

HIEPI Governance Workgroup Meeting Summary

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

Date	7/1/2010
Time	8am-12pm
Location	Brown Building, RM 232, Governor Gallen Campus, Concord, NH

AGENDA

Topic: "Casting a Wide Net"

	Led By	Start	End
OPENING REMARKS – Introductions, meeting purpose, set ground rules for open discussion	Micky	8:05 AM	8:15 AM
Review of Charter	Micky/Frank	8:20AM	8:35 AM
Description of Approach- Framework	Micky/Frank	8:35 AM	9:15 AM
Use case discussion, using guidelines outlined in presentation	Micky/Frank	9:15 AM	10:30 AM
BREAK		10:30 AM	11:00 AM
Options for state HIE Governance models and its value to clinical objectives	Micky/Frank	11:00 AM	11:45 AM
Next Steps – Prepare for Next Summit on Wednesday, July 7 th & CLOSING REMARKS	Micky/Frank	11:45 AM	12:00 PM

ATTENDEES

Name	In Attendance (Y or N)	Name	In Attendance (Y or N)
Cindy Rosenwald	n	Kelly Clark	y
Bob Bridgham (for Rep.Rosenwald)	y	Kirsten Platte	y
Deanne Morrison	y	Lisa Bujno	y
Denise Purington	y	Maggie Hassan	n
Dick LaFleur, MD	n	Mary Beth Eldredge	y
Janet Monahan	y	Susan Taylor	n
Kathy Bizzaro	y	Vanessa Santarelli	n

GUESTS

Name	In Attendance (Y or N)
Mark Belanger, MAeHC	y
Rebecca Hoizdahl	y

* Via telephone

MEETING SUMMARY

Item

1. INTRODUCTIONS/ROLL-CALL – Meeting participants reintroduced themselves to the group.

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2. OPENING REMARKS: Brief overview of Project and agenda for the meeting; briefly described general progression approach for our project building upon past work completed. Briefly discussed what other states are doing and our goal today of narrowing our options for governance
 3. OVERVIEW OF OVERALL APPROACH: Discussed the structure of our approach and the NHHA Vision for Adoption. Also discussed the value of work completed thus far with a goal to build upon where previous efforts left off. Our Planning Approach is a representative democracy consensus building approach where the expectation is for stakeholders to bring forth ideas for the group to consider.
 - a. The PowerPoint slide on the approach framework was assembled to give the group something to react to. An overview was provided detailing the process of identifying use cases and discussing their value, prioritizing and mapping to current building blocks.
 - b. The Project Timeline slide provided detail of where we are in the planning process under aggressive time constraints; currently in the middle of the 6 weeks project plan.
 4. OVERVIEW OF PROJECT MATURITY MODEL: Presenting a package of options or “building blocks” to encourage the group to consider.
 - a. Secure Routing is the base layer that satisfies HIE (this mimics things that already happen today-point to point communication; there is no persisted data anywhere, this is a push not a pull.

Q: What/how is the secure requirements (defined) of passing information across borders from state to state, it is important to understand these.

A: These will be federal standards; NH currently has 30-40% cross boundaries.

Clarification requested: We are talking about security and not consent?

A: Yes, this is the “electronic post office” to give you a mental model to frame your thinking.

Q: Are we going to discuss an inventory of what’s happening statewide?

A: Yes, UNH is conducting a survey and we have pulled initial information however the data will not be available until mid-way through our process. The strategy in the mean time is to create a hypothesis and validate that when we do have concrete information.

- b. Next Block Layer- Registries & Reporting, there are some key public health benefits, 2 ways to do this, Hospital- PCP, PCP to Immunization registries (there is persisted data at the end pt but not in the HIE).

Comment: Not maintained by a 3rd party correct?

A: This is the same as secure routing but now this is involving a party not considered a healthcare provider.

Comment: This is currently against NH state law and would require bringing this before the state legislature.

The group discussed the definition of what is HIE for treatment purposes and tabled the discussion for later analysis by the legal team. Within Registries & reporting, there is no data base holding the information; 1st case would be data held somewhere where it is held today and 2nd boundary to cross- There would be some sort of “Organization” that would be an aggregation point, maybe a state function or private entity.

