

Meeting of the RI AHRQ Health IT Project Steering Committee

October 23, 2008 ♦ 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

- Nancy Barisano, Westerly Hospital
- Virginia Burke, RI Health Care Association
- Nancy Coburn, NHPRI
- Carole Cotter, Lifespan, Co-Chair
- Gary Croteau, South County Hospital
- Yul Ejnes, MD, RI Medical Society
- Jim Feeney, East Side Clinical Laboratory
- Bill Florio, BCBS of Rhode Island
- Steve Foley, Prov. Community Health Ctrs
- Chuck Jones, Thundermist Health Center
- Ron Jordan, URI College of Pharmacy
- Jack Landers, RI Dept. of Administration
- Pat Moran*, Hospital Association of RI
- Don Nokes, NetCenergy
- Paul Oates, United Health Networks
- Cedric Priebe, MD, Care NE, Co-Chair
- Norma Tatterfield, BCBS of Rhode Island
- Alan Tavares, RI Partnership for Home Care
- Linda Tucker, RI Assoc of Facilities and Services for the Aging
- John Young, RI Dept of Hospitals (MHRH)

Management Committee

- Laura Adams, Rhode Island Quality Institute
- Rebekah Gardner, Quality Partners of RI
- Beth Perry, EDS
- Laura Ripp, Consultant, Project Staff
- Patrick Vivier, MD, Ph.D., Brown University
- Judy Wright, Rhode Island Quality Institute
- Amy Zimmerman, RI Department of Health

Other Attendees

- Lauren Capizzo, Quality Partners of RI
- Tracy Feeney, Rhode Island Quality Institute
- Geri Guardino, Rhode Island Quality Institute
- Dave Hemendinger, Lifespan
- Chris Hunter, Advocacy Solutions
- Nina Lennon, Rhode Island Quality Institute
- Kate Schell*, InterSystems
- Trey Reeves, InterSystems

MEETING PURPOSE

To communicate project updates; consider current *care* revocation policies and forms for approval and review; and discuss the approach and status of key implementation issues.

AGENDA

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| 7:00 – 7:05 | 1. Call to Order, Welcome and Introductions
<i>Cedric Priebe, MD, Care New England, Steering Committee Co-Chair</i> |
| 7:05 – 7:10 | 2. Consideration for Approval: 9/25 Meeting Minutes
<i>Cedric Priebe, MD, Care New England, Steering Committee Co-Chair</i> |
| 7:10 – 7:30 | 3. Project Update
<i>Cedric Priebe, MD, Care New England, Steering Committee Co-Chair</i> |
| 7:30 – 8:00 | 4. Discussion and Consideration for Vote: Revocation Policies and Procedures
<i>Cedric Priebe, MD, Care New England, Steering Committee Co-Chair</i> |
| 8:00 – 8:55 | 5. Review Status of Select current <i>care</i> Implementation Details
<i>Cedric Priebe, MD, Care New England, Steering Committee Co-Chair</i> |
| 8:55 – 9:00 | 6. Recap Next Steps and Adjourn
<i>Cedric Priebe, MD, Care New England, Steering Committee Co-Chair</i> |

SUMMARY OF DECISIONS AND ACTION ITEMS

- A. Decision: September 25, 2008 meeting minutes were approved with one editorial correction.
- B. Decision: Approve the current *care* Revocation of Authorization policy and related forms with refinements as defined.
- C. Action Item: Staff will make changes in the implementation status dashboard according to Steering Committee guidance.

MEETING DETAILS

1. Call to Order, Welcome and Introductions

Dr. Cedric Priebe, Steering Committee Co-Chair, opened the meeting at 7:00 a.m. and welcomed the group.

2. Consideration for Approval: 9/25 Meeting Minutes

ACTION

DECISION: The September 25, 2008 meeting minutes were approved with one change; Norma Tatterfield's name was corrected in the 3rd sentence of the last paragraph on page 5.

3. Project Update

The updates to the Steering Committee included the following topics:

- Status of Policy / EDS Deliverables and Project Schedule
- Status of HIE Enrollment Implementation
- RIQI Board Committees
- Other Updates

Major points of discussion:

➤ **Status of Policy / EDS Deliverables and Project Schedule**

Laura Ripp reviewed key points from the Project Deliverables Schedule that was distributed to the group. It was noted that the schedule reflects the impact of delays in several tasks related to implementation, such as the full installation and approval of hardware. However, the three key milestones of (1) enrollment, (2) data flow to current *care* (the HIE system), and (3) "go live" at provider pilot sites are currently on or close to schedule (see additional details in agenda item 5).

