

HIEPI Technical Infrastructure Workgroup Meeting Minutes

Meeting Owners	David Towne, State HIT Coordinator Lee Jones, MAeHC/GSI
Minutes Author	Nael Hafez
Version	1

Date	June 28, 2010
Time	1 – 3 PM
Location	Conference Call

AGENDA

Topic	Led By	Start	End
Roll Call/Attendance	Nael Hafez	1:00 PM	1:05 PM
Introductions	Group	1:05 PM	1:10 PM
Administrative Logistics	Nael Hafez	1:10 PM	1:15 PM
Review of Charter	David Towne	1:15 PM	1:30 PM
Description of Approach	Lee Jones	1:30 PM	1:45 PM
Use Case Discussion – Requirements & Constraints	Lee Jones	1:45 PM	2:30 PM
Next Steps – Prepare for July 8 th Meeting	David Towne	2:30 PM	2:45 PM
Other Business – Q/A	Group	2:45 PM	3:00 PM

ATTENDEES

Name	In Attendance (Y or N)	Name	In Attendance (Y or N)
David Towne	Y	Andrew Watt	Y (joined late)
Lee Jones	Y	John Kelly	Y
Nael Hafez	Y		
Sharon Beaty	Y		
Mark Nightingale	Y		
Bob Bridgham	Y		
Frank Catanese	Y		

GUESTS

Name	In Attendance (Y or N)
Mark Belanger	N
Sean Kelly	Y

* Via telephone

MEETING HANDOUTS

1. HIEPI Workgroup Charters
2. HIEPI Telecon 1 Presentation Tech Infrastructure.

MEETING SUMMARY

Roll Call of participants - completed by Nael

Introductions – All participants introduced themselves.

Administrative Issues – Addressed by Nael (Meeting schedule, Google Site, Doodle, etc.)

Review of Charter:

Work products/outcomes will set a definition for a statewide HIE infrastructure that meets requirements of stakeholders, achieves multiple strategic options, factor in the influence of the stakeholders; some level of cross pollination with other working groups

Several key areas: Hardware, Software, etc.

Surface key issues for statewide HIE, share with others, make recommendations for core team, define statewide exchange, identify and build on current and private efforts with stakeholders.

Basic environmental scan information that provides the level of detail of current significant EMR instantiations across the state is underway
Develop/facilitate creation of statewide technical infrastructure for:

- Electronic eligibility
- Quality reporting
- Clinical summary exchanges,
- Etc.

Provide direct inputs and concrete recommendations to overall strategic plans.

Whatever we discuss needs to be clearly articulated – notion of exchange opens up a broad range of possibilities and expectations; any solution will need to define it and provide input and recommendations within the context of that definition

Exchange/transfer/share/move/access/retrieve information, as well as interoperability. Need to spend time and attention providing a detailed definition of what we are accomplishing; this is important for us, due to technical dimensions and infrastructure requirements, but it clearly is something that should be provided to the larger forum so that we're all talking about the same thing.

There is already law governing HIE in NH. Exchange is allowed for purposes of treatment only. Other purposes are not currently warranted by law. A case needs to be made to satisfy the legislature for amendments to the law.

A couple of different masters we need to satisfy – ARRA (meaningful use) and State law; need to think about not just the words, but the context of the exchange. Verb vs. Noun. Governance vs. Activity of exchange. Need to be very clear about what the goals of this are? Are they to meet ARRA, meet State law, and/or meet state requirements?

Pull vs. (information access versus delivery) Push components to access of Health information; notion of an audit is built into state law – need to have a mechanism to log access to information; legal, policy, and technical constraints and the logistical/management issues involved.

Regarding secure messaging - We established that it was within the current law (as far as we can tell); we wanted it to be between EHRs; there was a sentiment to have it be a two step process with a request, then an explicit response; we wanted discrete data elements so we could import into record. We started to get into how the destination was addressed, but it got consumed in the discussion around one step versus two step pushes.

Such a model can be described in the context of a special relationship called a contract – between two healthcare entities, which would specify the nature of an exchange (noun), including security, authorization, parameters, data elements, and other details necessary to enable obtaining patient information from each other. Such a model could also support an auditing function. (Reference to Exeter Hospital initiatives.)

We need to pay attention to the Clinical Document Architecture (CDA) and especially one of its components, the Continuity of Care Document (CCD) that provides the framework for moving data in a structured format. It's beneficial to build on such prior and industry-specific tools and frameworks.

Good architecture provides a standard framework and allows a reasonable degree of freedom for implementation. Who, what, when? Or do we just build the highway.

We should not get into the weeds of other groups' issues; we should just focus on the technical issues

We'll need to consider use cases; workflows.

There is no clean demarcation from the other groups; we are not working in isolation; there will be cross pollination so that we can have the benefit of discussions and decisions taking place in the other working groups.

Need to have a process; move through these considerations in a systematic way.

We don't have to start from scratch; we can stand on the shoulders of giants; lots of people have thought about these issues before.

HIEs have core components; need to address broad strokes/concepts, such as connectivity, security, standards, nomenclature, etc.

HIE Options: Build, borrow, buy off the shelf; or HIE based on policies only.

Summary,

Whatever this Work Group proposes must be described in the context of precisely defined terms such as push, pull, exchange, interoperate, etc. Use cases will provide the necessary contexts within which this group (and others) will attempt to propose a solution or solution model. The fundamental constraints on our work are expressed in terms of current NH statutes that address privacy, security, data elements, and auditing. For example, from current NH law:

A health information exchange shall maintain an audit log of health care providers who access protected health information, including:

- (a) The identity of the health care provider accessing the information;
- (b) The identity of the individual whose protected health information was accessed by the health care provider;
- (c) The date the protected health information was accessed; and
- (d) The area of the record that was accessed.