- c. Next block layer: Shared Services- discussion tabled for now.
- d. Next block layer: Community Record- Once you get to this level, you can accomplish any of the other building block activities, and clearly this is a huge threshold to cross.

Comment: Current law requires any pt whose information may be exchanged to have the opportunity to opt out.

Comment: What is the definition of an “intermediary” for HIE?

A: Good question, this is currently being discussed at legal/ policy group @ ONC. If you purchase services from Axolotl they are acting on your behalf they are not outside of a relationship.

5. USE CASE PRIORITIZATION: the legal policy group has taken a first pass to understand each use case as legal or illegal. We then have drawn upon the technology group which has looked at this list and mapped each to MU. At an ONC level, the standards panel

led by John Halamka, MD, led an effort to develop use cases and has taken all of these and mapped them to the building blocks. All of these use cases related to secure routing involve a one way push. In secure routing -A great thing is that you do not need matching to make it work! From a technical, legal policy perspective this is basic, bare bones. From here you can add things on top; shared services to layer on top, for ex. the matching and authentication.

Q: *Is this list meant to be exhaustive?*

A: *Yes, for our purposes here so please let us know what is missing.*

Q: *Use case example of transferring a record EMR-to-EMR?*

A: *This type of exchange does not exist today in HIE- full EMR record to other EMR different vendors.*

Q: *If it is a request for request from pt or specialist for data; thinking specifically of "snow birds"?*

A: *that is community records- the patient wants access to health information. The issues are consent and patient identification.*

Comment: I think we need to keep in mind that there is a use case of patient to provider where the pts may say you give it me and I will be the keeper of my record. Our vendor (Epic) has a patient portal at a national level where the patient puts information there where the pts allows access to clinician. You could say Google health could be a national model of HIE.

Response: We could be looking in the future to the patient controlling their record and who has access. Then the privacy discussion goes away and shifts to security and validity of information.

The next phase, after legal policy group takes set use cases & consider what is legal/illegal, a first pass prioritization is done for each WG to weigh-in on and validate. The result is that we will end of with 15% that we will focus on and get the remaining 85% off the table.

Comment/Q: We need to consider long term care and HIE. Comment: Have there been discussions with Vitl in Vermont to understand what they are doing with entities with no routing functions, ex. Nursing homes?

A: *They are using GE XDS the biggest repository, they do not co-mingle the data, but have the documents all lined up. We will need to figure out how to treat these types of entities.*

Comment: There is a McKesson health we entities can look through a single software platform.

Comment/Q: Nursing home, no ability to do notes, medication lists etc... Need to be provided the functionality- how can they be assisted (shared service?) to do these activities.

Interdependencies -Issues with another workgroup-"EHR-Lite Capability" issue. EHR services can be lite but has to be certified. See above.

Q: *Which group will be looking at sustainability? Is anyone sustainable now?*

A: *The Financial Group & yes, Indiana, the hospital is paying for this-*

6. **PRIORITIZATION MATRIX:** Discussion of slide 10, priorities are from 2 sources, NHHA and applied MU requirements. The group discussed funding for exchange vs. adoption and \$dollars associated.

Comment: re: the EHR-Lite entities -The providers we are talking about do not have the dollars to even go out and get the functionality.

A: *The benefit can be to offer these services discounted to get them up. Let's say we got a concept together and went to vendor for a cheaper service why? Because they would get the larger HIE contract and could benefit from economies of scale.*

Q: *Can we have the vision printed on paper or up on the screen to keep us focused on why we are here- The Patients.*

A: *Yes.*

Comment: In yesterdays Finance meeting, we did a great exercise where we threw things against the wall to consider I see this as a great way to get people thinking about what bubbles up.

Comment: I don't see nursing homes represented on these groups – we need to keep that in mind.

Response: Yes, we will and remember that there will be 2 parts to this project to gather stakeholders to consensus.

