

**Meeting of the RI AHRQ Health IT Project Steering Committee
November 30, 2006 ♦ 7:00am – 9:00am**

Robinson C. Trowbridge Center at Kent Hospital ♦ 10 Health Lane ♦ Warwick, RI

MEETING MINUTES

MEETING ATTENDEES (*indicates participation by teleconference)

Steering Committee

- Ted Almon**, Consumer
- Fadya Al Rayess, MD**, Chad Brown Health
- Bryan Barrette**, RI Department of Health
- Kerrie Jones Clark**, RI Health Center Assoc.
- Carol Cotter**, Lifespan, Co-Chair
- Gary Croteau**, South County Hospital
- Yul Ejnes, MD**, RI Medical Society
- Jim Feeney**, East Side Clinical Laboratory
- Steve Foley**, Prov. Community Health Ctrs
- Kristine Klinger**, BCBS Rhode Island
- Heather Larch**, Pharmacist
- Kathleen Mahan**, SureScripts
- Maria Montanaro**, Thundermist Health Ctr
- Steven Mueller**, United Healthcare Network
- Pat Moran**, Hospital Association of RI
- Ray Ortelt**, Pawtucket Memorial Hospital
- Cedric Priebe, MD**, Care NE, Co-Chair
- Ray Sessler**, Neighborhood Health Plan of RI
- Tracy Williams**, RI Dept. of Administration
- John Young**, RI Department of Human Svcs

Management Committee

- Laura Adams**, RIQI
- Deidre Gifford, MD**, Quality Partners of RI
- Jeremy Giller**, Clarendon Group
- Leonard Green**, RI Department of Health
- Stacy Paterno**, Clarendon Group
- Laura Ripp**, Consultant, Project Staff
- Melinda Thomas**, Department of Human Svcs
- Patrick Vivier, MD, Ph.D.**, Brown University
- Judy Wright**, RIQI
- Amy Zimmerman**, RI Department of Health

Other Attendees

- Mary Ellen Casey**, Quality Partners of RI
- Reid Coleman, MD**, Lifespan
- David Gifford, MD**, RI Department of Health
- David Hemendinger**, Lifespan
- Nina Lennon**, RI Department of Health
- Jeff Newell**, Quality Partners of RI
- Jeneane Parkette**, BCBS Rhode Island
- Howard Rubin**, Care New England
- Fred Schulz***, United Healthcare Network

MEETING PURPOSE

To review, discuss and reach consensus on: a) approach to populate a regional Master Patient Index for the initial Health Information Exchange (HIE); and b) approach to reach full, cross-committee agreement on the consumer consent model pertaining to health data accessed through the HIE.

AGENDA

- | | |
|--------------------|--|
| 7:00 – 7:05 | 1. Call to Order, Welcome and Introductions
<i>Carole Cotter, Lifespan, Steering Committee Co-Chair</i> |
| 7:05 – 7:10 | 2. Consideration for Approval: 10/26/06 Meeting Minutes
<i>Carole Cotter, Lifespan, Steering Committee Co-Chair</i> |
| 7:10 – 7:30 | 3. Project Update
<i>Carole Cotter, Lifespan, Steering Committee Co-Chair</i>
<i>Amy Zimmerman, Rhode Island Department of Health</i> |
| 7:30 – 8:10 | 4. Confirm Approach to a Regional MPI for the HIE to Inform EDS Contract
<i>Carole Cotter, Lifespan, Steering Committee Co-Chair</i>
<i>Dave Hemendinger, Lifespan, Technical Solutions Group Co-Chair</i>
<i>Howard Rubin, Care New England, Technical Solutions Group Co-Chair</i> |
| 8:10 – 8:50 | 5. Discuss Status & Process for Determining the HIE Patient Consent Model
<i>Cedric Priebe, MD, Care New England, Steering Committee Co-Chair</i> |
| 8:50 - 9:00 | 6. Recap Next Steps and Adjourn
<i>Cedric Priebe, MD, Care New England, Steering Committee Co-Chair</i> |

MEETING SUMMARY

1. Call to Order, Welcome and Introductions

Carole Cotter, Co-Chair, opened the meeting at 7:05am and welcomed the group. Kristine Klinger introduced Jeanene Parkette from Blue Cross Blue Shield of RI's Center for Business Intelligence. Ms. Klinger noted that her position on the Steering Committee will be filled by Brad Weaver.

