eHealth Commission

May 11, 2016 | 1:00 to 4:00pm | HCPF Conf Rm 10A

Type of Meeting	Monthly Commission Meeting
Facilitator	Kate Kiefert, Carol Robinson, Matt Benson
Note Taker	Jacqueline Giordano
Timekeeper	Jacqueline Giordano
Commission Attendees	Jason Greer, Morgan Honea, Jim Holder, Marc Lassaux, Mary Anne Leach, Michelle Mills, Greg Reicks, Alexis Sgouros, Bill Stevens, Chris Underwood, Chris Wells, Herb Wilson, Kendall Alexander

Minutes

Call to Order

- Michelle Mills called the meeting to order as Chair of the eHealth Commission

Approval of Minutes
- Minutes were approved by unanimous vote

April Activity Debrief
- The output of the April discussion was captured and organized into 3 sections: Barriers (Questions 1 and 2 from April discussion), Recommendations (Question 3), and Commission Role (Question 4)
- This information will be used going forward in our discussions

Two Approaches to Provider Directory and Patient Index Solutions

Tim Pletcher, PhD, Michigan Health Information Network

- MIHIN is comprised of a network of networks and is the gate keeper or single point of entry to the State of Michigan in regards to security, external and internal alignment
- MIHIN Strategy
    - Everybody is welcome to the table
    - Shared infrastructure (for scalability)
    - Reduce burdens/waste
    - Promote lowest cost/open options
    - Innovative ideas but quick execution
- Path to get there: Start with public & population health > care coordination > quality improvement & research > payment reform

- Critical infrastructure
    - Provider attribution
    - Master person index/common key service
    - Health provider directory
    - Gateway services
- The infrastructure provides a prospective/real time way to link caregivers and consumers together – as opposed to "attribution"
- Active care relationships reports
    - All providers send these monthly or weekly
    - Identifies relationships between providers, payers, consumers
- Common Key Service
    - Identifier for everyone to keep in their systems so we can identify a patient
    - Providing incentives for hospitals to drive everyone to the Common Key Service
- Quality measures overlap
    - Leveraging the same attribution methodology to route supplemental clinical information from providers to payers – providers only pay for 1 interface (state) – gaps in care information shared back from payers to providers

Elaine Fontaine, Rhode Island Institute for Healthcare Quality

- There are about 15 hospitals and 3 major payers plus Medicaid in the RIQI network
    - Current state: all are managing their own provider directories
    - Future state: all will feed into a single statewide provider directory
- Keeping the data current is easier in a single source
    - The best source is kept for each data element (survivorship) to make a single record that is better than any one of the individual records
- Governance structure involves state entities, providers, and payers
- Value proposition
    - Master Provider Record
    - Web-based lookup service
    - Analytics support
- Development timeline utilizes a phased approach

Q&A Session/Discussion

- MIHIN: When sending Active care relationships to the State, big piece of the work that's done is the attribution of the common key
    - Financial incentives for commercial side, regulations for Medicaid
    - Most systems haven't had much of a problem including the key
    - Not forcing anyone to trust the common key yet, only asking that they include it everywhere possible
- MIHIN: What are the data sources?
    - Pulling from HIEs, hospital systems, etc.
    - Active care relationship structure comes from provider groups
    - Try to have the sources at least partner with an HIE, but it depends on the entity

- MIHIN: Business Model / sustainability – we look to those who pay or regulate care.
    - We sell the information to the payers, which funds incentives for Providers. The value for payer community is that they are paying incentives that will encourage providers to prioritize data sharing
    - State also pays for the data if they want to use it
    - Most hospitals pay the HIEs
- Top use cases for payers: real time ADTs, care summary with medications, closing the gaps in care, standardizing the quality measures that the provider community thinks are of value
- Initial funding source
    - MIHIN – ONC $5m, also 90/10 funding
    - RIQI – grants, payers, SIM