*Comment: Patient centered medical home? What can be considered meeting those requirements on this priority matrix?
Response: We have a team to expand our matrix with what level each is considered for PCMH.*

Comment: I want to comment on the NHHA column on the matrix, the NHHA has created use cases in collaboration with clinicians and others, and that these represent a very broad look at use cases.

There are three ways to unfold this conversation: what to create, connect Silo to Silo, and what about the 15% in the North Country?

7. DISCUSSION OF Slide 14: Each domain will have a different view over what is complex, what is not, what are the key issues, what is valuable, what is not valuable. We want to think through these things from each domain's perspective.
8. DISCUSSION OF Slide 15: Overview of approach for each domain group to come up with approach options for each building block level and capture constraints with each level as you move up the building blocks. Starting with the most basic level secure routing, what are the considerations across the domains is relatively simple and straight forward and then moving higher in complexity as you proceed up the block ladder. Discussion of what MA, NY governance groups are doing, legal entity structure (e.g. public/private, 501(c)(3), organization & business oversight, board structure, etc. at a very high level.
9. GOVERNANCE CONSIDERATIONS: slide 18
How does the governance discussion evolve and ultimately result in a narrowing down of options?

Q: Are we going to have a discussion about governance in the early stages right now (over the next few months) regarding reporting finances and transparency?

A: There is information re: finances to date on DHHS websites and work products from domain workgroups are on googlesites

Comment: I just want to acknowledge that we heard from < Molly Smith>, ONC at the first meeting that we may evolve our effort post August understanding 4 weeks is not enough time to get complete consensus.

Response: yes, that's our understanding, D. Blumenthal, MD from ONC stated that what they want to see is an environmental plan, what's been done thus far (where are the gaps) and where do you want to be.

Q: When is the environmental scan due?

A: Mid- late July, we agree the formal process is not getting us the information out fast enough and we are going to move toward a more informal way with a smaller pre-survey given out at the State CIO NHHA(?) meeting in July.

Q: Is the Medical Society active in NH?

A: yes.

Comment: When you talk about what is happening in the state- another group to consider is Mental Health; Patrick has been hired by them to produce information.

Comment: There are lists in the State that have not been merged, e.g. Dartmouth.

Response: Yes, Patrick is trying to get a hold of those lists, let's put together a list of what is out there.

DISCUSSION: Slide 18 continued...High-level considerations and how do we drill down, ownership & management, asking ourselves Is it a state function or is it completely private (501(c)(3), Maine info net, Vitl, etc... or is there a quasi- concept, for example MA, a public/private entity, operations HR functions through the state, and board chair is CEO of Genzyme.

This governance group is more reactive, thinking about what role does the state take in this entity, what are the dimensions we should look at. We will get input from other workgroups also throughout the process (the input will be more external to our process) once we do this we will be in a position to look at this in a few ways: Policy (state), Stakeholder Representation, and Fiduciary. There are these three components -these key things we want to think about.

Comment: Right now the law states that it <HIE noun form> can be Health & Human services or private entity.

Comment: Seems to me that Governance will follow the Money.

Comment: I also see it following the risk, both money & other. The people we have not heard from is the patients, it's their property.

Comment: I agree to put it into context of managing Risk.

Comment: Governance will need to be adaptable to changing money & risk in the future

Response: agreed

Q: Can you develop a matrix to show us what Indiana, etc... Are doing with pros & cons?

A: Yes, we can do that now.

Created a Matrix of currently sustainable models on Flip chart: see chart below

Understand that there is a new dynamic regarding state representation on these boards; it is changing with the introduction of state money, boards may be reconfigured with receiving of funds. An example for us could be like MA (MEHI) -<they> received federal funds and we could look at NEHEN being a contractor, we don't know at the end of the day how they will be configured.

Organization	NEHEN	Health Bridge	IHIE
Year began	1998	2002	2003
Legal Entity	501c3	501c3	501c3
Stakeholder	Multi-stakeholder	Multi-stakeholder	Multi-stakeholder
State Representation on board	Yes	No State	yes
State Funds	Yes	No State	not initially though has state funds now
Functionality	Created pharmacy gateway; also has secure routing	Does community wide lab, rad, transcription, operating notes, all uni directional from hospital to MD via web portal	Does community wide lab, rad, transcription, operating notes, all uni directional from hospital to MD via web portal; can also develop reports for pay for performance.