2. Consideration for Approval: 10/26/06 Meeting Minutes

Ms. Cotter directed the group to the last meeting minutes and asked for comments and corrections. A motion was made and seconded to approve the October 26, 2006 minutes as written. All Steering Committee members present voted in favor of approval.

Action Items:

October 26, 2006 meeting minutes are accepted as written.

3. Project Update

Amy Zimmerman referred the group to the Project Update handout summarizing project activities completed during November and those planned for December. Key areas of the update included:

- RI Health Information Exchange (HIE) Contract Status
- Consumer Advisory Committee (RIQI)
- Administrative Data Exchange Committee (RIQI)
- RIQI Standards Committee / Lab Subgroup of Data Sharing Partners (DSPs)
- Policy and Legal Committee (RIQI)
- Professional Advisory Panel (QPRI)
- Technical Solutions and Data Sharing Partners Workgroup (formerly TSG/DSP, now TSG)
- eRx/Pharmacy subgroup status (RIQI/QPRI)
- RI AHRQ HIT Project Evaluation (Brown University)
- Committee of Chairs (RIQI)
- Other Updates

Details are as follows:

■ RI Health Information Exchange (HIE) Contract Status

A. Zimmerman reported that contract negotiations with EDS are underway. Tracy Williams reported that she has secured assistance from an attorney at DHS that assisted with the current EDS contract for the Medicaid Management Information System. Of note, pre-contract discussions have included conferring with the Project's Technical Solutions Group on specific aspects of EDS' proposed technical architecture and development approach. Details will be discussed later in this meeting agenda.

Action Items:

Continued updates will be provided on the status of contract negotiations; any issues for Steering Committee consideration will be identified.

■ **Consumer Advisory Committee—CAC (RIQI)**

Stacy Paterno reported that the CAC continues to work toward consensus on an approach to managing patient consent that would allow or prohibit personal health information to be accessed through the HIE. The group is currently working to identify additional questions for providers, attorneys and others to help gain clarity on a range of related issues.

Action Items:

Ongoing updates will be provided.

■ **Administrative Data Exchange / Standards Committee (RIQI)**

Judy Wright reported on the Administrative Data Exchange Committee. Judy Wright noted that preliminary discussions have been conducted with payers to explore a “single sign-on” model by which providers could access administrative (health plan) data. Ms. Wright was clear in her statement that no decisions have been made.

Action Items:

Continued updates on progress will be provided.

■ **RIQI Standards Committee / Lab Subgroup of Data Sharing Partners (DSPs)**

Judy Wright reported that the Standards Committee has not met. Amy Zimmerman informed the Steering Committee that the lab subgroup of HIE Data Sharing Partners have identified a few remaining edits needed on the consensus HL7 specification for lab data exchange.

Action Items:

Updates on progress will be provided as indicated.

■ **Policy and Legal Committee—PLC (RIQI)**

A. Zimmerman reported that the PLC conducted a teleconference on November 1 to provide feedback on the draft HISPC Assessment of Variation in Organization-Level Business Practices Report. Dr. David Gifford noted that the group continues to discuss patient consent issues related to accessing health information through the HIE. These discussions are being conducted in the context of a range of legal interpretations of state and federal laws pertaining to protections for special classes of health information. The group will meet again in early December.

Action Items:

Continued updates on PLC activities will be provided.

■ **Professional Advisory Panel (PAP—QPRI)**

Mary Ellen Casey reported that the PAP met on November 8th. A briefing on the proposed EDS/InterSystems HIE solution was provided by project staff—the group had a favorable response to the offering. Dr. Patrick Vivier attended the meeting to present the RI AHRQ HIT Project Evaluation Plan to the group for consideration.

Action Items:

Continued updates on PAP activities will be provided.