Additionally, we need to be mindful of priorities – the first test of Meaningful Use is for Stage 1 which has specific expectations that need to be satisfied in order to qualify for additional incentive payments.

Description of Approach, Requirements, Constraints:

Review of schedule:

Offer a strategic plan and an operational plan; we'll do that for much of the summer; through the beginning of August; do it in a prescribed way via these calls and meetings

Time, attention, and mind share.

The first summit: we need to capture all the ideas and thoughts; coalesce in a framework that will allow us to migrate to the next step.

Move from unstructured to increasingly structured information gathering and ideas.

Specific areas: Push vs. pull; security, etc.

By second meeting; develop finite set of options; be clear about things we're sure about, and purposefully leave open ideas we're not really sure about.

By the third summit; converge on particular solutions we want to represent in these documents

This is not the only bite of the apple; we'll have other opportunities to further develop the HIE plan and architecture; these are base documents; e.g. RFP, RFI

Actual writing tasks around these documents will not begin until the third summit.

Review of Phases and Components of overarching approach:

1. Consider existing use cases; user stories; including those identified in the state.
2. Mapping to HIE building blocks – create different categories of functionality; segment the problem; stay focused when we get into detailed discussions; baseline for all groups
3. Domain specific considerations – hone in on the technical infrastructure issues brought about by the building blocks
4. Develop a roadmap for unified direction/consensus way forward

Review of HIE building blocks:

Mental model with which we can frame the discussion
Increasing complexity from more foundational aspects of HIE

Secure Routing (e.g. NHIN Direct) – moving something in a push fashion – sending information to someone else.
Less complicated from a policy standpoint; non-electronic analogs exist today (e.g. sneakernet)

Registries and Reporting – need to do some level of aggregation of data for particular purposes for some proper authority's requirements e.g. Public health reporting, quality reporting, etc. May or may not be considered secondary use of data

Shared services: where could we implement services for the benefit of the entire networked community; more efficient manner than each group trying to create them individually (e.g. CA, master patient index)

Community record: going out and finding information (pull); federated or centralized; complicated by additional policy considerations (e.g. consent; break the glass; auditing; etc.)

Some issues that cut across the building blocks: Federated vs Centralized vs. Hybrid; how do we identify patients and providers (registries), etc.

TI WG Need to consider capabilities:
Infrastructure implications/considerations
Introduce the build, buy, borrow framework – need to have an opinion, posture about this.

Review of consolidated use cases; (slide 7) who are the actors; flow; dependencies; branching points; etc. Need to focus on the technology aspect of it.

Move through each building block and for each, we need to get more concrete and detailed about what we're talking about (descriptions); the more precise we can be, the better.

Planning discussion (slide 12):

Ultimately, our goal is to write a SOP
Second order strategic considerations – e.g. predominance/penetration of EHRs;

Goals for Next Week –
Come out with some of the key definitions so we are talking the same language
Start with Secure Messaging as a starting point; flesh out things that define that (preparation: NHIN direct)
What kind of posture does NH want to have with the existing efforts (federal or others)?

State law rules out some possibilities – it would be worthwhile that as we move forward we need to factor in the state law; in order to pursue some ideas, we may have to get current law changed; may decide not to pursue options depending on constraints and to be consistent with state law.

We could apply these types of environmental constraints as part of a prioritization process; let's not use it as a filter. Recognizing that if we want to implement something beyond current law that it might take longer to do so.

Other constraints – patients have the option to opt out. Very difficult to centralize data aggregation; ongoing sentiment and concerns in NH about Privacy and Security. This law was written in the absence of any experience with HIE.

If we want to make a law change, we need to make a sell – e.g. enhancement of security and privacy, patient safety, etc.. Is it a long shot call? NO. Need to demonstrate that we will make a positive impact on citizens of NH.

Question regarding preparation of materials that might demonstrate how ARRA and NH law might be in conflict?

The concept of Provider to Provider PUSH seems allowable under current law for HIE. How do we facilitate this?

Exeter experience - providers want something to come through their EMR; need it in a usable format; don't want to go somewhere else or switch context. Everything needs to be within the EHR context.

What about the data that comes in? How discrete should they be? Is reviewing a document (e.g. PDF) good enough, or do we want the data to be discretely accessible (pull out a piece of data and incorporate into the medical record)?

You should be able to save/keep what was sent to you or retrieve it later in a reliable way if necessary for medicolegal purposes.

Push of data needs to be timely; Pulling data is more temporally appealing – getting the data now, when needed.

Sender must know recipient. May need to have a registry in the middle.

Data granularity? Lab values that can be graphed/charted would be good to have as discrete data; consults, reports, etc. could just be PDF.

We will need to have some sort of agreement/contract in place for HIE (DURSA).

Need information in real time; transaction authorized by a contract?

Action Items (From previous meetings and new)

Item #	Raised By	Action Item Description / Comment	Assigned To	Due Date	Status/ Remarks
1		Comparison between ARRA requirements and NH State law; can EPs in NH achieve meaningful use given the legal constraints? (e.g. eligibility checking)	MAeHC	7/8	
2		Need to ensure that everyone is defining terms the same way; need to establish common nomenclature	MAeHC	7/8	

ISSUES IDENTIFIED

Issue #	Raised By	Issue Description	Assigned To	Due Date	Status/Remarks
1		See above notes.			

DECISIONS MADE

Decision #	Sponsor	Decision Description	Approved (Y or N)	Comments
1	Lee	The concept of Data Push is acceptable; although not temporally appealing	Y	