 3:10pm-3:20pm

Summit 2 resumed at 3:20pm with a discussion of Slide 23 describing the logic flow for the decision tree as adding layers as you move up each rung of the ladder and describing the considerations associated with each move. An example was provided of storing data as an activity as you move up to the clinical repository "rung on the ladder" and understanding that this is now the retail world where all the considerations of authenticating users and patients will need to be taken on.

The final step up is a centrally orchestrated community record where there is organizing and matching by patient understanding that there is nothing illegal about that as long as providers are accessing the data only.

Q: Please explain centrally vs. federated model

A: One organizes by physician < *Clinical document repository*> then there is organizing by patient < *Patient-centric clinical document*> Federated is like NEHEN, I can bring together pt info and maintain info all separated and will query each system. Centrally is one big database; from an IT perspective there is really no difference the difference is control and from a privacy & security perspective. HIXNY is a federated model.

Comment: We have been discussing privacy & security and have not been talking about accuracy.

Comment: One way would be to verify with a patient portal.

Comment: What if they lie?

Response: There is no way to handle that.

The group discussed an "opt-in" vs. "opt-out" model and asked many questions in an effort to define each model, ascertain what states are currently doing and weigh the pros and cons of each model.

Comment: States are all over the place, the technology needs to manage consent management.

Comment: Each vendor has a different capacity to opt out.

Comment: The entity itself managing the pt request to opt out by entity

Comment: When patients moves MDs they contact the HIE

Comment: When we implemented 4 vendors only one vendor eCW was able to managed opt out by <entity >

Comment: In the Concord system we have a relationship with Dartmouth and can access each other's systems based upon opt in with a 5 year flag, the opt out rates are really low. We do not have a merged record but more a model for sharing information.

Comment: The challenge is a point to point system that won't work very well. Universal consent with those involved in managing my care is more manageable.

Comment: How do you make consent so that you don't impede care?

Response: NEHEN is looking at the concept of making a "consent wizard" so that a patient agrees to x,y,z...

Comment: NH is opt-in.

Comment: Compliance with Opt out is much better.

Comment: When we did this in our pilots, we did opt in and received over 90%, however we hired a marketing firm.

Clarification requested, what is Universal Consent?

A: Universal consent means a standard of understanding what consent is defined as so everyone is not figuring it out on their own.

The group agreed that there would need to be mechanism to allow the state to receive money and reviewed a potentially comparable model that currently exists under New Hampshire law- Federal Workforce Investment Act: set up within the Department of Resources and Economic Development (DRED). Although there are some parallels with HIE there seems to be more Federal oversight With the Workforce Investment Act. For example, there are multiple specific program and reporting requirements. Even configuration of the board is directed at the Federal level. New Hampshire has acted legislatively and placed responsibility within a state agency, but has also set up a public/private partnership to promote state and local investment to increase employment, earnings, occupational skills, workforce quality, etc. The Commissioner of DRED is responsible under the law to plan, develop and administer workforce investment activities programs and grants under the Act. And to coordinate with the NH Workforce Opportunity Council which is created by statute. The make up of membership is set forth in

the Federal law, but members are appointed by the Governor. The Council has 43 members, of which 22 are business representatives. This model seems larger than what might be required as governance for HIE, especially at the beginning.

Q: What is "Administratively attached" mean?

A: Administratively, they are attached to an agency for budgeting purposes this happens when an organization needs a "place to live".

Comment/Q: The Workman's Opportunity Council is an ongoing management of funds model so this HIE funding will change after the initial funding so there are major differences between these two things.

Comment: if we know that there is going to be this transition we don't want to create a complicated model for such a transition. So the state could be just a board member, but we do want it to be able to accept grants & gifts.

Comment: I am wondering if you can solve the issue with the state being a board member with a lot of provider and IT representation.
Comment: For ex. The Vermont Healthcare Fund that VITL has to apply for.

Comment/Q: If we want this to ultimately be self sustaining entity with some private funds, as a business decision, how much do I want the state to be tied up and can veto things.

Comment: The state designated DHHS to receive the funds.

Comment: The Healthy Kids has a public/private board and accepts public & private funds; they are a 501(c)(3) with public & private employees.

Comment: < We> need to have something "nimble".

Comment: Anything over 5k needs to go to the governor's council for a 5 member vote.

Response: Ok so that's not nimble.

The group discussed needing to work their way backwards with understanding that the state is involved in governance. Guidance document from ONC indicates that states and state designated entities... "shall coordinate with Medicaid and public health programs to establish an integrated approach including having both programs represented in the state's governance structure and processes."

Q: are we going to go out to a vendor like Axolotl or will we build it ourselves.

A: that is the next level of discussion

Comment: Why wouldn't we just join an existing one-if it is legal; building our own is the last thing I want to see.

Comment: Again, I wonder if this is an opportunity to use the money and help the state build their infrastructure and move from there.

Comment: One of the goals of HIE should be to put an end to faxing.

Comment: In the assessment <of public health> is there a way to go to each agency and understand what they are asking to be submitted and to get rid of duplicity.

Comment: To give you a flavor of the thinking out there on my committee 18 out of 20 people had a very big problem with asking what country your parents came from on a birth record. The response was "Why does the state have any business knowing what my parents background is"; if we can replace methods it would be more palatable and if it increases security, even better.

Comment: Lee Jones is building the Universal Public Health Node which buffers providers from multiple disparate public health reporting systems by having providers connect to only one place for public health reporting

Comment: the ad-hoc public health group formed attempting to do what we are doing, one of the things suggested is what is needed and useful for them to begin to think about bringing back here.

Comment: In the House < of Representatives> there is thinking that individual right takes precedent over public health so there is a risk to opening up this conversation.

Response: There are also times when ultimately it's really good policy and you need to continue move that forward. Finding out where the redundancies are would be helpful.

Q: Should we add what public health reporting of what are you doing now to the survey?

A: We have the back end of this already.

Comment: If the state can get their arms around it then you start to expand the ring and build it out.

Comment: Depends on the facts, I would like to see what the survey results are.

The meeting concluded with closing remarks about the next meeting which is a dial-in meeting next Wednesday July 14, 2010 from 1-3pm, and a brief discussion of accessing the googlesites for meeting minutes and document sharing.

Meeting closed at 5:05pm