■ **Technical Solutions and Data Sharing Partners Workgroup**

The RI AHRQ HIT Project Technical Solutions Group and Data Sharing Partners have been officially merged into a single Technical Solutions Group (TSG). The TSG met on November 10th to continue discussions on two key technical aspects of the proposed HIE: (1) the technical architecture, and (2) the approach to develop, test and refine the HIE Enterprise Master Person Index (EMPI). A summary of considerations and the group's current recommendations were included in the meeting materials. Details on the EMPI were discussed later in the meeting in Agenda Item #4.

Action Items:

The TSG will continue its work to reach consensus on the HIE architecture and other issues as identified to help inform EDS contract negotiations. Updates to the Steering Committee will be provided.

■ **eRx/Pharmacy Subgroup (QPRI, other)**

There was no report on ePrescribing activities. Amy Zimmerman noted that a meeting with SureScripts is scheduled to address its role as a data sharing partner and work toward a mutually acceptable approach to sharing medication history data through the HIE.

Action Items:

Continued updates on pharmacy data exchange issues will be provided.

■ **RI AHRQ HIT Project Evaluation**

Ms. Zimmerman meets with Dr. Patrick Vivier monthly to address Project Evaluation issues. She noted that feedback from AHRQ on the September 29th Draft Evaluation Plan is still pending.

Action Items:

Continued updates on Evaluation progress will be provided.

■ **RIQI Committee of Chairs**

Dr. Priebe reported that the Committee of RIQI Chairs has been focused on the priority issue of reaching consensus in the Rhode Island community on a patient consent management model for the HIE. Dr. Priebe noted the plan for a joint meeting of CAC, PAP, PLC and TSG to develop consensus which was discussed in more detail in Agenda Item #5.

Action Items:

The Committee of Chairs will continue to lead the process of developing community consensus on the HIE patient consent model. The Steering Committee will participate in this process; discussions will be incorporated into future meeting agendas.

4. Confirm Approach to a Regional MPI for the HIE to Inform EDS Contract Negotiations

■ **Discussion:**

Carole Cotter introduced the newly named co-chairs for the TSG, Dave Hemendinger, Chief Technology Officer at Lifespan and Howard Rubin, IS Director/Chief Technology Officer at Care New England. Working from a handout distributed with meeting materials, Mr. Hemendinger introduced the key issues pertaining to the HIE Master Person Index (MPI) and

reviewed the TSG's impressions about EDS / InterSystems. He then reviewed the TSG recommendations.

1. The first TSG recommendation is to: "Implement a *regional* MPI to address inter-DSP matching of patient records in the HIE." Key elements of the desired solution include usability, accuracy, comparability of information and risk mitigation. With these considerations, Howard Rubin noted the reasons why the Record Locator Service (RLS) federated (decentralized) model was not sufficient for the RI solution and that we would be pursuing a different approach for the EDS implementation of the RI HIE.

The Steering Committee explored some of the related issues. Ms. Zimmerman added that some of the critical issues also include the resources required to manage the deduplication and reconciliation of ambiguous records prior to user access to the HIE. This will involve assuring adequate human resource capacity on the HIE end of the information management spectrum.

Kristine Klinger asked whether it is an expectation that data deduplication would be ongoing. Dr. Priebe noted that organizations operating such MPIs must provide ongoing support. Bryan Barrette noted the shifting of some liability from the user to the HIE. Tracy Williams commented that the use of a unique ID could be a potential way to reduce the workload and potentially the risk associated with incorrect matching and merging of patient records. Ted Almon asked for more clarity on the process for matching and how people with like names will be distinguished from each other and their records will be associated according to the matching algorithm used in the EMPI. In this explanation was the fact that human action will be required to resolve the ambiguous records. Howard Rubin noted that the resources required to resolve ambiguous matches will be informed by how well the matching algorithm performs.

Judy Wright pointed out the budget implications and asked how HEALTH would pay for this additional staff capacity. Dr. Gifford noted that the ongoing responsibility for staffing will reside with the RHIO. He noted that this is one example of an operating cost that must be accounted for that is not currently included in the demonstration project budget. Ted Almon noted that liability insurance must also be factored into total operating costs. Ms. Zimmerman agreed and suggested that we would learn from the experience of other functioning RHIOs to get an estimate of insurance and other operating costs. Tracy Williams suggested asking AHRQ for additional funding and/or pursuing other funding sources.