Q: Would NEHEN fall apart if the BIDMC & Partners pulled out for Rx? Do they rely on them for financial stability?

A: No, they are sustained on Claims /eligibility transactions right now, wouldn't be affected if the hospitals pulled out.

Q: How do we think about the "build it and they will come" risk? How do we think about what if they don't come?

A: Think of these as building blocks; secure routing it's paid for ok, then moving to the next level only if we can pay for it.

Comment: Are we going to build this for the 15% that are not being served by community networks or do we look to the folks that are already committed in some way conceptually to do HIE.

Comment: There is a shrinking window of moment in time for MU, the question is opportunity- will something be ready to achieve \$ or if not then I will move on and not worry about it so I have no need to participate in connecting silos HIE.

Response: Let's understand the concept we are talking about here. A sense of how we are thinking about this- Tech infrastructure has been asked to look at the building blocks and give us infrastructure packages then Business Ops will give us operational aspects for each of these and a list of shared services and we will then give this list to the hospital systems to be able to flag the opportunities and understand different ways to do this.

Comment/Q: Another window of opportunity- I received a letter from Dr. Montero and Mike Bourne for lab reporting at the state level for syndrome surveillance related to H1N1, 5 hospitals selected to get 15k seed money to make this work. Maybe they should be looking at this group instead of 4-5 hospitals only? Is developing a state immunizations registry a window of opportunity as the state doesn't have one yet?

Response: yes, we will reach out.

Q: Are there examples in the state of good public/private partnerships?

A: none were brought forward-

Comment: It would be useful to have some place to have discussions. Perhaps this governance structure would be an excellent place to put these kinds of discussion together.

Comment: Is there a regulatory approach/model to this? Or perhaps a contractual model, for example, maternal & child health.

Comment: There is a 501(c)(3) Workforce Investment, a quasi-private model, federal legislation & federal dollars separating operations & board.

Comment: Most of state info today comes from claims data, as we develop more capability, I see the state being the one providing more of the money as they will benefit from it. Down the road, I see "Where should we be targeted free care" discussions come into play, this is an opportunity if it is done right to capitalize on understanding that it presents current privacy issues- I'm speaking down the road. It is a fence to walk understandably.

Interdependencies: Legal Policy group to look at data on pop/community health/Medicaid.

10. CLOSING REMARKS: Next meeting is a Summit, Wednesday July 7, 2010, 1pm-6pm, directions will be sent out. Things to think about for the next Summit:

- Pros/cons of state vs. quasi entity vs. private entity
- Maternal/child health model
- Is the state's role that of contractor?
- Separating out operations from board
- What is the changing nature of the state's role in this?

Action Item: Frank Nachman, DHHS Chief Legal Council, will research the following:

- public/private entities in the state and
- Find out if there is a public/private legal structure that is allowed here and are there any restrictions to the state being a board member.

At the next meeting we will synthesize the background information, understand the component view of the building blocks & the operational capabilities for the blocks. With this information we will be in a better position to have the conversation about the varying degrees of governance.

ACTION ITEMS (FROM PREVIOUS MEETINGS AND NEW)

Item #	Raised By	Action Item Description / Comment	Assigned To	Due Date	Status/ Remarks
1	Micky Tripathi	Research public/private entities in the state and find out if there is a public/private legal structure that is allowed and are there any restrictions to the state being a board member.	Frank Nachman	Next meeting	
2	Micky Tripathi	Interdependencies -Issues with another workgroup- "EHR-Lite Capability" issue. EHR services can be lite but has to be certified.	?Work Group Legal/Policy WG		*Needs to be assigned to a WG
3	Micky Tripathi	Interdependencies: Legal Policy group to look at data on pop/community health/Medicaid			

ISSUES IDENTIFIED

Issue #	Raised By	Issue Description	Assigned To	Due Date	Status/Remarks
1	WG	Need for Environmental Scan Data			

DECISIONS MADE

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