Specific areas of progress include:

- The EDS Draft Detail Design Specification (D23a) was accepted by HEALTH.
- EDS submitted the Test Plan Deliverable (D21) and is incrementally submitting a series of 12 Test Case Packages which are currently under review by the TSG.
- EDS submitted to HEALTH the second Lessons Learned document which is currently under review.
- HEALTH submitted the HIE Sustainability Plan Deliverable to AHRQ (federal funding agency) on September 29, 2008.
- The EDS/InterSystems subcontract for the consent management solution development was completed on October 2, 2008. Development of the "Participation Gateway" is expected to take 90 days. Critical contracts in progress

include: (1) the data sharing (business associate) agreement which details mutual performance requirements for Data Submitting Partners and HEALTH; (2) EDS's subcontract with Apelon, the taxonomy solution provider for the current *care* implementation.

- Technical development has been concentrated in several key areas: (1) reviewing the Test Plan and Test Cases to guide system testing; (2) installing and configuring production hardware and (4) configuring the HIE software.
- Policy development has been focused has on finalizing the HIE Revocation of Authorization Policy and Forms.
- EDS performed system demonstrations to stakeholder audiences including RIQI and OSHEAN.

➤ **Status of HIE Enrollment Implementation**

Geri Guardino (current *care* Enrollment Specialist, RIQI) provided a presentation to update the Steering Committee on progress on consumer enrollment in current *care*. Key points include:

- A series of active strategies are being pursued and assessed. These include mail-based enrollment for Medicaid beneficiaries; onsite enrollment at a community health center and provider offices; and employer- and hospital-enabled approaches. Early lessons learned are helping to inform next steps.
- A regional enrollment strategy will also be deployed with the intent to saturate a specific market. Warwick is being considered as an initial area of focus. Support will be sought from the mayor and a schedule will be developed for the campaign including site visits and waves of activities and information building to an action, i.e., enrollment. Chris Hunter, Advocacy Solutions, noted that other town mayors will likely want to join the movement. The ideal outcome is to be successful somewhere. Regional initiatives would provide an opportunity to demonstrate how enrollment in current *care* can be effectively accomplished since such efforts could be more readily evaluated. Laura Adams noted that the voluntary nature of enrollment should be preserved.
- Current challenges include: Supporting processes to confirm patient identity (authentication); assuring compliance with legal and regulatory protocols; addressing confusion about enrollment options; addressing the financial realities of high labor costs for the resource-intensive strategies; building brand awareness for current *care*; and implementing mechanisms to reduce language barriers.

Discussion: Dr. Priebe inquired about efforts to engage data submitting partners (DSPs) as enrollment channels. Ms. Guardino noted that, depending on the nature of the data submitting partners' encounter with the patient, the education and consent processes may be difficult to accomplish in DSP-centric enrollment efforts, however, awareness-building could potentially be reinforced in some DSP settings. The goal of enrollment continues to focus on aligning patients with their data and providers and some DSPs may be well positioned to contribute to this alignment.

Laura Adams commented that the enrollment and consent process is a significant challenge on several fronts and various options will be pursued as implementation

progresses and funding becomes available; for example, online patient enrollment can be feasible when the consent management solution is in place (target March 2009). Chris Hunter commented that much of the challenge lies in the need for large scale awareness building and the relatively small number of places where consumers can go to enroll. While provider-based enrollment strategies, i.e., those tied to care delivery, are believed to be the most effective, the capacity to conduct provider education may not be sufficient to support enrollment goals.

Nancy Coburn noted the open enrollment period of employers and inquired as to whether this approach could work as an enrollment channel for current *care*. Judy Wright noted that some employer-based enrollment efforts would be pursued, however, there are known operational and perceptual challenges that must be effectively addressed.

Amy Zimmerman noted that long-term care (LTC) facilities will be a focus for enrollment and Medicaid Transformation Grant (MTG) funding is available to directly support these efforts. Quality Partners of Rhode Island (QPRI) has reviewed ten LTC facilities to understand more about their readiness to participate. Will be merging these efforts with the regional strategy; other LTC facilities outside the target region will be brought in as early enrollment sites and user sites.

Ms Guardino concluded the discussion by inviting the group to enroll themselves and their organization into current *care*. The enrollment team is available to meet with interested organizations to discuss how enrollment can be integrated into routine business processes. Further, messaging about enrollment can be included in existing business communication channels, including websites, newsletters, etc.