Carole Cotter led the group through a summary of the work effort required to build and maintain the EMPI. The group agreed to support the work effort according to the second set of TSG recommendations as follows:

- 2a. The Steering Committee agreed with the TSG statement: "*Community/Project participants* must support the work required to agree on a strong matching algorithm and help determine the selection and weighting of data elements to achieve high probability matching."
- 2b. There was discussion on several aspects of the TSG statement, "*DSPs* must compile and submit bulk data sets of health information for initial and subsequent loading into the HIE. DSPs prefer to embed a demographic data set with clinical data sufficient to support the agreed upon algorithms to perform the matching of patient records. [Note: DSPs also need to consider the initial data requirements to support development and testing of

the matching/merging algorithms integral to the HIE.]”

This statement describes an EMPI development approach that includes a starting point whereby transacting will occur in a test mode. Kristine Klinger asked about the cutover plan. It was made clear that a cutover plan has not yet been developed. Tracy Williams noted that using a bulk transmission mode to populate the EMPI may facilitate other insights about the data that could be beneficial. Dave agreed that some DSPs may have to submit bulk data so we should also provide support for this option.

A. Zimmerman asked for clarification on the approach to testing the matching algorithms. D. Hemendinger noted that the information loaded in the test database will be test data only. He pointed out that before real records are put into the HIE, the patient consent issue must be resolved. Under the limited scope of the pilot, the health information provided by the current DSPs may not be sufficient to satisfy users’ need for complete information. To help address this issue, it is assumed that there will be a period where transactions will flow prior to going live to increase the likelihood that a user will find records in the HIE. Jim Feeney pointed out that a key advantage of taking a transactional approach to test the system is that this is the way the data will be flowing in the real system. This approach helps prevent the return of an empty record. Dr. Yul Ejnes noted similarities with the Surescripts system experience and suggested that we could learn from that.

The group continued the discussion of “value” and generally expects that early beneficiaries of the HIE would likely be Emergency Departments and Long Term Care facilities. T. Williams noted that the strategic sequence of bringing on the nine DSPs (included in the proposed EDS approach) may help increase the real and perceived value of the HIE.

Steve Foley noted that the availability of administrative information is still an important element of value for providers. Kristine Klinger asked when the payers would be brought into the discussion. Judy Wright noted that the complexity of involving the payers is apparent and noted that one initial approach may be to consider using the RLS “pointer” functionality to identify where patient records may reside in existing payer portals.

- 2c. The Steering Committee agreed with the TSG statement: “*The HIE* must be able to support manual error resolution and deduplication of inter-DSP records. This will require human resources at the HIE “center”. The initial and ongoing level of effort and funding mechanisms are to be determined.”
- 2d. The Steering Committee agreed with the TSG statement: “*End users* must realize that data that has not yet been clearly identified as matching to an existing patient or as a new patient will be put in a queue for resolution and hence may not be provided in real time.”

Action Items:

On behalf of the TSG and the RI community, HEALTH will advance these recommendations to EDS for consideration in contract discussions.

5. Discuss Status & Process for Determining the Patient Consent Model for the RI HIE

■ **Discussion:**

Dr. Priebe directed the group to the two page table that represents where four distinct committees and work groups currently stand on issues around patient consent for information to be disclosed through the HIE. He noted that the information in the table is currently evolving and that the question set represents a high level account – there may be other questions that must be answered. Dr. Gifford noted that these discussions have occurred independently and there is a plan to bring these four groups together in early 2007 in an attempt to reach consensus. Dr. Priebe noted that a strawman model will be proposed to help move the groups to consensus. A. Zimmerman noted the need to balance and incorporate some practical process considerations to help influence the consent policy as it evolves. She pointed out the value of the HISPC project in that it has allowed us to look closer at legal and policy details. Stacy Paterno added that the consumer group is working to formulate additional questions for consideration that point to the need for further input. The group had no additional comments on the suggested consensus-building process.