One Approach to Personal Health Record

Alexandra Cohen, New York eHealth Collaborative

- NYeC is a NY State consolidated HIE, non-profit public-private partnership that promotes the adoption of EHRs
- The patient portal is a secure network for sharing electronic records
- It is opt-in and patient consent required – patients can decide which entities can access their records
- Network of networks – regional RHIOs work very closely with their providers, payers, public health orgs, etc. doing a lot of the work to create the interfaces with providers
- RHIOs provide key services
    - Aggregate health records
    - Allow providers to search for and find records from other providers in their region
    - Deliver notifications/secure messages
    - Some analytics
- Providers must be connected to a RHIO for their patient data to be available in the patient portal
- Provider based search – provider requests from statewide service, statewide service requests from other RHIOs, statewide service provides information back from responding RHIOs
- NYeC took a unique, collaborative approach to define requirements and held a statewide competition for look & feel
- NYeC is currently rolling out the portal
- Providers that want their patients to use this portal will get meaningful use credit
- The main reason for patients to use the portal is that it's a single source of information, as opposed to multiple doctors plus payers; working with RHIOs to work with their providers to encourage patient adoption, but also looking at SSO options with some of the larger aggregate patient portals (e.g. Epic)

Health IT Infrastructure Needs to Support Population Health Improvements in Colorado

Art Davidson, MD, Denver Health

- The biggest problem in Health IT is identity management, there is no sure method to uniquely identify a client/patient/provider
- Statewide identity management is a "team" sport
    - Discussed an example of patient overlap reported by several providers
    - Deterministic vs probabilistic
- Identity Management functions
    - Regular automated receipt of data
    - Standardized data
    - Quality assurance performed on the data
    - Disambiguation of records (Deterministic vs. probabilistic)
    - Tools available to manage the process and feedback
- Colorado has an opportunity (and has been encouraged by CMS) to use 90/10 funding to build out statewide master data management functions

Q&A Session/Discussion

- Beyond tools, how do we get the right workflow upstream and downstream? This is a lot of work. There is just as much work to be done in workflow, process improvement, governance, and policy.
    - Agreed, we need to start with real requirements, not tools. And we need funding so we can hire people to do this
- We need the incentives (referred to MIHIN), there needs to be a strong value proposition for all stakeholders; what value is there to provide good quality data?
- Need to establish use cases to determine where a patient has been, what happened, what does quality look like, how do we get into more robust analytics
- What value is there to the data sources to provide good quality data? Incentives and disincentives
- It seems like if we just simplified the process [of providing data], it could be more successful. We want lots of data but can't make use of it all. What if we reduced the amount of data we are asking for to that of what we truly need?
- We have a lot of existing investments in Colorado that we need to leverage, but we also don't want existing work to limit our thinking when solving for these problems long-term

Public Comment

Carrie Paykoc, Office of eHealth Innovation Coordinator, asked for suggestions or volunteers to be interviewed for SIM HIT Strategic Planning

Next Steps and Action Items

#	Action Item	Owner	Timeframe	Status
1	CedarBridge Group will be reaching out to each of the Commission members to gain an understanding of how their organizations fit into the interests of the Office as well as their current state and strategic priorities. The primary focus of these conversations will be on Personal Health Records, Master Patient Index, and Master Provider Directory (mainly because this is where there is existing CMS funding).	CedarBridge Group; Commission Members	Prior to March Commission meeting	Completed
2	Review Organizational Charter; send feedback or comments to Matthew.Benson@northhighland.com or Veronica.Menard@state.co.us	Commission Members	Prior to March Commission meeting	Completed
3	Provide background information and additional reading materials on the Health IT topics, including Person Identification	CedarBridge Group	Prior to March Commission Meeting	
4	Vote to approve Organizational Charter	Commission Members	At March Commission meeting	Completed
5	Consider nominations for Chair and Vice-Chair of the Commission; send nominations to Chris.Underwood@state.co.us	Commission Members	Prior to April Commission meeting	Completed
6	Review SOPs; send feedback or comments to Matthew.Benson@northhighland.com or Veronica.Menard@state.co.us	Commission Members	Prior to April Commission Meeting	Completed
7	Describe some of the thinking that brought the Office to the identification of the 3 priorities presented.	Office of eHealth Innovation	April Commission Meeting	In Progress