➤ **RIQI Board Committees**

Laura Adams reported that open meetings were held to review draft charters for new RIQI Board Committees; the charters will be reviewed by the full RIQI Board in November.

Charters have been developed for the following committees:

1. RHIO Oversight (will not overlap with other RIQI or project committees)
2. Audit and Compliance (unbundling from the Finance Committee)
3. Operations Oversight (the Finance Committee will consider these issues)
4. Nominating and Governance Committee (expansion of the Nominating Committee)

Ms. Adams also reported that RIQI received additional donations to engage Boston Consulting Group (BCG) to prepare a business plan for the RHIO and HIE (current *care*) operations. She noted that BCG is also the firm that developed the business plan for HIEs in Massachusetts.

Ms. Adams announced that the ceremonial signing of the RI HIE Act of 2008 was conducted on Monday, September 29, 2008 at the State House.

➤ **Other Updates**

Ms. Zimmerman reported that HEALTH is moving ahead with draft regulations pertaining to the HIE Act of 2008. A tight schedule has been proposed which will follow a standard review and revision process. Draft regulations will be released and two opportunities for community review will be offered. The first review is an informal process scheduled for

early November after which revisions are made and a second community review will be offered. A formal public hearing is then conducted to hear testimony after which final regulations will be advanced.

4. Discussion and Consideration for Vote: Revocation Policies and Procedures

Dr. Priebe directed the group to the set of current *care* Revocation policy and forms. Each policy/form has been fully reviewed by RI HIE Committees, RIQI internal legal counsel and the Steering Committee. Dr. Priebe noted that the most current changes to the documents reflect the Steering Committee guidance to allow revocation of access at the individual provider level in addition to the organization level.

Discussion: The group reviewed each document. Brief discussion resulted in one change—the word “(fax)” will be added as a descriptor of facsimile to the last line of the forms.

The following motions were presented for Steering Committee consideration and vote:

- a) Accept the policy document titled: **current*care* Revocation of Authorization Policy** as written.

ACTION

DECISION: The Steering Committee moved to approve the motion as stated; the motion was seconded and a vote was conducted that resulted in all members of the voting quorum voting in favor with no abstentions.

- b) Accept the Revocation Policy Form titled: **current*care* Revocation of Authorization: Patient Enrollment** as amended.

ACTION

DECISION: The Steering Committee moved to approve and seconded the motion as stated; all members of the voting quorum voted in favor with no abstentions.

- c) Accept the Revocation Policy Form titled: **current*care* Revocation of Authorization: Provider / Provider Organization Access** as amended.

ACTION

DECISION: The Steering Committee moved to approve and seconded the motion as stated; all members of the voting quorum voted in favor with no abstentions.

5. Review Status of Select *currentcare* Implementation Details

Select topics were presented to inform the group on the status of issues and activities that have an impact on *currentcare* implementation. Topics included:

- Pilot User Site Selection (Guardino)
 - DSP Selection (Feeney)
 - Go / No Go Decision on Pilot Site “Go Live” (Priebe)
 - System / Network Security (Zimmerman)
 - Lab transaction processing (mapping-Zimmerman) (display-Priebe)
 - Patient Matching (Priebe)
- **Pilot User Site Selection**

Geri Guardino noted that five *currentcare* user sites will be targeted for the initial pilot rollout, currently scheduled for June 2009. She referred to the previous enrollment presentation and reiterated the intent to build on the relationship between enrollment sites and user sites, i.e., where patients receive care. Lauren Capizzo, Project Manager at

QPRI, noted that care delivery sites in the Warwick area have been canvassed as part of QPRI's contractual role to engage providers. QPRI has developed criteria to help guide pilot user site selection. Next steps include reaching agreement with target sites, addressing any preparatory tasks and training their managers and staff on specific policies and user roles, including enrollment, if applicable.

➤ **DSP Selection**

Tracy Feeney, currentcare Technical Manager, reviewed the list of current and potential Data Submitting Partners. She noted the primary strategies for DSP prioritization include achieving near complete participation of data sources for lab results and medication history as well as alignment of DSP selection with the geographic strategy for enrollment and provider site selection. Ms. Feeney noted that discussions are underway to determine the next wave of DSPs and their ability and willingness to participate.