Dr. Priebe moved the group to examine the four policy statements included in the consent material:

Q1. *What options should patients/consumers have about whether their information is transferred **through** the Health Information Exchange (HIE)?* Dr. Gifford noted that current state laws add complexity to consent issues. For example, due to current interpretation of state law regarding the protection of sensitive information, and specifically, information about sexually transmitted diseases (STD), disclosure of this type of information requires active consent by the patient for every incidence of disclosure including use of the information for purposes of coordination of care —this is a different state legal requirement than for any other class of sensitive data. This exception may require changes to the law.

Kerrie Jones Clark asked for clarification on what “coordination of care” means relative to the time parameters of consent. Dr. Gifford noted that our understanding today implies that once consent is given, it persists. He also noted that there are probably inadvertent disclosures today due to the complexity of clinical practice and data management. Dr. Gifford noted that the issues around consent are made more complex because consumers are not really aware of current practices. Steve Foley asked if a patient “opts out” of having their information disclosed through the HIE, could the information still be transferred to the HIE without disclosure? There was discussion about this question—it is clear that there are details of the evolving consent model that still need to be decided.

In summary, due to the variability in state law and the more stringent requirements for protected classes of information, the approach to developing an acceptable consent policy has moved from a passive consent model to an active consent model without consideration of all the details around how this consent would be obtained. Many issues must be explored, including getting additional opinions on the current interpretation of federal and state laws. Dr. Gifford noted that active consent models currently exist that can provide insights into a solution for Rhode Island.

Q2. *Should patients be able to “block” certain classes of health information from being transferred (to) through the HIE?* The RIQI Consumer Advisory Committee considered this question and have mixed opinions as to whether a patient should be able to selectively block information from disclosure and whether, if blocked, the record must be flagged to notify a provider that something has been blocked. Dr. Priebe noted that there are at least two levels of consent that are under consideration here—this question

relates to the first consent, i.e., is the information eligible to be viewed? That is, a person's information is either all in or all out. However, enabling multiple levels of blocking is felt to be technically feasible if the data is all codified but it is not likely to be successfully implemented in real clinical practice.

Maria Montenaro related the PLC discussion that, in support of patient privacy, the patient would consent to have their information in the HIE with the understanding that the information is only to be shared for clinical care. She emphasized the goal of providing complete information to support safe, high quality care. In this case, consumers would need to be better educated about which providers could actually view the information. Steve Foley added that a patient's list of who can see their information is the most important. Dr. Gifford added further that the audit function strengthens the consent model. Stacy Paterno emphasized the need for good education.

Pat Moran surfaced the issue regarding the HIE being subject to subpoena as a source of health records for litigation purposes. M. Montenaro noted that the HIE is not a "provider" and she felt there may be some ways to reduce the likelihood of subpoena.

- Q3.** *"If a patient chooses to opt-out of having all data transferred through the HIE, should each Data Sharing Partner (DSP) be responsible for suppressing data from being transferred to the HIE?"* This issue has been previously discussed. DSPs will generally be unable to technically support a consent model that requires filtering non-consented data prior to transfer to the HIE. Therefore, The HIE should be responsible for preventing patient information from being transferred through the HIE when a patient "opts out". There was no detailed discussion.
- Q4.** *"Should patients be required to give their consent to a health care provider in order for that provider to obtain the patient's information from the Health Information Exchange for purposes of treatment?"* A model that includes obtaining consent at the point health information disclosure to an authorized provider constitutes an additional consent process that is stricter than current state and federal laws. Dr. Gifford noted the different interpretation of consent; he cited the practice of getting informed consent for all vaccinations. Must define consent so there can be a common dialogue. Ted Almon suggested that we adopt a clear definition of "in" or "out". The group was supportive of the goal of consent at disclosure.

Action Items:

Dr. Priebe reviewed the proposed process of moving this consent policy discussion to consensus. It is likely that any decision will come back to the Steering Committee and perhaps move to the RIQI Board if deemed necessary.

6. Recap Next Steps and Adjourn

Dr. Priebe noted that we will consider the need for a December meeting based on whether there were important issues to address or decisions to be made. He thanked the group and adjourned the meeting at 8:55 am.