

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE
Meeting Minutes, January 19, 2005

Members in Attendance: Stanley Block, MD; Jeffrey Borkan, MD, PhD; Mark Braun, MD; L. Anthony Cirillo, MD; Sarah Fessler, MD; Michael Fine, MD; William Hollinshead, MD, MPH; Victor Lerish, MD; Sharon Marable, MD, MPH; Patricia Nolan, MD, MPH; Richard Wagner, MD. HEALTH Staff: Amy Zimmerman, MPH. PCPAC Staff: Carla Lundquist, Mary Anne Miller, RN, MPH.

Members not in Attendance: Ray Maxim, MD, Chair; Munawar Azam, MD; Herbert Brennan, DO; Herbert Constantine, MD; Charles Eaton, MD; Deidre Gifford, MD, MPH; Arnold Goldberg, MD; Ellen Gurney, MD; Omar Meer, MD; James Monti, Jr., MD; John Murphy, MD; Donya Powers, MD; Mark Schwager, MD; John Young.

- *To meet the goals of being useful, usable, and used, the Master Patient Index will need to demonstrate cost effectiveness, security and confidentiality, accuracy, ease of use, and visible benefits for clinicians and patients.*

Dr. Nolan opened the meeting at 7:40 AM. Minutes of the December 15, 2004 meeting were approved as written.

Amy Zimmerman, MPH, Family Health, delivered a presentation on Statewide Connectivity of Health Information Technology (HIT). (See attached pdf file of the presentation handout.) RI received a grant from the Agency for Healthcare Research and Quality (AHRQ) of \$5M over five years to create, implement and evaluate a Master Patient Index (MPI) as the backbone of an interconnected information system putting the right information into the hands of clinicians and their patients when and where it is needed. Deliverables for this project include identifying core clinical data elements/core health care entities (data sharing partners); convening a Technical Advisory Panel; and establishing/increasing data exchange from 25% at end of year one to 100% (of core data elements between entities) at end of year three, with expansion beyond core elements/entities and measurable improvements in years four/five. To sustain the MPI after five years, stakeholders need to build the cost of managing data into the cost of doing business, and to encourage Medicare/private insurer participation.

The MPI will consist of a central patient demographic database that stores unique patient identifiers of data sharing partners. Use of the MPI will require unique patient and provider "keys" and secure data connections. The MPI may serve as single authentication portal to data sharing partners' information; various architectural models will be considered. The MPI Project will have five components subcontracted to partner organizations: (1) Technical Assistance and Coordination with other HIT efforts within the state [RI Quality Institute (RIQI)]; (2) Technical design and development of the MPI [TBD]; (3) Health care provider engagement, training and participation [Quality Partners of RI (QPRI)]; (4) Consumer education and engagement [TBD]; and (5) Well-defined and rigorous evaluation [Brown University]. Several stakeholder meetings have been held to disseminate information, identify needs, and discuss architectural models to ensure the system will be useful, usable, and used. Per a poll of stakeholders, the top five attributes the system should demonstrate to achieve this are cost effectiveness, security and confidentiality, accuracy, ease of use, and visible benefits for clinicians and patients.

The initial phases of the project must be able to meet AHRQ deliverables with the funding provided but must also be flexible for future expansion toward the ultimate goals of the project. Certain categories of information that present technical challenges and/or are not currently available in centralized databases will be considered for future project expansion. These types of information include radiology/imaging information, pharmacy information, and patient data from private practice physicians, who will not be data sharers initially, but can be data users. As the MPI matures and becomes a valuable tool to data users, they will be asked to become data sharers as well.

There are many challenges and issues in making data access sufficiently secure, confidential, and HIPAA compliant, yet at the same time easy to use and allowing for emergency access. Determining the unique patient identifier to be used by all systems is a major issue to address. The project partners will look to convene an Identity Management Workgroup. However, all information on a patient cannot be accessible via one "master key"; there are mandates against making certain information available without explicit patient consent. It may be necessary, although technically complex, to have various levels of access per consumer authorization.

Per PCPAC comments, the MPI system design should include: (1) the capability to easily download individual patient demographic data which would alleviate some of the data-entry burden at physician offices, (2) easy access to avoid having to login to multiple sites, and (3) the ability to work with a variety of hardware/peripherals/firewalls. It should not be subject to platform obsolescence issues. If web-based, the system should be accessible to standard browsers. It must also be compatible with a variety of Electronic Medical Records (EMR).

Ms. Zimmerman noted that the project is exploring how to get EMRs that are effective clinical tools into provider offices; this project must keep EMR compatibility/system specs in mind, especially to assist providers who do not yet have EMR. RIQI has an IT committee working to identify a set of EMR products that might be recommended. A group purchase may be possible in the future, and RIQI would work with vendors to ensure interoperability. QPRI is sponsoring a HIT Fair in early March that will include facilitated demonstrations of EMR software.

On behalf of past and present PCPAC Chairs and members, Dr. Fine thanked Dr. Nolan for maintaining this committee and listening to the concerns of primary care providers over the last 10 years. Dr. Nolan plans to emphasize the value and importance of PCPAC as a way to connect with what is going on in the clinical practice community to the incoming Director of Health.

Dr. Nolan noted that the time for purchasing flu vaccine for the 2005-2006 season is fast approaching. A better, interactive flu vaccine distribution system is needed, but in the interim RI needs to encourage participation in the buying cooperative and increase uptake of FluMist. Intranasal vaccine has been a hard sell and Dr. Nolan feels the risks have been overstated. Thus far, promotion of FluMist has been targeted to health care workers, not the general public. It was suggested that health care workers be required to have the flu vaccine with FluMist used as appropriate. It may be effective to target teachers and day-care workers for flu vaccination, in addition to targeting school children.

NEXT PCPAC MEETING WEDNESDAY, FEBRUARY 16, 2005