➤ **Go / No Go Decision on Pilot Site "Go Live"**

Dr. Priebe directed the group to a handout titled "Status of Project Implementation". This one page executive dashboard is intended to be used to communicate the status of critical components of currentcare implementation to the Steering Committee and, ultimately, to represent those elements required to be successfully completed to confirm a "GO" decision for system deployment in a live environment. The group reviewed and discussed the form and suggested that the indicator box with green, yellow, red circles be reduced to a single circle with a G, Y, or R label to more simply indicate the status color of the corresponding component.

ACTION

Staff will make changes in the implementation status dashboard according to Steering Committee guidance.

➤ **System / Network Security**

Amy Zimmerman described two EDS deliverables, the currentcare Security Plan and Disaster Recovery (DR) Plan and noted that, due to the sensitive nature of the content of these documents, the deliverables approval process is different than for other technical deliverables. In addition to the State, the only contractually bound party, a qualified group of reviewers from several organizations (including RIQI and some DSPs) has been identified. Ms. Zimmerman described challenges with obtaining non-disclosure agreements (NDA) to enable these parties to participate in the review process. Further, DSPs have identified an additional requirement to review relevant security audit results as well. Efforts are underway to try to balance the concerns of all parties to disclose / review these documents. It was noted that these discussions have delayed the ability to review and approve the Security Plan. However, the DR Plan is currently being reviewing in a modified format without requiring an NDA and the State is proceeding with its review by a certified security professional (CISSP). The current approach is to pursue an acceptable NDA with DSPs; EDS has proposed an additional approach to provide assurances through the audit process. Will continue to pursue approaches to near-term resolution and take into account that subsequent DSPs will need assurance that the security procedures are satisfactory.

Norma Tatterfield noted that BCBSRI always requires a review of its data partners' security plan and audit and may pay for an independent audit as well. Dr. Priebe noted that the BAA is also a way to establish the legal relationship between the DSPs and EDS / HEALTH.

Amy Zimmerman will provide updates on progress made to define and complete the security plan review process.

➤ **Lab Transaction Processing**

Ms. Zimmerman introduced the notion of mapping data transactions between and among DSP lab result values. The project had worked under the assumption that there was an existing mapping set developed for other local data exchanges that could be leveraged. However, it has been determined that the currentcare mapping will need to be developed. This work is resource intensive and could potentially delay the implementation schedule for data submissions to currentcare from the initial lab DSPs. The most recent decision is to use the Lifespan codes as the master code set. The result names used for display in the Lifelinks system will also be adopted. While the approach has been resolved, the work must now be performed. This constitutes a delay in the schedule that must be absorbed.

Dr. Priebe described another challenges around the reference ranges for the same lab tests presented in a cumulative view. After further discussion with EDS, this issue seems to be resolved by suppressing the "Reference Range" column for the cumulative view.

➤ **Patient Matching**

Dr. Priebe introduced a discussion regarding challenges pertaining to the matching of patient information coming from various sources in currentcare. The key issue is that there are a limited number patient demographic/descriptive fields attached to lab results so matching them to enrolled patients will likely be a challenge. Matching will be accomplished using a probabilistic model in which an algorithm will be applied to determine the probability that the intended patient is the actual patient. The question is whether to rethink the matching approach.

Amy Zimmerman noted that before any data moves into currentcare, the identity of the patient must be matched with that patient's enrollment/consent profile. Since the data on a first time transmission will be lost if no match is obtained, the "first time match" problem appears to be the biggest challenge. Some strategies have been discussed to perform manual disambiguation for failed matches. Have worked with the DSPs to explore strategies to improve the first time match rate, however, any approach will require some additional level of effort.

Judy Wright suggested that insurer eligibility database may be able to provide an insurer ID number that, if incorporated into the matching algorithm, may improve matching. Dr. Priebe asked what the general sense for what the expected match rate would be if the minimum data set were used. Jim Feeney added that his experience with EMRs is an 80-85% match rate. Dave Hemendinger added that the actual match rate may not be improved by additional data elements. Lifespan's match rate is also around 85% using up to 20 elements.

Ms. Zimmerman added that additional approaches are being explored to pre-test the algorithm prior to data flow. Unfortunately, there are not many comparable data sets available to test.

Dr. Priebe polled the group as to their advice. Chuck Jones noted that the false positives are also a question and a concern. It was further noted that there is a balance with how the matching threshold is set versus the rate of false negatives.

Don Nokes asked about use of the unique system identifier; it was noted that this number is created and stored by currentcare and is intended to be incorporated into contributing systems and EHRs over time.

Additional updates on the status of this issue will be provided over time.

6. Recap Next Steps and Adjourn

Dr. Priebe adjourned the meeting at 9:00 a.m.